

1 TO THE HOUSE OF REPRESENTATIVES:

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

8 * * * Pharmacy Benefit Managers * * *

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

10 § 9471. DEFINITIONS

11 As used in this subchapter:

12 * * *

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

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

17 § 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES

18 WITH RESPECT TO PHARMACIES

19 * * *

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

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

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

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

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

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

3 (b) Each oral and written notice shall include:

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

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

10 (3) a statement that the individual may contact the Office of the Health
11 Care Advocate or the Vermont State Health Insurance Assistance Program to
12 understand better the implications of placement in observation status.

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

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

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

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

8 The General Assembly requests that the Vermont Association of Hospitals
9 and Health Systems and the Office of the Health Care Advocate consider the
10 appropriate notice of hospital observation status that patients with commercial
11 insurance should receive and the circumstances under which such notice
12 should be provided. The General Assembly requests that the Vermont
13 Association of Hospitals and Health Systems and the Office of the Health Care
14 Advocate provide their findings and recommendations to the House Committee
15 on Health Care and the Senate Committee on Health and Welfare on or before
16 January 15, 2016.

17 * * * Reports * * *

18 Sec. 5. VERMONT HEALTH CARE INNOVATION PROJECT; UPDATES

19 The Project Director of the Vermont Health Care Innovation Project
20 (VHCIP) shall provide an update at least quarterly to the House Committees on
21 Health Care and on Ways and Means, the Senate Committees on Health and

1 Welfare and on Finance, and the Health Reform Oversight Committee
2 regarding VHCIP implementation and the use of the federal State Innovation
3 Model (SIM) grant funds. The Project Director's update shall include
4 information regarding:

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

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

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

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

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

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

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

21 **Sec. 6. REDUCING DUPLICATION OF SERVICES; REPORT**

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

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

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

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

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

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

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

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

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

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

13 (3) Cost-sharing assistance shall be available for the same qualified
14 health benefit plans for which federal cost-sharing assistance is available and
15 administered using the same methods as set forth in Section 1402 of the
16 Affordable Care Act.

17 Sec. 8. COST-SHARING SUBSIDY; APPROPRIATION

18 (a) Increasing the cost-sharing subsidies available to Vermont residents
19 will not only make it easier for people with incomes below 300 percent of the
20 federal poverty level to access health care services, but it may encourage some

1 residents without insurance to enroll for coverage if they know they will be
2 able to afford to use it.

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

7 (c) The sum of \$2,000,000.00 is appropriated from the General Fund to the
8 Department of Vermont Health Access in fiscal year 2016 to increase
9 Exchange cost-sharing subsidies beginning on January 1, 2016 to provide
10 coverage at an 83 percent actuarial value for individuals with incomes between
11 200 and 250 percent of the federal poverty level and at a 79 percent actuarial
12 value for individuals with incomes between 250 and 300 percent of the federal
13 poverty level.

14 * * * Strengthening Primary Care * * *

15 Sec. 9. INVESTING IN PRIMARY CARE SERVICES

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

20 Sec. 10. BLUEPRINT FOR HEALTH INCREASES

1 (a) The sum of \$4,085,826.00 in Global Commitment funds is appropriated
2 to the Department of Vermont Health Access in fiscal year 2016 to increase
3 payments to patient-centered medical homes and community health teams
4 pursuant to 18 V.S.A. § 702.

5 (b) In its use of the funds appropriated in this section, the Blueprint for
6 Health shall work collaboratively to begin including family-centered
7 approaches and adverse childhood experience screenings consistent with the
8 report entitled “Integrating ACE-Informed Practice into the Blueprint for
9 Health.” Considerations should include prevention, early identification, and
10 screening, as well as reducing the impact of adverse childhood experiences
11 through trauma-informed treatment and suicide prevention initiatives.

12 Sec. 11. AREA HEALTH EDUCATION CENTERS

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

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

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

20 (a) The sum of \$862,767.00 is appropriated to the Green Mountain Care
21 Board in fiscal year 2016, of which \$184,636.00 comes from the General

1 Fund, \$224,774.00 is in Global Commitment funds, \$393,357.00 comes from
2 the Board’s bill-back authority pursuant to 18 V.S.A. § 9374(h), and
3 \$60,000.00 comes from the Health IT-Fund.

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

5 (1) \$502,767.00 for positions and operating expenses related to the
6 Board’s provider rate-setting authority, the all-payer model, and the Medicaid
7 cost shift;

8 (2) \$300,000.00 for contracts and third-party services related to the
9 all-payer model, provider rate-setting, and the Medicaid cost shift; and

10 (3) \$60,000.00 to provide oversight of the budget and activities of the
11 Vermont Information Technology Leaders, Inc.

12 Sec. 13. GREEN MOUNTAIN CARE BOARD; POSITIONS

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

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

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

18 Sec. 14. OFFICE OF THE HEALTH CARE ADVOCATE;

19 APPROPRIATION; INTENT

20 (a) The Office of the Health Care Advocate has a critical function in the
21 Vermont’s health care system. The Health Care Advocate provides

1 information and assistance to Vermont residents who are navigating the health
2 care system and represents their interests in interactions with health insurers,
3 health care providers, Medicaid, the Green Mountain Care Board, the General
4 Assembly, and others. The continuation of the Office of the Health Care
5 Advocate is necessary to achieve additional health care reform goals.

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

9 (c) It is the intent of the General Assembly that, beginning with the 2017
10 fiscal year budget, the Governor's budget proposal developed pursuant to
11 32 V.S.A. chapter 5 should include a separate provision identifying the
12 aggregate sum to be appropriated from all State sources to the Office of the
13 Health Care Advocate.

14 Sec. 15. CONSUMER INFORMATION AND PRICE TRANSPARENCY

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

1 Committee on Health Care, the Senate Committees on Health and Welfare and
2 on Finance, and the Health Reform Oversight Committee.

3 * * * Universal Primary Care * * *

4 Sec. 16. PURPOSE

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

11 Sec. 17. [Deleted.]

12 Sec. 18. DEFINITION OF PRIMARY CARE

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

21 Sec. 19. COST ESTIMATES FOR UNIVERSAL PRIMARY CARE

1 (a) On or before October 15, 2015, the Joint Fiscal Office, in consultation
2 with the Green Mountain Care Board and the Secretary of Administration or
3 designee, shall provide to the Joint Fiscal Committee, the Health Reform
4 Oversight Committee, the House Committees on Appropriations, on Health
5 Care, and on Ways and Means, and the Senate Committees on Appropriations,
6 on Health and Welfare, and on Finance an estimate of the costs of providing
7 primary care to all Vermont residents, with and without cost-sharing by the
8 patient, beginning on January 1, 2017.

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

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

21 Sec. 20. APPROPRIATION

1 Up to \$200,000.00 is appropriated from the General Fund to the Joint Fiscal
2 Office in fiscal year 2016 to be used for assistance in the calculation of the cost
3 estimates required in Sec. 19 of this act; provided, however, that the
4 appropriation shall be reduced by the amount of any external funds received by
5 the Office to carry out the estimates and analysis required by Sec. 19.

6 * * * Green Mountain Care Board * * *

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

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

9 * * *

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

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

20 (C) Annually review and approve the budget, consistent with
21 available funds, and the core activities associated with public funding, of the

1 Vermont Information Technology Leaders, Inc., which shall include
2 establishing the interconnectivity of electronic medical records held by health
3 care professionals, and the storage, management, and exchange of data
4 received from such health care professionals, for the purpose of improving the
5 quality of and efficiently providing health care to Vermonters. This review
6 shall take into account the Vermont Information Technology Leaders’
7 responsibilities in section 9352 of this title and shall be conducted according to
8 a process established by the Board by rule pursuant to 3 V.S.A. chapter 25.

9 * * *

10 * * * Vermont Information Technology Leaders * * *

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

12 § 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

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

20 The Board of Directors shall comprise the following:

- 1 (A) one member of the General Assembly, appointed jointly by the
2 Speaker of the House and the President Pro Tempore of the Senate, who shall
3 be entitled to the same per diem compensation and expense reimbursement
4 pursuant to 2 V.S.A. § 406 as provided for attendance at sessions of the
5 General Assembly;
- 6 (B) one individual appointed by the Governor;
- 7 (C) one representative of the business community;
- 8 (D) one representative of health care consumers;
- 9 (E) one representative of Vermont hospitals;
- 10 (F) one representative of Vermont physicians;
- 11 (G) one practicing clinician licensed to practice medicine
12 in Vermont;
- 13 (H) one representative of a health insurer licensed to do business
14 in Vermont;
- 15 (I) the President of VITL, who shall be an ex officio, nonvoting
16 member;
- 17 (J) two individuals familiar with health information technology,
18 at least one of whom shall be the chief technology officer for a health care
19 provider; and
- 20 (K) two at-large members.

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

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

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

17 (2) Notwithstanding any provision of 3 V.S.A. § 2222 or 2283b to the
18 contrary, upon request of the Secretary of Administration, the Department of
19 Information and Innovation shall review VITL's technology for security,
20 privacy, and interoperability with State government information technology.

1 consistent with the State's health information technology plan required by
2 section 9351 of this title.

3 * * *

4 * * * Referral Registry * * *

5 Sec. 23. REFERRAL REGISTRY

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

12 * * * Ambulance Reimbursement * * *

13 Sec. 24. MEDICAID; AMBULANCE REIMBURSEMENT

14 The Department of Vermont Health Access shall evaluate the methodology
15 used to determine reimbursement amounts for ambulance and emergency
16 medical services delivered to Medicaid beneficiaries to determine the basis for
17 the current reimbursement amounts and the rationale for the current level of
18 reimbursement, and shall consider any possible adjustments to revise the
19 methodology in a way that is budget neutral or of minimal fiscal impact to the
20 Agency of Human Services for fiscal year 2016. On or before December 1,
21 2015, the Department shall report its findings and recommendations to the

1 House Committees on Health Care and on Human Services, the Senate
2 Committee on Health and Welfare, and the Health Reform Oversight
3 Committee.

4 * * * Direct Enrollment for Individuals * * *

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

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

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

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

1 (2) To the extent permitted by the U.S. Department of Health and
2 Human Services, a small employer or an employee of a small employer may
3 purchase a health benefit plan through the Exchange website, through
4 navigators, by telephone, or directly from a ~~health insurer~~ registered carrier
5 under contract with the Vermont Health Benefit Exchange.

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

8 * * * Extension of Presuit Mediation * * *

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

10 Subchapter 2. Mediation Prior to Filing a Complaint of Malpractice

11 § 7011. PURPOSE

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

17 § 7012. PRESUIT MEDIATION; SERVICE

18 (a) A potential plaintiff may serve upon each known potential defendant a
19 request to participate in presuit mediation prior to filing a civil action in tort or
20 in contract alleging that an injury or death resulted from the negligence of a

1 health care provider and to recover damages resulting from the personal injury
2 or wrongful death.

3 (b) Service of the request required in subsection (a) of this section shall be
4 in letter form and shall be served on all known potential defendants by certified
5 mail. The date of mailing such request shall toll all applicable statutes of
6 limitations.

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

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

15 § 7013. MEDIATION RESPONSE

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

20 (b) If the potential defendant agrees to participate, within 60 days of the
21 service of the request to participate in presuit mediation, each potential

1 defendant shall serve a responsive certificate on the potential plaintiff by
2 mailing a certified letter indicating that he or she, or his or her counsel, has
3 consulted with a qualified expert within the meaning of section 1643 of this
4 title and that expert is of the opinion that there are reasonable grounds to
5 defend the potential plaintiff's claims of medical negligence. Notwithstanding
6 the potential defendant's acceptance of the request to participate, if the
7 potential defendant does not serve such a responsive certificate within the
8 60-day period, then the potential plaintiff need not participate in the presuit
9 mediation under this title and may file suit. If the potential defendant is willing
10 to participate, presuit mediation may take place without a responsive certificate
11 of merit from the potential defendant at the plaintiff's election.

12 § 7014. PROCESS; TIME FRAMES

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

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

1 (1) within 90 days of the potential plaintiff's receipt of the potential
2 defendant's letter refusing mediation, the failure of the potential defendant to
3 file a responsive certificate of merit within the specified time period, or the
4 mediator's signed letter certifying that mediation was not appropriate or that
5 the process was complete; or

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

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

10 § 7015. CONFIDENTIALITY

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

15 * * * Blueprint for Health; Reports * * *

16 Sec. 28. BLUEPRINT FOR HEALTH; REPORTS

17 (a) The 2016 annual report of the Blueprint for Health shall present an
18 analysis of the value-added benefits and return on investment to the Medicaid
19 program of the new funds appropriated in the fiscal year 2016 budget,
20 including the identification of any costs avoided that can be directly attributed

1 to those funds, and the means of the analysis that was used to draw any such
2 conclusions.

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

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

6 Sec. 29. PAYMENT REFORM AND DIFFERENTIAL PAYMENTS TO
7 PROVIDERS

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

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

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

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

18 * * * Cigarette Tax * * *

19 Sec. 30. 32 V.S.A. § 7771 is amended to read:

20 § 7771. RATE OF TAX

21 * * *

1 (d) The tax imposed under this section shall be at the rate of ~~137.5~~ 150
2 mills per cigarette or little cigar and for each 0.0325 ounces of roll-your-own
3 tobacco. The interest and penalty provisions of section 3202 of this title shall
4 apply to liabilities under this section.

5 Sec. 31. 32 V.S.A. § 7814(b) is amended to read:

6 (b) Cigarettes, little cigars, or roll-your-own tobacco. Notwithstanding the
7 prohibition against further tax on stamped cigarettes, little cigars, or
8 roll-your-own tobacco under section 7771 of this title, a floor stock tax is
9 hereby imposed upon every dealer of cigarettes, little cigars, or roll-your-own
10 tobacco in this State who is either a wholesaler, or a retailer who at 12:01 a.m.
11 on July 1, ~~2014~~ 2015, has more than 10,000 cigarettes or little cigars or who
12 has \$500.00 or more of wholesale value of roll-your-own tobacco, for retail
13 sale in his or her possession or control. The amount of the tax shall be the
14 amount by which the new tax exceeds the amount of the tax already paid for
15 each cigarette, little cigar, or roll-your-own tobacco in the possession or
16 control of the wholesaler or retail dealer at 12:01 a.m. on July 1, ~~2014~~ 2015,
17 and on which cigarette stamps have been affixed before July 1, ~~2014~~ 2015.
18 A floor stock tax is also imposed on each Vermont cigarette stamp in the
19 possession or control of the wholesaler at 12:01 a.m. on July 1, ~~2014~~ 2015, and
20 not yet affixed to a cigarette package, and the tax shall be at the rate of ~~\$0.13~~
21 \$0.25 per stamp. Each wholesaler and retail dealer subject to the tax shall, on

1 or before July 25, ~~2014~~ 2015, file a report to the Commissioner in such form as
2 the Commissioner may prescribe showing the cigarettes, little cigars, or
3 roll-your-own tobacco and stamps on hand at 12:01 a.m. on July 1, ~~2014~~ 2015,
4 and the amount of tax due thereon. The tax imposed by this section shall be
5 due and payable on or before July 25, ~~2014~~ 2015, and thereafter shall bear
6 interest at the rate established under section 3108 of this title. In case of timely
7 payment of the tax, the wholesaler or retail dealer may deduct from the tax due
8 two and three-tenths of one percent of the tax. Any cigarettes, little cigars, or
9 roll-your-own tobacco with respect to which a floor stock tax has been
10 imposed under this section shall not again be subject to tax under section 7771
11 of this title.

12 * * * Repeal * * *

13 Sec. 32. REPEAL

14 12 V.S.A. chapter 215, subchapter 2 (presuit mediation) is repealed on
15 July 1, 2018.

16 * * * Effective Dates * * *

17 Sec. 33. EFFECTIVE DATES

18 (a) Secs. 1 and 2 (pharmacy benefit managers), 4a (report on observation
19 status), 5 and 6 (reports), 15 (consumer information), 21 (Green Mountain
20 Care Board duties), 22 (VITL), 23 (referral registry), 24 (ambulance
21 reimbursement), 27 (extension of presuit mediation), 28 (Blueprint for Health;

1 reports), 29 (Green Mountain Care Board; payment reform), 32 (repeal), and
2 this section shall take effect on passage.

3 (b) Secs. 7 and 8 (Exchange cost-sharing subsidies), 9 (primary care
4 provider increases), 10 (Blueprint increases), 11 (AHEC appropriation), 12
5 (Green Mountain Care Board appropriation), 13 (Green Mountain Care Board
6 positions), 14 (Health Care Advocate), 16–20 (primary care study), 30
7 (cigarette tax), and 31 (floor stock tax) shall take effect on July 1, 2015.

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

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

13

14

15

16

17 (Committee vote: _____)

18

19

Representative _____

20

FOR THE COMMITTEE