TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 139 entitled "An act relating to pharmacy benefit managers and hospital observation status" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Pharmacy Benefit Managers * * *

Sec. 1. 18 V.S.A. § 9471 is amended to read:

§ 9471. DEFINITIONS

As used in this subchapter:

* * *

(6) "Maximum allowable cost" means the per unit drug product reimbursement amount, excluding dispensing fees, for a group of equivalent multisource generic prescription drugs.

Sec. 2. 18 V.S.A. § 9473 is amended to read:

§ 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO PHARMACIES

* * *

(c) For each drug for which a pharmacy benefit manager establishes a maximum allowable cost in order to determine the reimbursement rate, the pharmacy benefit manager shall do all of the following:

(1) Make available, in a format that is readily accessible and understandable by a pharmacist, the actual maximum allowable cost for each drug and the source used to determine the maximum allowable cost.

(2) Update the maximum allowable cost at least once every seven calendar days. In order to be subject to maximum allowable cost, a drug must be widely available for purchase by all pharmacies in the State, without limitations, from national or regional wholesalers and must not be obsolete or temporarily unavailable.

(3) Establish or maintain a reasonable administrative appeals process to allow a dispensing pharmacy provider to contest a listed maximum allowable cost.

(4) Respond in writing to any appealing pharmacy provider within 10 calendar days after receipt of an appeal, provided that a dispensing pharmacy provider shall file any appeal within 10 calendar days from the date its claim for reimbursement is adjudicated.

* * * Notice of Hospital Observation Status * * *

Sec. 3. 18 V.S.A. § 1905 is amended to read:

§ 1905. LICENSE REQUIREMENTS

Upon receipt of an application for license and the license fee, the licensing agency shall issue a license when it determines that the applicant and hospital facilities meet the following minimum standards:

* * *

(22) All hospitals shall provide oral and written notices to each individual that the hospital places in observation status as required by section 1911a of this title.

Sec. 4. 18 V.S.A. § 1911a is added to read:

1911a. NOTICE OF HOSPITAL OBSERVATION STATUS

(a)**(1)** Each hospital shall provide oral and written notice to each ~~individual~~ **Medicare beneficiary** that the hospital places in observation status as soon as possible but no later than 24 hours following such placement, unless the individual is discharged or leaves the hospital before the 24-hour period expires. The written notice shall be a uniform form developed by the Department of Health, in consultation with interested stakeholders, for use in all hospitals.

(2) If a patient is admitted to the hospital as an inpatient before the notice of observation has been provided, and under Medicare rules the

observation services may be billed as part of the inpatient stay, the hospital shall not be required to provide notice of observation status.

(b) Each oral and written notice shall include:

(1) a statement that the individual is under observation as an outpatient and is not admitted to the hospital as an inpatient;

(2) a statement that observation status may affect the individual's Medicare ~~**or private insurance**~~ coverage for hospital services, including medications and pharmaceutical supplies, and for rehabilitative or skilled nursing services at a skilled nursing facility if needed upon discharge from the hospital; and

(3) a statement that the individual may contact ~~**his or her health insurance provider,**~~ the Office of the Health Care Advocate~~,~~ or the Vermont State Health Insurance Assistance Program to understand better the implications of placement in observation status.

(c) Each written notice shall include the name and title of the hospital representative who gave oral notice; the date and time oral and written notice were provided; the means by which written notice was provided, if not provided in person; and contact information for the Office of the Health Care Advocate and the Vermont State Health Insurance Assistance Program.

(d) Oral and written notice shall be provided in a manner that is understandable by the individual placed in observation status or by his or her **representative or** legal guardian ~~**or authorized representative**~~.

(e) The hospital representative who provided the written notice shall request a signature and date from the individual or, if applicable, his or her **representative or** legal guardian ~~**or authorized representative**~~, to verify receipt of the notice. If a signature and date were not obtained, the hospital representative shall document the reason.

Sec. 4a. NOTICE OF OBSERVATION STATUS FOR PATIENTS WITH COMMERCIAL INSURANCE

The General Assembly requests that the Vermont Association of Hospitals and Health Systems and the Office of the Health Care Advocate consider the appropriate notice of hospital observation status that patients with commercial insurance should receive and the circumstances under which such notice should be provided. The General Assembly requests that the Vermont Association of Hospitals and Health Systems and the Office of the Health Care Advocate provide their findings and recommendations to the House Committee on Health Care and the Senate Committee on Health and Welfare on or before January 15, 2015.

* * * Reports * * *

Sec. 5. VERMONT HEALTH CARE INNOVATION PROJECT; UPDATES

The Project Director of the Vermont Health Care Innovation Project (VHCIP) shall provide an update at least quarterly to the House Committees on Health Care and on Ways and Means, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee regarding VHCIP implementation and the use of the federal State Innovation Model (SIM) grant funds. The Project Director's update shall include information regarding:

(1) the VHCIP pilot projects and other initiatives undertaken using SIM grant funds, including a description of the projects and initiatives, the timing of their implementation, the results achieved, and the replicability of the results;

(2) how the VHCIP projects and initiatives fit with other payment and delivery system reforms planned or implemented in Vermont;

(3) how the VHCIP projects and initiatives meet the goals of improving health care access and quality and reducing costs;

(4) how the VHCIP projects and initiatives will reduce administrative costs;

(5) how the VHCIP projects and initiatives compare to the principles expressed in 2011 Acts and Resolves No. 48;

(6) what will happen to the VHCIP projects and initiatives when the SIM grant funds are no longer available; and

(7) how to protect the State's interest in any health information technology and security functions, processes, or other intellectual property developed through the VHCIP.

Sec. 6. REDUCING DUPLICATION OF SERVICES; REPORT

(a) The Agency of Human Services shall evaluate the services offered by each entity licensed, administered, or funded by the State, including the designated agencies, to provide services to individuals receiving home- and community-based long-term care services or who have developmental disabilities, mental health needs, or substance use disorder. The Agency shall determine areas in which there are gaps in services and areas in which programs or services are inconsistent with the Health Resource Allocation Plan or are overlapping, duplicative, or otherwise not delivered in the most efficient, cost-effective, and high-quality manner and shall develop recommendations for consolidation or other modification to maximize high-quality services, efficiency, service integration, and appropriate use of public funds.

(b) On or before January 15, 2016, the Agency shall report its findings and recommendations to the House Committee on Human Services and the Senate Committee on Health and Welfare.

* * * Strengthening Affordability and Access to Health Care * * *

Sec. 7. 33 V.S.A. § 1812(b) is amended to read:

(b)(1) An individual or family with income at or below 300 percent of the federal poverty guideline shall be eligible for cost-sharing assistance, including a reduction in the out-of-pocket maximums established under Section 1402 of the Affordable Care Act.

(2) The Department of Vermont Health Access shall establish cost-sharing assistance on a sliding scale based on modified adjusted gross income for the individuals and families described in subdivision (1) of this subsection. Cost-sharing assistance shall be established as follows:

(A) for households with income at or below 150 percent of the federal poverty level (FPL): 94 percent actuarial value;

(B) for households with income above 150 percent FPL and at or below 200 percent FPL: 87 percent actuarial value;

(C) for households with income above 200 percent FPL and at or below 250 percent FPL: ~~77~~ 83 percent actuarial value;

(D) for households with income above 250 percent FPL and at or below 300 percent FPL: ~~73~~ 79 percent actuarial value.

(3) Cost-sharing assistance shall be available for the same qualified health benefit plans for which federal cost-sharing assistance is available and

administered using the same methods as set forth in Section 1402 of the Affordable Care Act.

Sec. 8. COST-SHARING SUBSIDY; APPROPRIATION

(a) Increasing the cost-sharing subsidies available to Vermont residents will not only make it easier for people with incomes below 300 percent of the federal poverty level to access health care services, but it may encourage some residents without insurance to enroll for coverage if they know they will be able to afford to use it.

(b) The sum of $761,308.00 is appropriated from the General Fund to the Department of Vermont Health Access in fiscal year 2016 for the Exchange cost-sharing subsidies for individuals at the actuarial levels in effect on January 1, 2015.

(c) The sum of $2,000,000.00 is appropriated from the General Fund to the Department of Vermont Health Access in fiscal year 2016 to increase Exchange cost-sharing subsidies beginning on January 1, 2016 to provide coverage at an 83 percent actuarial value for individuals with incomes between 200 and 250 percent of the federal poverty level and at a 79 percent actuarial value for individuals with incomes between 250 and 300 percent of the federal poverty level.

* * * Strengthening Primary Care * * *

Sec. 9. INVESTING IN PRIMARY CARE SERVICES

The sum of $7,000,000.00 in Global Commitment funds is appropriated to the Department of Vermont Health Access in fiscal year 2016 to increase reimbursement rates for primary care providers for services provided to Medicaid beneficiaries.

Sec. 10. BLUEPRINT FOR HEALTH INCREASES

(a) The sum of $4,310,826.00 in Global Commitment funds is appropriated to the Department of Vermont Health Access in fiscal year 2016 to increase payments to patient-centered medical homes and community health teams **pursuant to 18 V.S.A. § 702**.

(b) ~~**Beginning on July 1, 2015, the Department of Vermont Health Access shall:**~~

~~**(1) increase payments to the Blueprint for Health community health teams under 18 V.S.A. § 705 by $1,171,802.00 in Global Commitment funds; and**~~

~~**(2) increase payments to patient-centered medical homes under 18 V.S.A. § 704 by $3,639,024.00 in Global Commitment funds.**~~

~~**(c)**~~ In its use of the funds appropriated in this section, the Blueprint for Health shall work collaboratively to begin including family-centered approaches and adverse childhood experience screenings consistent with the

report entitled "Integrating ACE-Informed Practice into the Blueprint for Health." Considerations should include prevention, early identification, and screening, as well as reducing the impact of adverse childhood experiences through trauma-informed treatment and suicide prevention initiatives.

Sec. 11. AREA HEALTH EDUCATION CENTERS

The sum of $700,000.00 in Global Commitment funds is appropriated to the Department of Health in fiscal year 2016 for a grant to the Area Health Education Centers for repayment of educational loans for health care providers and health care educators.

* * * Investing in Structural Reform for Long-Term Savings * * *

Sec. 12. GREEN MOUNTAIN CARE BOARD; ALL-PAYER WAIVER; RATE-SETTING

(a) The sum of $862,767.00 is appropriated to the Green Mountain Care Board in fiscal year 2016, of which $184,636.00 comes from the General Fund, $224,774.00 is in Global Commitment funds, $393,357.00 comes from the Board's bill-back authority pursuant to 18 V.S.A. § 9374(h), and $60,000.00 comes from the Health IT-Fund.

(b) Of the funds appropriated pursuant to this section, the Board shall use:

(1) $502,767.00 for positions and operating expenses related to the Board's provider rate-setting authority, the all-payer model, and the Medicaid cost shift;

(2) $300,000.00 for contracts and third-party services related to the all-payer model, provider rate-setting, and the Medicaid cost shift; and

(3) $60,000.00 to provide oversight of the budget and activities of the Vermont Information Technology Leaders, Inc.

Sec. 13. GREEN MOUNTAIN CARE BOARD; POSITIONS

(a) On July 1, 2015, two classified positions are created for the Green Mountain Care Board.

(b) On July 1, 2015, one exempt position, attorney, is created for the Green Mountain Care Board.

* * * Consumer Information, Assistance, and Representation * * *

Sec. 14. OFFICE OF THE HEALTH CARE ADVOCATE; APPROPRIATION; INTENT

(a) The Office of the Health Care Advocate has a critical function in the Vermont's health care system. The Health Care Advocate provides information and assistance to Vermont residents who are navigating the health care system and represents their interests in interactions with health insurers, health care providers, Medicaid, the Green Mountain Care Board, the General Assembly, and others. The continuation of the Office of the Health Care Advocate is necessary to achieve additional health care reform goals.

(b) The sum of $40,000.00 is appropriated from the General Fund to the Agency of Administration in fiscal year 2016 for its contract with the Office of the Health Care Advocate.

(c) It is the intent of the General Assembly that, beginning with the 2017 fiscal year budget, the Governor's budget proposal developed pursuant to 32 V.S.A. chapter 5 should include a separate provision identifying the aggregate sum to be appropriated from all State sources to the Office of the Health Care Advocate.

Sec. 15. CONSUMER INFORMATION AND PRICE TRANSPARENCY

The Green Mountain Care Board shall evaluate potential models for providing consumers with information about the cost and quality of health care services available across the State, including a consideration of the models used in Maine, Massachusetts, and New Hampshire, as well as any platforms developed and implemented by health insurers doing business in this State. On or before October 1, 2015, the Board shall report its findings and a proposal for a robust Internet-based consumer health care information system to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee.

* * * Universal Primary Care * * *

Sec. 16. PURPOSE

The purpose of Secs. 16 through 20 of this act is to establish the administrative framework and reduce financial barriers as preliminary steps to the implementation of the principles set forth in 2011 Acts and Resolves No. 48 to enable Vermonters to receive necessary health care and examine the cost of providing primary care to all Vermonters without deductibles, coinsurance, or co-payments or, if necessary, with limited cost-sharing.

Sec. 17. [Deleted.]

Sec. 18. DEFINITION OF PRIMARY CARE

As used in Secs. 16 through 20 of this act, "primary care" means health services provided by health care professionals who are specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and includes pediatrics, internal and family medicine, gynecology, primary mental health services, and other health services commonly provided at federally qualified health centers. Primary care does not include dental services.

Sec. 19. COST ESTIMATES FOR UNIVERSAL PRIMARY CARE

(a) On or before October 15, 2015, the Joint Fiscal Office, in consultation with the Green Mountain Care Board and the Secretary of Administration or

designee, shall provide to the Joint Fiscal Committee, the Health Reform Oversight Committee, the House Committees on Appropriations, on Health Care, and on Ways and Means, and the Senate Committees on Appropriations, on Health and Welfare, and on Finance an estimate of the costs of providing primary care to all Vermont residents, with and without cost-sharing by the patient, beginning on January 1, 2017.

(b) The report shall include an estimate of the cost of primary care to those Vermonters who access it if a universal primary care plan is not implemented, and the sources of funding for that care, including employer-sponsored and individual private insurance, Medicaid, Medicare, and other government-sponsored programs, and patient cost-sharing such as deductibles, coinsurance, and co-payments.

(c) Departments and agencies of State government and the Green Mountain Care Board shall provide such data to the Joint Fiscal Office as needed to permit the Joint Fiscal Office to perform the estimates and analysis required by this section. If necessary, the Joint Fiscal Office may enter into confidentiality agreements with departments, agencies, and the Board to ensure that confidential information provided to the Office is not further disclosed.

Sec. 20. APPROPRIATION

Up to $200,000.00 is appropriated from the General Fund to the Joint Fiscal Office in fiscal year 2016 to be used for assistance in the calculation of the cost

estimates required in Sec. 19 of this act; provided, however, that the appropriation shall be reduced by the amount of any external funds received by the Office to carry out the estimates and analysis required by Sec. 19.

* * * Green Mountain Care Board * * *

Sec. 21. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

* * *

(2)(A) Review and approve Vermont's statewide Health Information Technology Plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the State to achieve the principles expressed in section 9371 of this title. Vermont Information Technology Leaders, Inc. shall be an interested party in the Board's review.

(B) Review and approve the criteria required for health care providers and health care facilities to create or maintain connectivity to the State's health information exchange as set forth in section 9352 of this title. Within 90 days following this approval, the Board shall issue an order explaining its decision.

(C) Annually review and approve the budget, consistent with available funds, and the core activities associated with public funding, of the Vermont Information Technology Leaders, Inc., which shall include establishing the interconnectivity of electronic medical records held by health

care professionals, and the storage, management, and exchange of data received from such health care professionals, for the purpose of improving the quality of and efficiently providing health care to Vermonters. This review shall take into account the Vermont Information Technology Leaders' responsibilities in section 9352 of this title and shall be conducted according to a process established by the Board by rule pursuant to 3 V.S.A. chapter 25.

* * *

* * * Vermont Information Technology Leaders * * *

Sec. 22. 18 V.S.A. § 9352 is amended to read:

§ 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

(a)(1) Governance. The ~~General Assembly and the Governor shall each appoint one representative to the~~ Vermont Information Technology Leaders, Inc. (VITL) Board of Directors shall consist of no fewer than nine nor more than 14 members. The term of each member shall be two years, except that of the members first appointed, approximately one-half shall serve a term of one year and approximately one-half shall serve a term of two years, and members shall continue to hold office until their successors have been duly appointed. The Board of Directors shall comprise the following:

(A) one member of the General Assembly, appointed jointly by the Speaker of the House and the President Pro Tempore of the Senate, who shall be entitled to the same per diem compensation and expense reimbursement

pursuant to 2 V.S.A. § 406 as provided for attendance at sessions of the General Assembly;

(B) one individual appointed by the Governor;

(C) one representative of the business community;

(D) one representative of health care consumers;

(E) one representative of Vermont hospitals;

(F) one representative of Vermont physicians;

(G) one practicing clinician licensed to practice medicine in Vermont;

(H) one representative of a health insurer licensed to do business in Vermont;

(I) the President of VITL, who shall be an ex officio, nonvoting member;

(J) two individuals familiar with health information technology, at least one of whom shall be the chief technology officer for a health care provider; and

(K) two at-large members.

(2) Except for the members appointed pursuant to subdivisions (1)(A) and (B) of this subsection, whenever a vacancy on the Board occurs, the members of the Board of Directors then serving shall appoint a new member who shall meet the same criteria as the member he or she replaces.

(b) Conflict of interest. In carrying out their responsibilities under this section, Directors of VITL shall be subject to conflict of interest policies established by the Secretary of Administration to ensure that deliberations and decisions are fair and equitable.

(c)(1) Health information exchange operation. VITL shall be designated in the Health Information Technology Plan pursuant to section 9351 of this title to operate the exclusive statewide health information exchange network for this State. ~~The~~ After the Green Mountain Care Board approves VITL's core activities and budget pursuant to chapter 220 of this title, the Secretary of Administration or designee shall enter into procurement grant agreements with VITL pursuant to 8 V.S.A. § 4089k. Nothing in this chapter shall impede local community providers from the exchange of electronic medical data.

(2) Notwithstanding any provision of 3 V.S.A. § 2222 or 2283b to the contrary, upon request of the Secretary of Administration, the Department of Information and Innovation shall review VITL's technology for security, privacy, and interoperability with State government information technology, consistent with the State's health information technology plan required by section 9351 of this title.

* * *

* * * Referral Registry * * *

Sec. 23. REFERRAL REGISTRY

On or before October 1, 2015, the Department of Mental Health and the Division of Alcohol and Drug Abuse Programs in the Department of Health shall develop jointly a registry of mental health and addiction services providers in Vermont, organized by county. The registry shall be updated at least annually and shall be made available to primary care providers participating in the Blueprint for Health and to the public.

* * * Ambulance Reimbursement * * *

Sec. 24. MEDICAID; AMBULANCE REIMBURSEMENT

The Department of Vermont Health Access shall evaluate the methodology used to determine reimbursement amounts for ambulance and emergency medical services delivered to Medicaid beneficiaries to determine the basis for the current reimbursement amounts and the rationale for the current level of reimbursement, and shall consider any possible adjustments to revise the methodology in a way that is budget neutral or of minimal fiscal impact to the Agency of Human Services for fiscal year 2016. On or before December 1, 2015, the Department shall report its findings and recommendations to the House Committees on Health Care and on Human Services, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee.

* * * Direct Enrollment for Individuals * * *

Sec. 25. 33 V.S.A. § 1803(b)(4) is amended to read:

(4) To the extent permitted by the U.S. Department of Health and Human Services, the Vermont Health Benefit Exchange shall permit qualified individuals and qualified employers to purchase qualified health benefit plans through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

Sec. 26. 33 V.S.A. § 1811(b) is amended to read:

(b)(1) ~~No person may provide a health benefit plan to an individual unless the plan is offered through the Vermont Health Benefit Exchange~~ To the extent permitted by the U.S. Department of Health and Human Services, an individual may purchase a health benefit plan through the Exchange website, through navigators, by telephone, or directly from a registered carrier under contract with the Vermont Health Benefit Exchange, if the carrier elects to make direct enrollment available. A registered carrier enrolling individuals in health benefit plans directly shall comply with all open enrollment and special enrollment periods applicable to the Vermont Health Benefit Exchange.

(2) To the extent permitted by the U.S. Department of Health and Human Services, a small employer or an employee of a small employer may purchase a health benefit plan through the Exchange website, through

navigators, by telephone, or directly from a ~~health insurer~~ registered carrier under contract with the Vermont Health Benefit Exchange.

(3) No person may provide a health benefit plan to an individual or small employer unless the plan complies with the provisions of this subchapter.

* * * Extension of Presuit Mediation * * *

Sec. 27. 12 V.S.A. chapter 215, subchapter 2 is added to read:

Subchapter 2. Mediation Prior to Filing a Complaint of Malpractice

§ 7011. PURPOSE

The purpose of mediation prior to filing a medical malpractice case is to identify and resolve meritorious claims and reduce areas of dispute prior to litigation, which will reduce the litigation costs, reduce the time necessary to resolve claims, provide fair compensation for meritorious claims, and reduce malpractice-related costs throughout the system.

§ 7012. PRESUIT MEDIATION; SERVICE

(a) A potential plaintiff may serve upon each known potential defendant a request to participate in presuit mediation prior to filing a civil action in tort or in contract alleging that an injury or death resulted from the negligence of a health care provider and to recover damages resulting from the personal injury or wrongful death.

(b) Service of the request required in subsection (a) of this section shall be in letter form and shall be served on all known potential defendants by certified

mail. The date of mailing such request shall toll all applicable statutes of limitations.

(c) The request to participate in presuit mediation shall name all known potential defendants, contain a brief statement of the facts that the potential plaintiff believes are grounds for relief, and be accompanied by a certificate of merit prepared pursuant to section 1051 of this title, and may include other documents or information supporting the potential plaintiff's claim.

(d) Nothing in this chapter precludes potential plaintiffs and defendants from presuit negotiation or other presuit dispute resolution to settle potential claims.

§ 7013. MEDIATION RESPONSE

(a) Within 60 days of service of the request to participate in presuit mediation, each potential defendant shall accept or reject the potential plaintiff's request for presuit mediation by mailing a certified letter to counsel or if the party is unrepresented to the potential plaintiff.

(b) If the potential defendant agrees to participate, within 60 days of the service of the request to participate in presuit mediation, each potential defendant shall serve a responsive certificate on the potential plaintiff by mailing a certified letter indicating that he or she, or his or her counsel, has consulted with a qualified expert within the meaning of section 1643 of this title and that expert is of the opinion that there are reasonable grounds to

defend the potential plaintiff's claims of medical negligence. Notwithstanding the potential defendant's acceptance of the request to participate, if the potential defendant does not serve such a responsive certificate within the 60-day period, then the potential plaintiff need not participate in the presuit mediation under this title and may file suit. If the potential defendant is willing to participate, presuit mediation may take place without a responsive certificate of merit from the potential defendant at the plaintiff's election.

§ 7014. PROCESS; TIME FRAMES

(a) The mediation shall take place within 60 days of the service of all potential defendants' acceptance of the request to participate in presuit mediation. The parties may agree to an extension of time. If in good faith the mediation cannot be scheduled within the 60-day time period, the potential plaintiff need not participate and may proceed to file suit.

(b) If presuit mediation is not agreed to, the mediator certifies that mediation is not appropriate, or mediation is unsuccessful, the potential plaintiff may initiate a civil action as provided in the Vermont Rules of Civil Procedure. The action shall be filed upon the later of the following:

(1) within 90 days of the potential plaintiff's receipt of the potential defendant's letter refusing mediation, the failure of the potential defendant to file a responsive certificate of merit within the specified time period, or the

mediator's signed letter certifying that mediation was not appropriate or that the process was complete; or

(2) prior to the expiration of the applicable statute of limitations.

(c) If presuit mediation is attempted unsuccessfully, the parties shall not be required to participate in mandatory mediation under Rule 16.3 of the Vermont Rules of Civil Procedure.

§ 7015. CONFIDENTIALITY

All written and oral communications made in connection with or during the mediation process set forth in this chapter shall be confidential. The mediation process shall be treated as a settlement negotiation under Rule 408 of the Vermont Rules of Evidence.

* * * Blueprint for Health; Reports * * *

Sec. 28. BLUEPRINT FOR HEALTH; REPORTS

(a) The 2016 annual report of the Blueprint for Health shall present an analysis of the value-added benefits and return on investment to the Medicaid program of the new funds appropriated in the fiscal year 2016 budget, including the identification of any costs avoided that can be directly attributed to those funds, and the means of the analysis that was used to draw any such conclusions.

(b) The Blueprint for Health shall explore and report back to the General Assembly on or before January 15, 2016 on potential wellness incentives.

* * * Green Mountain Care Board; Payment Reform * * *

Sec. 29. PAYMENT REFORM AND DIFFERENTIAL PAYMENTS TO PROVIDERS

In implementing an all-payer model and provider rate-setting, the Green Mountain Care Board shall consider:

(1) the benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service models;

(2) the impact of hospital acquisitions of independent physician practices on the health care system costs, including any disparities between reimbursements to hospital-owned practices and reimbursements to independent physician practices; and

(3) the effects of differential reimbursement for different types of providers when providing the same services billed under the same codes.

* * * Federally Supported State-Based Marketplace * * *

Sec. 30. VERMONT HEALTH CONNECT OUTCOMES; JOINT FISCAL COMMITTEE [*placeholder for language under development*]

* * * Repeal * * *

Sec. 31. REPEAL

12 V.S.A. chapter 215, subchapter 2 (presuit mediation) is repealed on July 1, 2018.

* * * Effective Dates * * *

Sec. 32. EFFECTIVE DATES

(a) Secs. 1 and 2 (pharmacy benefit managers), **4a (report on observation status),** 5 and 6 (reports), 15 (consumer information), 21 (Green Mountain Care Board duties), 22 (VITL), 23 (referral registry), 24 (ambulance reimbursement), 27 (extension of presuit mediation), 28 (Blueprint for Health; reports), 29 (Green Mountain Care Board; payment reform), 30 (federally supported State-based marketplace), 31 (repeal), and this section shall take effect on passage.

(b) Secs. 7 and 8 (Exchange cost-sharing subsidies), 9 (primary care provider increases), 10 (Blueprint increases), 11 (AHEC appropriation), 12 (Green Mountain Care Board appropriation), 13 (Green Mountain Care Board positions), 14 (Health Care Advocate), and 16–20 (primary care study) shall take effect on July 1, 2015.

(c) Secs. 25 and 26 (direct enrollment in Exchange plans) shall take effect on July 1, 2015 and shall apply beginning with the 2016 open enrollment period.

(d) Secs. 3 and 4 (notice of hospital observation status) shall take effect on December 1, 2015.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE