

1 TO THE HONORABLE SENATE:

2 Senator Kitchel moves that the Senate concur in the House Proposal of
3 Amendment with further proposal of amendment by striking out all after the
4 enacting clause and inserting in lieu thereof the following:

5 * * * Cost Containment Measures * * *

6 Sec. 1. ALL-PAYER MODEL; SCOPE

7 The Secretary of Administration or designee and the Green Mountain Care
8 Board shall jointly explore an all-payer model, which may be achieved through
9 a waiver from the Centers for Medicare and Medicaid Services. The Secretary
10 or designee and the Board shall consider a model that includes payment for a
11 broad array of health services, a model applicable to hospitals only, and a
12 model that enables the State to establish global hospital budgets for each
13 hospital licensed in Vermont.

14 * * * Pharmacy Benefit Managers * * *

15 Sec. 2. 18 V.S.A. § 9471 is amended to read:

16 § 9471. DEFINITIONS

17 As used in this subchapter:

18 * * *

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

1 Sec. 3. 18 V.S.A. § 9473 is amended to read:

2 § 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES
3 WITH RESPECT TO PHARMACIES

4 * * *

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

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

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

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

19 (4) Respond in writing to any appealing pharmacy provider within 10
20 calendar days after receipt of an appeal, provided that a dispensing pharmacy

1 provider shall file any appeal within 10 calendar days from the date its claim
2 for reimbursement is adjudicated.

3 * * * Notice of Hospital Observation Status * * *

4 Sec. 4. 18 V.S.A. § 1905 is amended to read:

5 § 1905. LICENSE REQUIREMENTS

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

9 * * *

10 (22) All hospitals shall provide oral and written notices to each
11 individual that the hospital places in observation status as required by section
12 1911a of this title.

13 Sec. 5. 18 V.S.A. § 1911a is added to read:

14 1911a. NOTICE OF HOSPITAL OBSERVATION STATUS

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

1 (2) If a patient is admitted to the hospital as an inpatient before the
2 notice of observation has been provided, and under Medicare rules the
3 observation services may be billed as part of the inpatient stay, the hospital
4 shall not be required to provide notice of observation status.

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

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

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

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

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

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

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

9 Sec. 6. NOTICE OF OBSERVATION STATUS FOR PATIENTS WITH

10 COMMERCIAL INSURANCE

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

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* * * Telemedicine * * *

Sec. 7. 33 V.S.A. § 1901i is added to read:

§ 1901i. MEDICAID COVERAGE FOR PRIMARY CARE

TELEMEDICINE

(a) Beginning on October 1, 2015, the Department of Vermont Health Access shall provide reimbursement for Medicaid-covered primary care consultations delivered through telemedicine to Medicaid beneficiaries outside a health care facility. The Department shall reimburse health care professionals for telemedicine consultations in the same manner as if the services were provided through in-person consultation. Coverage provided pursuant to this section shall comply with all federal requirements imposed by the Centers for Medicare and Medicaid Services.

(b) Medicaid shall only provide coverage for services delivered through telemedicine outside a health care facility that have been determined by the Department's Chief Medical Officer to be clinically appropriate. The Department shall not impose limitations on the number of telemedicine consultations a Medicaid beneficiary may receive or on which Medicaid beneficiaries may receive primary care consultations through telemedicine that exceed limitations otherwise placed on in-person Medicaid covered services.

1 (c) As used in this section:

2 (1) “Health care facility” shall have the same meaning as in 18 V.S.A.
3 § 9402.

4 (2) “Health care provider” means a physician licensed pursuant to
5 26 V.S.A. chapter 23 or 33, a naturopathic physician licensed pursuant to
6 26 V.S.A. chapter 81, an advanced practice registered nurse licensed pursuant
7 to 26 V.S.A. chapter 28, subchapter 3, or a physician assistant licensed
8 pursuant to 26 V.S.A. chapter 31.

9 (3) “Telemedicine” means the delivery of health care services such as
10 diagnosis, consultation, or treatment through the use of live interactive audio
11 and video over a secure connection that complies with the requirements of the
12 Health Insurance Portability and Accountability Act of 1996, Public Law
13 104-191. Telemedicine does not include the use of audio-only telephone, e-
14 mail, or facsimile.

15 Sec. 8. **TELEMEDICINE; IMPLEMENTATION REPORT**

16 On or before April 15, 2016, the Department of Vermont Health Access
17 shall submit to the House Committee on Health Care and the Senate
18 Committees on Health and Welfare and on Finance a report providing data
19 regarding the first six months of implementation of Medicaid coverage for
20 primary care consultations delivered through telemedicine outside a health care
21 facility. The report shall include demographic information regarding Medicaid

1 beneficiaries receiving the telemedicine services, the types of services
2 received, and an analysis of the effects of providing primary care consultations
3 through telemedicine outside a health care facility on health care costs, quality,
4 and access.

5 * * * Green Mountain Care Board; Duties * * *

6 Sec. 9. 18 V.S.A. § 9375(b) is amended to read:

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

8 (1) Oversee the development and implementation, and evaluate the
9 effectiveness, of health care payment and delivery system reforms designed to
10 control the rate of growth in health care costs and maintain health care quality
11 in Vermont, including ensuring that the payment reform pilot projects set forth
12 in this chapter are consistent with such reforms.

13 (A) Implement by rule, pursuant to 3 V.S.A. chapter 25,
14 methodologies for achieving payment reform and containing costs that may
15 include the participation of Medicare and Medicaid, which may include the
16 creation of health care professional cost-containment targets, global payments,
17 bundled payments, global budgets, risk-adjusted capitated payments, or other
18 uniform payment methods and amounts for integrated delivery systems, health
19 care professionals, or other provider arrangements.

1 Within 90 days following this approval, the Board shall issue an order
2 explaining its decision.

3 (C) Annually review the budget and all activities of VITL and
4 approve the budget, consistent with available funds, and the core activities
5 associated with public funding, which shall include establishing the
6 interconnectivity of electronic medical records held by health care
7 professionals and the storage, management, and exchange of data received
8 from such health care professionals, for the purpose of improving the quality of
9 and efficiently providing health care to Vermonters. This review shall take
10 into account VITL's responsibilities pursuant to 18 V.S.A. § 9352 and the
11 availability of funds needed to support those responsibilities.

12 * * *

13 Sec. 10. 18 V.S.A. § 9376(b)(2) is amended to read:

14 (2) Nothing in this subsection shall be construed to:

15 (A) limit the ability of a health care professional to accept less than
16 the rate established in subdivision (1) of this subsection from a patient without
17 health insurance or other coverage for the service or services received; or

18 (B) reduce or limit the covered services offered by Medicare or
19 Medicaid.

1 * * * Vermont Information Technology Leaders * * *

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

3 § 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

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

11 The Board of Directors shall comprise the following:

12 (A) one member of the General Assembly, appointed jointly by the
13 Speaker of the House and the President Pro Tempore of the Senate, who shall
14 be entitled to the same per diem compensation and expense reimbursement
15 pursuant to 2 V.S.A. § 406 as provided for attendance at sessions of the
16 General Assembly;

17 (B) one individual appointed by the Governor;

18 (C) one representative of the business community;

19 (D) one representative of health care consumers;

20 (E) one representative of Vermont hospitals;

21 (F) one representative of Vermont physicians;

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

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

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

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

10 (K) two at-large members.

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

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

19 (c)(1) Health information exchange operation. VITL shall be designated in
20 the Health Information Technology Plan pursuant to section 9351 of this title
21 to operate the exclusive statewide health information exchange network for

1 this State. ~~The~~ After the Green Mountain Care Board approves VITL's core
2 activities and budget pursuant to chapter 220 of this title, the Secretary of
3 Administration or designee shall enter into procurement grant agreements with
4 VITL pursuant to 8 V.S.A. § 4089k. Nothing in this chapter shall impede local
5 community providers from the exchange of electronic medical data.

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

12 * * *

13 (f) Funding authorization. VITL is authorized to seek matching funds to
14 assist with carrying out the purposes of this section. In addition, it may accept
15 any and all donations, gifts, and grants of money, equipment, supplies,
16 materials, and services from the federal or any local government, or any
17 agency thereof, and from any person, firm, foundation, or corporation for any
18 of its purposes and functions under this section and may receive and use the
19 same, subject to the terms, conditions, and regulations governing such
20 donations, gifts, and grants. VITL shall not use any State funds for health care
21 consumer advertising, marketing, lobbying, or similar services.

1 Sec. 14. 33 V.S.A. § 1811(b) is amended to read:

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

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

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

18 * * * Large Group Insurance Market * * *

19 Sec. 15. 33 V.S.A. § 1802 is amended to read:

20 § 1802. DEFINITIONS

21 As used in this subchapter:

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(5) “Qualified employer”:

(A) means an entity which employed an average of not more than 50 employees on working days during the preceding calendar year and which:

(i) has its principal place of business in this State and elects to provide coverage for its eligible employees through the Vermont Health Benefit Exchange, regardless of where an employee resides; or

(ii) elects to provide coverage through the Vermont Health Benefit Exchange for all of its eligible employees who are principally employed in this State.

(B) on and after January 1, 2016, shall include an entity which:

(i) employed an average of not more than 100 employees on working days during the preceding calendar year; and

(ii) meets the requirements of subdivisions (A)(i) and (A)(ii) of this subdivision (5).

(C) on and after January 1, ~~2017~~ 2018, shall include all employers meeting the requirements of subdivisions (A)(i) and (ii) of this subdivision (5), regardless of size.

* * *

1 Sec. 16. 33 V.S.A. § 1804(c) is amended to read:

2 (c) On and after January 1, ~~2017~~ 2018, a qualified employer shall be an
3 employer of any size which elects to make all of its full-time employees
4 eligible for one or more qualified health plans offered in the Vermont Health
5 Benefit Exchange, and the term “qualified employer” includes self-employed
6 persons. A full-time employee shall be an employee who works more than 30
7 hours per week.

8 Sec. 17. LARGE GROUP MARKET; IMPACT ANALYSIS

9 The Green Mountain Care Board, in consultation with the Department of
10 Financial Regulation, shall analyze the projected impact on rates in the large
11 group health insurance market if large employers are permitted to purchase
12 qualified health plans through the Vermont Health Benefit Exchange beginning
13 in 2018. The analysis shall estimate the impact on premiums for employees in
14 the large group market if the market were to transition from experience rating
15 to community rating beginning with the 2018 plan year.

16 * * * Universal Primary Care * * *

17 Sec. 18. PURPOSE

18 The purpose of Secs. 18 through 21 of this act is to establish the
19 administrative framework and reduce financial barriers as preliminary steps to
20 the implementation of the principles set forth in 2011 Acts and Resolves
21 No. 48 to enable Vermonters to receive necessary health care and examine the

1 cost of providing primary care to all Vermonters without deductibles,
2 coinsurance, or co-payments or, if necessary, with limited cost-sharing.

3 Sec. 19. DEFINITION OF PRIMARY CARE

4 As used in Secs. 18 through 21 of this act, “primary care” means health
5 services provided by health care professionals who are specifically trained for
6 and skilled in first-contact and continuing care for individuals with signs,
7 symptoms, or health concerns, not limited by problem origin, organ system, or
8 diagnosis, and includes pediatrics, internal and family medicine, gynecology,
9 primary mental health services, and other health services commonly provided
10 at federally qualified health centers. Primary care does not include dental
11 services.

12 Sec. 20. COST ESTIMATES FOR UNIVERSAL PRIMARY CARE

13 (a) On or before October 15, 2015, the Secretary of Administration or
14 designee, in consultation with the Green Mountain Care Board and the Joint
15 Fiscal Office, shall provide to the Joint Fiscal Office a draft estimate of the
16 costs of providing primary care to all Vermont residents, with and without
17 cost-sharing by the patient, beginning on January 1, 2017. The Joint Fiscal
18 Office shall conduct an independent review of the draft estimate and shall
19 provide its comments and feedback to the Secretary or designee on or before
20 December 2, 2015. On or before December 16, 2015, the Secretary of
21 Administration or designee shall provide to the Joint Fiscal Committee, the

1 Health Reform Oversight Committee, the House Committees on
2 Appropriations, on Health Care, and on Ways and Means, and the Senate
3 Committees on Appropriations, on Health and Welfare, and on Finance a
4 finalized report of the costs of providing primary care to all Vermont residents,
5 with and without cost-sharing by the patient, beginning on January 1, 2017.
6 The Joint Fiscal Office shall present its independent review to the same
7 committees by January 6, 2016.

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

14 (c) The Secretary of Administration or designee, in collaboration with the
15 Joint Fiscal Office, shall arrange for the actuarial services needed to perform
16 the estimates and analysis required by this section. Departments and agencies
17 of State government and the Green Mountain Care Board shall provide such
18 data to the Joint Fiscal Office as needed to permit the Joint Fiscal Office to
19 perform the estimates and analysis. If necessary, the Joint Fiscal Office may
20 enter into confidentiality agreements with departments, agencies, and the

1 Board to ensure that confidential information provided to the Office is not
2 further disclosed.

3 Sec. 21. APPROPRIATION

4 Up to \$100,000.00 is appropriated from the General Fund to the Agency of
5 Administration, Secretary's Office in fiscal year 2016 to be used for assistance
6 in the calculation of the cost estimates required in Sec. 20 of this act; provided,
7 however, that the appropriation shall be reduced by the amount of any external
8 funds received to carry out the estimates and analysis required by Sec. 20.

9 * * * Consumer Information * * *

10 Sec. 22. 18 V.S.A. § 9413 is added to read:

11 § 9413. HEALTH CARE QUALITY AND PRICE COMPARISON

12 Each health insurer with more than 200 covered lives in this State shall
13 establish an Internet-based tool to enable its members to compare the price of
14 medical care in Vermont by service or procedure, including office visits,
15 emergency care, radiologic services, and preventive care such as
16 mammography and colonoscopy. The tool shall include provider quality
17 information as available and to the extent consistent with other applicable laws
18 and regulations. The tool shall allow members to compare price by selecting a
19 specific service or procedure and a geographic region of the State. Based on
20 the criteria specified, the tool shall provide the member with an estimate for
21 each provider of the amount the member would pay for the service or

1 procedure, an estimate of the amount the insurance plan would pay, and an
2 estimate of the combined payments. The price information shall reflect the
3 cost-sharing applicable to a member's specific plan, as well as any remaining
4 balance on the member's deductible for the plan year.

5 * * * Public Employees' Health Benefits * * *

6 Sec. 23. PUBLIC EMPLOYEES' HEALTH BENEFITS; REPORT

7 (a) The Director of Health Care Reform in the Agency of Administration
8 shall identify options and considerations for providing health care coverage to
9 all public employees, including State and judiciary employees, school
10 employees, municipal employees, and State and teacher retirees, in a
11 cost-effective manner that will not trigger the excise tax on high-cost,
12 employer-sponsored health insurance plans imposed pursuant to 26 U.S.C.
13 § 4980I. One of the options to be considered shall be an intermunicipal
14 insurance agreement, as described in 24 V.S.A. chapter 121, subchapter 6.

15 (b) The Director shall consult with representatives of the Vermont-NEA,
16 the Vermont School Boards Association, the Vermont Education Health
17 Initiative, the Vermont State Employees' Association, the Vermont Troopers
18 Association, the Vermont League of Cities and Towns, the Department of
19 Human Resources, the Office of the Treasurer, and the Joint Fiscal Office.

20 (c) On or before November 1, 2015, the Director shall report his or her
21 findings and recommendations to the House Committees on Appropriations, on

1 Education, on General, Housing, and Military Affairs, on Government
2 Operations, on Health Care, and on Ways and Means; the Senate Committees
3 on Appropriations, on Education, on Economic Development, Housing, and
4 General Affairs, on Government Operations, on Health and Welfare, and on
5 Finance; and the Health Reform Oversight Committee.

6 * * * Provider Payment Parity * * *

7 Sec. 24. PAYMENT REFORM AND DIFFERENTIAL REIMBURSEMENT
8 TO PROVIDERS

9 (a) In implementing an all-payer model and provider rate-setting, the
10 Green Mountain Care Board shall consider the effects of differential
11 reimbursement for professional services provided by health care providers
12 employed by academic medical centers and other health care providers and
13 methods for reducing or eliminating such differences, as appropriate.

14 (b) The Board shall require any health insurer as defined in 18 V.S.A.
15 § 9402 with more than 5,000 covered lives for major medical insurance to
16 develop and submit to the Board, on or before July 1, 2016, an implementation
17 plan for providing fair and equitable reimbursement amounts for professional
18 services to promote parity between professional services provided by academic
19 medical centers and other professionals. Each plan shall ensure that proposed
20 changes to reimbursement create no increase in health insurance premiums or
21 public funding of health care. Any academic medical center located in

1 Vermont shall collaborate in the development of the plan. Upon receipt of
2 such a plan, the Board may direct the health insurer to submit modifications to
3 the plan and may approve, modify, or reject the plan. If the Board approves a
4 plan pursuant to this section, the Board shall require any Vermont academic
5 medical center to accept the reimbursements included in the plan, through the
6 hospital budget process and other appropriate enforcement mechanisms.

7 (c) The Board shall include a description of its progress on the issues
8 identified in this section in the annual report required by 18 V.S.A. § 9375(d).

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

10 Sec. 25. PAYMENT REFORM AND DIFFERENTIAL PAYMENTS TO
11 PROVIDERS

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

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

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

20 (3) the effects of differential reimbursement for different types of
21 providers when providing the same services billed under the same codes; and

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

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

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

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

10 Sec. 27. REDUCING DUPLICATION OF SERVICES; REPORT

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

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

4 Sec. 28. REPURPOSING EXCESS HOSPITAL FUNDS

5 (a) The 2014 Vermont Household Health Insurance Survey indicates that
6 the number of uninsured Vermonters has decreased from 6.8 percent in 2012 to
7 3.7 percent in 2014, which is a 46 percent reduction in the rate of uninsured.
8 Over the same time, however, hospital funds to support the uninsured have not
9 declined in a manner that is proportionate to the reduction in the number of
10 uninsured the funds are intended to support. Disproportionate Share Hospital
11 (DSH) payments have remained unchanged and will total \$38,289,419.00 in
12 fiscal year 2015, and the amount of “free care” charges in approved hospital
13 budgets was \$53,034,419.00 in fiscal year 2013 and \$58,652,440.00 in fiscal
14 year 2015. The reduction in the number of uninsured Vermonters has
15 increased costs to the General Fund, but the funds allocated in hospital budgets
16 to serve those Vermonters have not “followed the customer.” In essence, these
17 funds are stranded in the hospital budgets to pay for “phantom” uninsured
18 patients.

19 (b) The Green Mountain Care Board, in its fiscal year 2016 hospital budget
20 review process, shall analyze proposed hospital budgets to identify any
21 stranded dollars and shall report its findings on or before October 15, 2015 to

1 the House Committee on Health Care, the Senate Committees on Health and
2 Welfare and on Finance, the Health Reform Oversight Committee, and the
3 Joint Fiscal Committee. It is the intent of the General Assembly to repurpose
4 the stranded dollars to enhance State spending on the Blueprint for Health.

5 * * * Medicaid Rates * * *

6 Sec. 29. PROVIDER RATE SETTING; MEDICAID

7 (a) The Department of Disabilities, Aging, and Independent Living and the
8 Division of Rate Setting in the Agency of Human Services shall review current
9 reimbursement rates for providers of enhanced residential care, assistive
10 community care, and other long term home-and community-based care
11 services and shall consider ways to:

12 (1) ensure that rates are reviewed regularly and are sustainable,
13 reasonable, and adequately reflect economic conditions, new home- and
14 community-based services rules, and health system reforms; and

15 (2) encourage providers to accept residents without regard to their
16 source of payment.

17 (b) On or before January 15, 2016, the Department and the Agency shall
18 provide their findings and recommendations to the House Committee on
19 Human Services and the Senate Committees on Health and Welfare and on
20 Finance.

1 * * * Designated Agency Budgets * * *

2 Sec. 30. GREEN MOUNTAIN CARE BOARD; DESIGNATED AGENCY
3 BUDGETS

4 The Green Mountain Care Board shall analyze the budget and Medicaid
5 rates of one or more designated agencies providing services to Vermont
6 residents using criteria similar to the Board’s review of hospital budgets
7 pursuant to 18 V.S.A. § 9456. The Board shall also consider whether to
8 include designated and specialized service agencies in the all-payer model. On
9 or before January 31, 2016, the Board shall recommend to the House
10 Committees on Appropriations, on Health Care, and on Human Services and
11 the Senate Committees on Appropriations, on Health and Welfare, and on
12 Finance whether the Board should be responsible for the annual review of all
13 designated agency budgets and whether designated and specialized service
14 agencies should be included in the all-payer model.

15 * * * Rate Increases for Designated Agencies * * *

16 Sec. 31. DESIGNATED AGENCIES; SPECIALIZED SERVICE
17 AGENCIES; EFFECT OF MEDICAID RATE INCREASE

18 (a)(1) A designated agency or specialized service agency shall use any
19 additional funding the agency receives as a result of a Medicaid rate increase to
20 provide additional compensation or benefits, or both, to the agency’s direct
21 care workers or other employees.

1 (2) The designated agency or specialized service agency shall designate
2 the direct care workers or other employees who will receive additional
3 compensation or benefits pursuant to subdivision (1) of this subsection, and
4 shall provide the additional compensation and benefits in a manner that the
5 agency determines will best address its recruitment and retention needs.

6 (3) If the designated agency or specialized service agency is a party to a
7 collective bargaining agreement for the direct care workers or other employees
8 that the agency has designated to receive an increase in compensation or
9 benefits pursuant to subdivision (1) of this subsection, the amount and terms of
10 the increased compensation or benefits shall be determined through collective
11 bargaining between the agency and the exclusive representative of the workers
12 or employees. Nothing in this subsection is intended to prevent a party to the
13 collective bargaining agreement from indicating during negotiations that its
14 previous or current proposal regarding compensation or benefits accounts for
15 an actual or anticipated increase in funding received by the agency as a result
16 of a Medicaid rate increase.

17 (b) Each designated agency and specialized service agency shall report to
18 the Agency of Human Services regarding its compliance with this section.

1 * * * Presuit Mediation for Medical Malpractice Claims * * *

2 Sec. 32. 12 V.S.A. chapter 215, subchapter 2 is added to read:

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

4 § 7011. PURPOSE

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

10 § 7012. PRESUIT MEDIATION; SERVICE

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

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

20 (c) The request to participate in presuit mediation shall name all known
21 potential defendants, contain a brief statement of the facts that the potential

1 plaintiff believes are grounds for relief, and be accompanied by a certificate of
2 merit prepared pursuant to section 1051 of this title, and may include other
3 documents or information supporting the potential plaintiff's claim.

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

7 § 7013. MEDIATION RESPONSE

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

12 (b) If the potential defendant agrees to participate, within 60 days of the
13 service of the request to participate in presuit mediation, each potential
14 defendant shall serve a responsive certificate on the potential plaintiff by
15 mailing a certified letter indicating that he or she, or his or her counsel, has
16 consulted with a qualified expert within the meaning of section 1643 of this
17 title and that expert is of the opinion that there are reasonable grounds to
18 defend the potential plaintiff's claims of medical negligence. Notwithstanding
19 the potential defendant's acceptance of the request to participate, if the
20 potential defendant does not serve such a responsive certificate within the
21 60-day period, then the potential plaintiff need not participate in the presuit

1 mediation under this title and may file suit. If the potential defendant is willing
2 to participate, presuit mediation may take place without a responsive certificate
3 of merit from the potential defendant at the plaintiff's election.

4 § 7014. PROCESS; TIME FRAMES

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

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

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

19 (2) prior to the expiration of the applicable statute of limitations,
20 whichever is later.

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

4 § 7015. CONFIDENTIALITY

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

9 Sec. 33. REPORT

10 On or before December 1, 2019, the Secretary of Administration or
11 designee shall report to the Senate Committees on Health and Welfare and on
12 Judiciary and the House Committees on Health Care and on Judiciary on the
13 impacts of 12 V.S.A. § 1042 (certificate of merit) and 12 V.S.A. chapter 215,
14 subchapter 2 (presuit mediation). The report shall address the impacts that
15 these reforms have had on:

16 (1) consumers, physicians, and the provision of health care services;

17 (2) the rights of consumers to due process of law and to access to the
18 court system; and

19 (3) any other service, right, or benefit that was or may have been
20 affected by the establishment of the medical malpractice reforms in 12 V.S.A.
21 § 1042 and 12 V.S.A. chapter 215, subchapter 2.

1 injury, hospital indemnity, dental care, vision care, disability income,
2 long-term care, student health insurance coverage, Medicare supplemental
3 coverage, or other limited benefit coverage, or to benefit plans that are paid
4 directly to an individual insured or to his or her assigns and for which the
5 amount of the benefit is not based on potential medical costs or actual costs
6 incurred. Premium rates and rules for the classification of risk for Medicare
7 supplemental insurance policies shall be governed by sections 4062b and
8 4080e of this title.

9 * * *

10 (3) ~~Medicare supplemental insurance policies shall be exempt only from~~
11 ~~the requirement in subdivisions (a)(1) and (2) of this section for the Green~~
12 ~~Mountain Care Board's approval on rate requests and shall be subject to the~~
13 ~~remaining provisions of this section. [Repealed.]~~

14 * * *

15 Sec. 35. 8 V.S.A. § 4089b(g) is amended to read:

16 (g) ~~On or before July 15 of each year, health insurance companies doing~~
17 ~~business in Vermont whose individual share of the commercially insured~~
18 ~~Vermont market, as measured by covered lives, comprises at least five percent~~
19 ~~of the commercially insured Vermont market, shall file with the~~
20 ~~Commissioner, in accordance with standards, procedures, and forms approved~~
21 ~~by the Commissioner:~~

1 ~~(1) A report card on the health insurance plan’s performance in relation~~
2 ~~to quality measures for the care, treatment, and treatment options of mental and~~
3 ~~substance abuse conditions covered under the plan, pursuant to standards and~~
4 ~~procedures adopted by the Commissioner by rule, and without duplicating any~~
5 ~~reporting required of such companies pursuant to Rule H 2009-03 of the~~
6 ~~Division of Health Care Administration and regulation 95-2, “Mental Health~~
7 ~~Review Agents,” of the Division of Insurance, as amended, including:~~

8 ~~(A) the discharge rates from inpatient mental health and substance~~
9 ~~abuse care and treatment of insureds;~~

10 ~~(B) the average length of stay and number of treatment sessions for~~
11 ~~insureds receiving inpatient and outpatient mental health and substance abuse~~
12 ~~care and treatment;~~

13 ~~(C) the percentage of insureds receiving inpatient and outpatient~~
14 ~~mental health and substance abuse care and treatment;~~

15 ~~(D) the number of insureds denied mental health and substance abuse~~
16 ~~care and treatment;~~

17 ~~(E) the number of denials appealed by patients reported separately~~
18 ~~from the number of denials appealed by providers;~~

19 ~~(F) the rates of readmission to inpatient mental health and substance~~
20 ~~abuse care and treatment for insureds with a mental condition;~~

1 ~~(G) the level of patient satisfaction with the quality of the mental~~
2 ~~health and substance abuse care and treatment provided to insureds under the~~
3 ~~health insurance plan; and~~

4 ~~(H) any other quality measure established by the Commissioner.~~

5 ~~(2) The health insurance plan's revenue loss and expense ratio relating~~
6 ~~to the care and treatment of mental conditions covered under the health~~
7 ~~insurance plan. The expense ratio report shall list amounts paid in claims for~~
8 ~~services and administrative costs separately. A managed care organization~~
9 ~~providing or administering coverage for treatment of mental conditions on~~
10 ~~behalf of a health insurance plan shall comply with the minimum loss ratio~~
11 ~~requirements pursuant to the Patient Protection and Affordable Care Act of~~
12 ~~2010, Public Law 111-148, as amended by the Health Care and Education~~
13 ~~Reconciliation Act of 2010, Public Law 111-152, applicable to the underlying~~
14 ~~health insurance plan with which the managed care organization has contracted~~
15 ~~to provide or administer such services. The health insurance plan shall also~~
16 ~~bear responsibility for ensuring the managed care organization's compliance~~
17 ~~with the minimum loss ratio requirement pursuant to this subdivision.~~

18 ~~[Repealed.]~~

19 Sec. 36. 18 V.S.A. § 9402 is amended to read:

20 § 9402. DEFINITIONS

21 As used in this chapter, unless otherwise indicated:

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* * *

(4) ~~“Division” means the division of health care administration.~~

[Repealed.]

* * *

(10) “Health resource allocation plan” means the plan adopted by the
~~commissioner of financial regulation~~ Green Mountain Care Board under
section 9405 of this title.

* * *

Sec. 37. 18 V.S.A. § 9404 is amended to read:

§ 9404. ADMINISTRATION

(a) The Commissioner and the Green Mountain Care Board shall supervise
and direct the execution of all laws vested in the Department and the Board,
respectively, by this chapter, and shall formulate and carry out all policies
relating to this chapter.

(b) The Commissioner and the Board may:

(1) apply for and accept gifts, grants, or contributions from any person
for purposes consistent with this chapter;

(2) adopt rules necessary to implement the provisions of this
chapter; and

(3) enter into contracts and perform such acts as are necessary to
accomplish the purposes of this chapter.

1 (c) ~~There is hereby created a fund to be known as the Health Care~~
2 ~~Administration Regulatory and Supervision Fund for the purpose of providing~~
3 ~~the financial means for the Commissioner of Financial Regulation to~~
4 ~~administer this chapter and 33 V.S.A. § 6706. All fees and assessments~~
5 ~~received by the Department pursuant to such administration shall be credited to~~
6 ~~this Fund. All fines and administrative penalties, however, shall be deposited~~
7 ~~directly into the General Fund.~~

8 (1) ~~All payments from the Health Care Administration Regulatory and~~
9 ~~Supervision Fund for the maintenance of staff and associated expenses,~~
10 ~~including contractual services as necessary, shall be disbursed from the State~~
11 ~~Treasury only upon warrants issued by the Commissioner of Finance and~~
12 ~~Management, after receipt of proper documentation regarding services~~
13 ~~rendered and expenses incurred.~~

14 (2) ~~The Commissioner of Finance and Management may anticipate~~
15 ~~receipts to the Health Care Administration Regulatory and Supervision Fund~~
16 ~~and issue warrants based thereon. [Repealed.]~~

17 Sec. 38. 18 V.S.A. § 9410 is amended to read:

18 § 9410. HEALTH CARE DATABASE

19 (a)(1) The Board shall establish and maintain a unified health care database
20 to enable the ~~Commissioner and the~~ Board to carry out ~~their~~ its duties under
21 this chapter, chapter 220 of this title, and Title 8, including:

- 1 (A) determining the capacity and distribution of existing resources;
- 2 (B) identifying health care needs and informing health care policy;
- 3 (C) evaluating the effectiveness of intervention programs on
- 4 improving patient outcomes;
- 5 (D) comparing costs between various treatment settings and
- 6 approaches;
- 7 (E) providing information to consumers and purchasers of health
- 8 care; and
- 9 (F) improving the quality and affordability of patient health care and
- 10 health care coverage.

11 ~~(2)(A) The program authorized by this section shall include a consumer~~
12 ~~health care price and quality information system designed to make available to~~
13 ~~consumers transparent health care price information, quality information, and~~
14 ~~such other information as the Board determines is necessary to empower~~
15 ~~individuals, including uninsured individuals, to make economically sound and~~
16 ~~medically appropriate decisions.~~

17 ~~(B) The Commissioner may require a health insurer covering at least~~
18 ~~five percent of the lives covered in the insured market in this State to file with~~
19 ~~the Commissioner a consumer health care price and quality information plan in~~
20 ~~accordance with rules adopted by the Commissioner.~~

1 § 9414. QUALITY ASSURANCE FOR MANAGED CARE

2 ORGANIZATIONS

3 (a) The ~~commissioner~~ Commissioner shall have the power and
4 responsibility to ensure that each managed care organization provides quality
5 health care to its members, in accordance with the provisions of this section.

6 * * *

7 (4) The Commissioner or designee may resolve any consumer complaint
8 arising out of this subsection as though the managed care organization were an
9 insurer licensed pursuant to Title 8.

10 * * *

11 (d)(1) In addition to its internal quality assurance program, each managed
12 care organization shall evaluate the quality of health and medical care provided
13 to members. The organization shall use and maintain a patient record system
14 which will facilitate documentation and retrieval of statistically meaningful
15 clinical information.

16 (2) A managed care organization may evaluate the quality of health and
17 medical care provided to members through an independent accreditation
18 organization, ~~provided that the commissioner has established criteria for such~~
19 ~~independent evaluations.~~

20 (e) ~~The commissioner shall review a managed care organization's~~
21 ~~performance under the requirements of this section at least once every three~~

1 ~~years and more frequently as the commissioner deems proper. If upon review~~
2 ~~the commissioner determines that the organization's performance with respect~~
3 ~~to one or more requirements warrants further examination, the commissioner~~
4 ~~shall conduct a comprehensive or targeted examination of the organization's~~
5 ~~performance. The commissioner may designate another organization to~~
6 ~~conduct any evaluation under this subsection. Any such independent designee~~
7 ~~shall have a confidentiality code acceptable to the commissioner, or shall be~~
8 ~~subject to the confidentiality code adopted by the commissioner under~~
9 ~~subdivision (f)(3) of this section. In conducting an evaluation under this~~
10 ~~subsection, the commissioner or the commissioner's designee shall employ,~~
11 ~~retain, or contract with persons with expertise in medical quality assurance.~~

12 [Repealed.]

13 (f)(1) For the purpose of evaluating a managed care organization's
14 performance under the provisions of this section, the ~~commissioner~~
15 Commissioner may examine and review information protected by the
16 provisions of the patient's privilege under 12 V.S.A. § 1612(a), or otherwise
17 required by law to be held confidential, ~~except that the commissioner's access~~
18 ~~to and use of minutes and records of a peer review committee established~~
19 ~~under subsection (c) of this section shall be governed by subdivision (2) of this~~
20 ~~subsection.~~

1 ~~Commissioner pursuant to section 9414 of this title and 8 V.S.A. § 4088h~~
2 ~~relating to pay for performance or other payment methodology standards.~~

3 Sec. 41. 18 V.S.A. § 9418b(f) is amended to read:

4 (f) Nothing in this section shall be construed to prohibit a health plan from
5 applying payment policies that are consistent with applicable federal or State
6 laws and regulations, or to relieve a health plan from complying with payment
7 standards established by federal or State laws and regulations, ~~including rules~~
8 ~~adopted by the Commissioner pursuant to section 9408 of this title, relating to~~
9 ~~claims administration and adjudication standards, and rules adopted by the~~
10 ~~Commissioner pursuant to section 9414 of this title and 8 V.S.A. § 4088h,~~
11 ~~relating to pay for performance or other payment methodology standards.~~

12 Sec. 42. 18 V.S.A. § 9420 is amended to read:

13 § 9420. CONVERSION OF NONPROFIT HOSPITALS

14 (a) Policy and purpose. The ~~state~~ State has a responsibility to assure that
15 the assets of nonprofit entities, which are impressed with a charitable trust, are
16 managed prudently and are preserved for their proper charitable purposes.

17 (b) Definitions. As used in this section:

18 * * *

19 (2) ~~“Commissioner” is the commissioner of financial regulation.~~

20 [Repealed.]

21 * * *

1 (10) “Green Mountain Care Board” or “Board” means the Green
2 Mountain Care Board established in chapter 220 of this title.

3 (c) Approval required for conversion of qualifying amount of charitable
4 assets. A nonprofit hospital may convert a qualifying amount of charitable
5 assets only with the approval of the ~~commissioner~~ Green Mountain Care
6 Board, and either the ~~attorney general~~ Attorney General or the ~~superior court~~
7 Superior Court, pursuant to the procedures and standards set forth in this
8 section.

9 (d) Exception for conversions in which assets will be owned and controlled
10 by a nonprofit corporation:

11 (1) Other than subsection (q) of this section and subdivision (2) of this
12 subsection, this section shall not apply to conversions in which the party
13 receiving assets of a nonprofit hospital is a nonprofit corporation.

14 (2) In any conversion that would have required an application under
15 subsection (e) of this section but for the exception set forth in subdivision (1)
16 of this subsection, notice to or written waiver by the ~~attorney general~~ Attorney
17 General shall be given or obtained as if required under 11B V.S.A. § 12.02(g).

18 (e) Application. Prior to consummating any conversion of a qualifying
19 amount of charitable assets, the parties shall submit an application to the
20 ~~attorney general~~ Attorney General and the ~~commissioner~~ Green Mountain Care
21 Board, together with any attachments complying with subsection (f) of this

1 section. If any material change occurs in the proposal set forth in the filed
2 application, an amendment setting forth such change, together with copies of
3 all documents and other material relevant to such change, shall be filed with
4 the ~~attorney general~~ Attorney General and the ~~commissioner~~ Board within two
5 business days, or as soon thereafter as practicable, after any party to the
6 conversion learns of such change. If the conversion involves a hospital
7 system, and one or more of the hospitals in the system desire to convert
8 charitable assets, the ~~attorney general~~ Attorney General, in consultation with
9 the ~~commissioner~~ Board, shall determine whether an application shall be
10 required from the hospital system.

11 (f) Completion and contents of application.

12 (1) Within 30 days of receipt of the application, or within 10 days of
13 receipt of any amendment thereto, whichever is longer, the ~~attorney general~~
14 Attorney General, with the ~~commissioner's~~ Green Mountain Care Board's
15 agreement, shall determine whether the application is complete. The Attorney
16 General shall promptly notify the parties of the date the application is deemed
17 complete, or of the reasons for a determination that the application is
18 incomplete. A complete application shall include the following:

19 * * *

1 (N) any additional information the ~~attorney general~~ Attorney General
2 or ~~commissioner~~ Green Mountain Care Board finds necessary or appropriate
3 for the full consideration of the application.

4 (2) The parties shall make the contents of the application reasonably
5 available to the public prior to any hearing for public comment described in
6 subsection (g) of this section to the extent that they are not otherwise exempt
7 from disclosure under 1 V.S.A. § 317(b).

8 (g) Notice and hearing for public comment on application.

9 (1) The ~~attorney general~~ Attorney General and ~~commissioner~~ the Green
10 Mountain Care Board shall hold one or more public hearings on the transaction
11 or transactions described in the application. A record shall be made of any
12 hearing. The hearing shall commence within 30 days of the determination by
13 the ~~attorney general~~ Attorney General that the application is complete. If a
14 hearing is continued or multiple hearings are held, any hearing shall be
15 completed within 60 days of the ~~attorney general's~~ Attorney General's
16 determination that an application is complete. In determining the number,
17 location, and time of hearings, the ~~attorney general~~ Attorney General, in
18 consultation with the ~~commissioner~~ Board, shall consider the geographic areas
19 and populations served by the nonprofit hospital and most affected by the
20 conversion and the interest of the public in commenting on the application.

1 (2) The ~~attorney general~~ Attorney General shall provide reasonable
2 notice of any hearing to the parties, the ~~commissioner~~ Board, and the public,
3 and may order that the parties bear the cost of notice to the public. Notice to
4 the public shall be provided in newspapers having general circulation in the
5 region affected and shall identify the applicants and the proposed conversion.
6 A copy of the public notice shall be sent to the ~~state~~ State health care and long-
7 term care ombudspersons and to the ~~senators~~ Senators and members of the
8 ~~house of representatives~~ House of Representatives representing the county and
9 district and to the ~~clerk, chief municipal officer~~ Clerk, Chief Municipal
10 Officer, and legislative body, of the municipality in which the nonprofit
11 hospital is principally located. Upon receipt, the ~~clerk~~ Clerk shall post notice
12 in or near the ~~clerk's~~ Clerk's office and in at least two other public places in
13 the municipality. Any person may testify at a hearing under this section and,
14 within such reasonable time as the ~~attorney general~~ Attorney General may
15 prescribe, file written comments with the ~~attorney general~~ Attorney General
16 and ~~commissioner~~ Board concerning the proposed conversion.

17 (h) Determination by ~~commissioner~~ the Green Mountain Care Board.

18 (1) The ~~commissioner~~ Green Mountain Care Board shall consider the
19 application, together with any report and recommendations from the Board's
20 staff ~~of the department~~ requested by the ~~commissioner~~ Board, and any other
21 information submitted into the record, and approve or deny it within 50 days

1 following the last public hearing held pursuant to subsection (g) of this section,
2 unless the ~~commissioner~~ Board extends such time up to an additional 60 days
3 with notice prior to its expiration to the ~~attorney general~~ Attorney General and
4 the parties.

5 (2) The ~~commissioner~~ Board shall approve the proposed transaction if
6 the ~~commissioner~~ Board finds that the application and transaction will satisfy
7 the criteria established in section 9437 of this title. For purposes of applying
8 the criteria established in section 9437, the term “project” shall include a
9 conversion or other transaction subject to the provisions of this subchapter.

10 (3) A denial by the ~~commissioner~~ Board may be appealed to the
11 ~~supreme court~~ Supreme Court pursuant to ~~the procedures and standards set~~
12 ~~forth in 8 V.S.A. § 16~~ section 9381 of this title. If no appeal is taken or if the
13 ~~commissioner’s~~ Board’s order is affirmed by the ~~supreme court~~ supreme court,
14 the application shall be terminated. A failure of the ~~commissioner~~ Board to
15 approve of an application in a timely manner shall be considered a final order
16 in favor of the applicant.

17 (i) Determination by ~~attorney general~~ Attorney General. The ~~attorney~~
18 ~~general~~ Attorney General shall make a determination as to whether the
19 conversion described in the application meets the standards provided in
20 subsection (j) of this section.

1 (1) If the ~~attorney general~~ Attorney General determines that the
2 conversion described in the application meets the standards set forth in
3 subsection (j) of this section, the ~~attorney general~~ Attorney General shall
4 approve the conversion and so notify the parties in writing.

5 (2) If the ~~attorney general~~ Attorney General determines that the
6 conversion described in the application does not meet such standards, the
7 ~~attorney general~~ Attorney General may not approve the conversion and shall so
8 notify the parties of such disapproval and the basis for it in writing, including
9 identification of the standards listed in subsection (j) of this section that the
10 ~~attorney general~~ Attorney General finds not to have been met by the proposed
11 conversion. Nothing in this subsection shall prevent the parties from amending
12 the application to meet any objections of the ~~attorney general~~ Attorney
13 General.

14 (3) The notice of approval or disapproval by the ~~attorney general~~
15 Attorney General under this subsection shall be provided no later than either
16 60 days following the date of the last hearing held under subsection (g) of this
17 section or ten days following approval of the conversion by the ~~commissioner~~
18 Board, whichever is later. The ~~attorney general~~ Attorney General, for good
19 cause, may extend this period an additional 60 days.

1 (j) Standards for ~~attorney general's~~ Attorney General's review. In
2 determining whether to approve a conversion under subsection (i) of this
3 section, the ~~attorney general~~ Attorney General shall consider whether:

4 * * *

5 (7) the application contains sufficient information and data to permit the
6 ~~attorney general~~ Attorney General and ~~commissioner~~ the Green Mountain Care
7 Board to evaluate the conversion and its effects on the public's interests in
8 accordance with this section; and

9 (8) the conversion plan has made reasonable provision for reports, upon
10 request, to the ~~attorney general~~ Attorney General on the conduct and affairs of
11 any person that, as a result of the conversion, is to receive charitable assets or
12 proceeds from the conversion to carry on any part of the public purposes of the
13 nonprofit hospital.

14 (k) Investigation by ~~attorney general~~ Attorney General. The ~~attorney~~
15 ~~general~~ Attorney General may conduct an investigation relating to the
16 conversion pursuant to the procedures set forth generally in 9 V.S.A. § 2460.
17 The ~~attorney general~~ Attorney General may contract with such experts or
18 consultants the ~~attorney general~~ Attorney General deems appropriate to assist
19 in an investigation of a conversion under this section. The ~~attorney general~~
20 Attorney General may order any party to reimburse the ~~attorney general~~
21 Attorney General for all reasonable and actual costs incurred by the ~~attorney~~

1 ~~general~~ Attorney General in retaining outside professionals to assist with the
2 investigation or review of the conversion.

3 (l) Superior ~~court~~ Court action. If the ~~attorney general~~ Attorney General
4 does not approve the conversion described in the application and any
5 amendments, the parties may commence an action in the ~~superior court~~
6 Superior Court of Washington County, or with the agreement of the ~~attorney~~
7 ~~general~~ Attorney General, of any other county, within 60 days of the ~~attorney~~
8 ~~general's~~ Attorney General's notice of disapproval provided to the parties
9 under subdivision (i)(2) of this section. The parties shall notify the
10 ~~commissioner~~ Green Mountain Care Board of the commencement of an action
11 under this subsection. The ~~commissioner~~ Board shall be permitted to request
12 that the ~~court~~ Court consider the ~~commissioner's~~ Board's determination under
13 subsection (h) of this section in its decision under this subsection.

14 (m) Court determination and order.

15 * * *

16 (4) Nothing herein shall prevent the ~~attorney general~~ Attorney General,
17 while an action brought under subsection (l) of this section is pending, from
18 approving the conversion described in the application, as modified by such
19 terms as are agreed between the parties, the ~~attorney general~~ Attorney General,
20 and the ~~commissioner~~ Green Mountain Care Board to bring the conversion into
21 compliance with the standards set forth in subsection (j) of this section.

1 (n) Use of converted assets or proceeds of a conversion approved pursuant
2 to this section. If at any time following a conversion, the ~~attorney general~~
3 Attorney General has reason to believe that converted assets or the proceeds of
4 a conversion are not being held or used in a manner consistent with
5 information provided to the ~~attorney general~~ Attorney General, the
6 ~~commissioner~~ Board, or a court in connection with any application or
7 proceedings under this section, the ~~attorney general~~ Attorney General may
8 investigate the matter pursuant to procedures set forth generally in 9 V.S.A.
9 § 2460 and may bring an action in Washington ~~superior court~~ Superior Court
10 or in the ~~superior court~~ Superior Court of any county where one of the parties
11 has a principal place of business. The ~~court~~ Court may order appropriate relief
12 in such circumstances, including avoidance of the conversion or transfer of the
13 converted assets or proceeds or the amount of any private inurement to a
14 person or party for use consistent with the purposes for which the assets were
15 held prior to the conversion, and the award of costs of investigation and
16 prosecution under this subsection, including the reasonable value of legal
17 services.

18 (o) Remedies and penalties for violations.

19 (1) The ~~attorney general~~ Attorney General may bring or maintain a civil
20 action in the Washington ~~superior court~~ Superior Court, or any other county in
21 which one of the parties has its principal place of business, to enjoin, restrain,

1 or prevent the consummation of any conversion which has not been approved
2 in accordance with this section or where approval of the conversion was
3 obtained on the basis of materially inaccurate information furnished by any
4 party to the ~~attorney general~~ Attorney General or the ~~commissioner~~ Board.

5 * * *

6 (p) Conversion of less than a qualifying amount of assets.

7 (1) The ~~attorney general~~ Attorney General may conduct an investigation
8 relating to a conversion pursuant to the procedures set forth generally in
9 9 V.S.A. § 2460 if the ~~attorney general~~ Attorney General has reason to believe
10 that a nonprofit hospital has converted or is about to convert less than a
11 qualifying amount of its assets in such a manner that would:

12 (A) if it met the qualifying amount threshold, require an application
13 under subsection (e) of this section; and

14 (B) constitute a conversion that does not meet one or more of the
15 standards set forth in subsection (j) of this section.

16 (2) The ~~attorney general~~ Attorney General, in consultation with the
17 ~~commissioner~~ Green Mountain Care Board, may bring an action with respect
18 to any conversion of less than a qualifying amount of assets, according to the
19 procedures set forth in subsection (n) of this section. The ~~attorney general~~
20 Attorney General shall notify the ~~commissioner~~ Board of any action
21 commenced under this subsection. The ~~commissioner~~ Board shall be permitted

1 to investigate and determine whether the transaction satisfies the criteria
2 established in subdivision (g)(2) of this section, and to request that the ~~court~~
3 Court consider the ~~commissioner's~~ Board's recommendation in its decision
4 under this subsection. In such an action, the ~~superior court~~ Superior Court may
5 enjoin or void any transaction and may award any other relief as provided
6 under subsection (n) of this section.

7 (3) In any action brought by the ~~attorney general~~ Attorney General
8 under this subdivision, the ~~attorney general~~ Attorney General shall have the
9 burden to establish that the conversion:

10 (A) violates one or more of the standards listed in subdivision (j)(1),
11 (3), (4), or (6); or

12 (B) substantially violates one or more of the standards set forth in
13 subdivisions (j)(2) and (5) of this section.

14 (q) Other preexisting authority.

15 (1) Nothing in this section shall be construed to limit the authority of the
16 ~~commissioner~~ Green Mountain Care Board, ~~attorney general~~ Attorney General,
17 ~~department of health~~ Department of Health, or a court of competent
18 jurisdiction under existing law, or the interpretation or administration of a
19 charitable gift under 14 V.S.A. § 2328.

20 (2) This section shall not be construed to limit the regulatory and
21 enforcement authority of the ~~commissioner~~ Board, or exempt any applicant or

1 other person from requirements for licensure or other approvals required
2 by law.

3 Sec. 43. 18 V.S.A. § 9440 is amended to read:

4 § 9440. PROCEDURES

5 * * *

6 (c) The application process shall be as follows:

7 (1) Applications shall be accepted only at such times as the Board shall
8 establish by rule.

9 (2)(A) Prior to filing an application for a certificate of need, an applicant
10 shall file an adequate letter of intent with the Board no less than 30 days or, in
11 the case of review cycle applications under section 9439 of this title, no less
12 than 45 days prior to the date on which the application is to be filed. The letter
13 of intent shall form the basis for determining the applicability of this
14 subchapter to the proposed expenditure or action. A letter of intent shall
15 become invalid if an application is not filed within six months of the date that
16 the letter of intent is received or, in the case of review cycle applications under
17 section 9439 of this title, within such time limits as the Board shall establish by
18 rule. ~~Except for requests for expedited review under subdivision (5) of this~~
19 ~~subsection, The Board shall post public notice of such letters of intent shall be~~
20 ~~provided in newspapers having general circulation in the region of the State~~
21 ~~affected by the letter of intent~~ on its website electronically within five business

1 days of receipt. The public notice shall identify the applicant, the proposed
2 new health care project, and the date by which a competing application or
3 petition to intervene must be filed. ~~In addition, a copy of the public notice~~
4 ~~shall be sent to the clerk of the municipality in which the health care facility is~~
5 ~~located. Upon receipt, the clerk shall post the notice in or near the clerk's~~
6 ~~office and in at least two other public places in the municipality.~~

7 (B) Applicants who agree that their proposals are subject to
8 jurisdiction pursuant to section 9434 of this title shall not be required to file a
9 letter of intent pursuant to subdivision (A) of this subdivision (2) and may file
10 an application without further process. Public notice of the application shall be
11 ~~provided upon filing~~ posted electronically on the Board's website as provided
12 for in subdivision (A) of this subdivision (2) for letters of intent.

13 * * *

14 (5) An applicant seeking expedited review of a certificate of need
15 application may simultaneously file ~~a letter of intent and~~ with the Board a
16 request for expedited review and an application with the Board. ~~Upon~~ After
17 receiving the request and an application, the Board shall issue public notice of
18 the request and application in the manner set forth in subdivision (2) of this
19 subsection. At least 20 days after the public notice was issued, if no competing
20 application has been filed and no party has sought and been granted, nor is
21 likely to be granted, interested party status, the Board, upon making a

1 determination that the proposed project may be uncontested and does not
2 substantially alter services, as defined by rule, or upon making a determination
3 that the application relates to a health care facility affected by bankruptcy
4 proceedings, ~~the Board shall issue public notice of the application and the~~
5 ~~request for expedited review and identify a date by which a competing~~
6 ~~application or petition for interested party status must be filed. If a competing~~
7 ~~application is not filed and no person opposing the application is granted~~
8 ~~interested party status, the Board~~ may formally declare the application
9 uncontested and may issue a certificate of need without further process, or with
10 such abbreviated process as the Board deems appropriate. If a competing
11 application is filed or a person opposing the application is granted interested
12 party status, the applicant shall follow the certificate of need standards and
13 procedures in this section, except that in the case of a health care facility
14 affected by bankruptcy proceedings, the Board after notice and an opportunity
15 to be heard may issue a certificate of need with such abbreviated process as the
16 Board deems appropriate, notwithstanding the contested nature of the
17 application.

18 * * *

19 Sec. 44. 18 V.S.A. § 9445 is amended to read:

20 § 9445. ENFORCEMENT

1 (a) Any person who offers or develops any new health care project within
2 the meaning of this subchapter without first obtaining a certificate of need as
3 required herein, or who otherwise violates any of the provisions of this
4 subchapter, may be subject to the following administrative sanctions by the
5 Board, after notice and an opportunity to be heard:

6 (1) The Board may order that no license or certificate permitted to be
7 issued by ~~the Department~~ or any other State agency may be issued to any
8 health care facility to operate, offer, or develop any new health care project for
9 a specified period of time, or that remedial conditions be attached to the
10 issuance of such licenses or certificates.

11 (2) The Board may order that payments or reimbursements to the entity
12 for claims made under any health insurance policy, subscriber contract, or
13 health benefit plan offered or administered by any public or private health
14 insurer, including the Medicaid program and any other health benefit program
15 administered by the State be denied, reduced, or limited, and in the case of a
16 hospital that the hospital's annual budget approved under subchapter 7 of this
17 chapter be adjusted, modified, or reduced.

18 (b) In addition to all other sanctions, if any person offers or develops any
19 new health care project without first having been issued a certificate of need or
20 certificate of exemption for the project, or violates any other provision of this
21 subchapter or any lawful rule adopted pursuant to this subchapter, the Board,

1 ~~the Commissioner~~, the Office of the Health Care Advocate, the State
2 Long-Term Care Ombudsman, and health care providers and consumers
3 located in the State shall have standing to maintain a civil action in the
4 Superior Court of the county in which such alleged violation has occurred, or
5 in which such person may be found, to enjoin, restrain, or prevent such
6 violation. Upon written request by the Board, it shall be the duty of the
7 Vermont Attorney General to furnish appropriate legal services and to
8 prosecute an action for injunctive relief to an appropriate conclusion, which
9 shall not be reimbursed under subdivision (a)(2) of this section.

10 * * *

11 Sec. 45. 18 V.S.A. § 9456(h) is amended to read:

12 (h)(1) If a hospital violates a provision of this section, the Board may
13 maintain an action in the Superior Court of the county in which the hospital is
14 located to enjoin, restrain, or prevent such violation.

15 * * *

16 (3)(A) The Board shall require the officers and directors of a hospital to
17 file under oath, on a form and in a manner prescribed by the ~~Commissioner~~
18 Board, any information designated by the Board and required pursuant to this
19 subchapter. The authority granted to the Board under this subsection is in
20 addition to any other authority granted to the Board under law.

1 (B) A person who knowingly makes a false statement under oath or
2 who knowingly submits false information under oath to the Board or to a
3 hearing officer appointed by the Board or who knowingly testifies falsely in
4 any proceeding before the Board or a hearing officer appointed by the Board
5 shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

6 Sec. 46. SUSPENSION; PROHIBITION ON MODIFICATION OF

7 UNIFORM FORMS

8 The Department of Financial Regulation shall not modify the existing
9 common forms, procedures, and rules based on 18 V.S.A. §§ 9408, 9408a(b),
10 9408a(e), and 9418(f) prior to January 1, 2017. The Commissioner of
11 Financial Regulation may review and examine, at his or her own discretion or
12 in response to a complaint, a managed care organization's administrative
13 policies and procedures, quality management and improvement procedures,
14 credentialing practices, members' rights and responsibilities, preventive health
15 services, medical records practices, member services, financial incentives or
16 disincentives, disenrollment, provider contracting, and systems and data
17 reporting capacities described in 18 V.S.A. § 9414(a)(1).

18 Sec. 47. UNIFORM FORMS; EVALUATION

19 (a) The Director of Health Care Reform in the Agency of Administration,
20 in collaboration with the Green Mountain Care Board and the Department of
21 Financial Regulation, shall evaluate:

1 (1) the necessity of maintaining provisions regarding common claims
2 forms and procedures, uniform provider credentialing, and suspension of
3 interest accrual for failure to pay claims if the failure was not within the
4 insurer’s control, as those provisions are codified in 18 V.S.A. §§ 9408,
5 9408a(b), 9408a(e), and 9418(f);

6 (2) the necessity of maintaining provisions requiring the Commissioner
7 to review and examine a managed care organization’s administrative policies
8 and procedures, quality management and improvement procedures,
9 credentialing practices, members’ rights and responsibilities, preventive health
10 services, medical records practices, member services, financial incentives or
11 disincentives, disenrollment, provider contracting, and systems and data
12 reporting capacities, as those provisions are codified in 18 V.S.A. § 9414(a)(1);

13 (3) the appropriate entity to assume responsibility for any such function
14 that should be retained and the appropriate enforcement process; and

15 (4) the requirements in federal law applicable to the Department of
16 Vermont Health Access in its role as a public managed care organization in
17 order to identify opportunities for greater alignment between federal law and
18 18 V.S.A. § 9414(a)(1).

19 (b) In performing the evaluation required by subsection (a) of this section,
20 the Director shall consult regularly with interested stakeholders, including

1 health insurance and managed care organizations, as defined in 18 V.S.A.
2 9402; health care providers; and the Office of the Health Care Advocate.

3 (c) On or before December 15, 2015, the Director shall provide his or her
4 findings and recommendations to the House Committee on Health Care, the
5 Senate Committees on Health and Welfare and on Finance, and the Health
6 Reform Oversight Committee.

7 * * * Appropriations * * *

8 Sec. 48. MAINTAINING EXCHANGE COST-SHARING SUBSIDIES

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

13 Sec. 49. AREA HEALTH EDUCATION CENTERS

14 The sum of \$667,111.00 in Global Commitment funds is appropriated to the
15 Department of Health in fiscal year 2016 for a grant to the Area Health
16 Education Centers for repayment of educational loans for health care providers
17 and health care educators.

18 Sec. 50. OFFICE OF THE HEALTH CARE ADVOCATE;

19 APPROPRIATION; INTENT

20 (a) The Office of the Health Care Advocate has a critical function in
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. 51. GREEN MOUNTAIN CARE BOARD; ALL-PAYER WAIVER;
15 RATE-SETTING; VITL OVERSIGHT

16 (a) The following appropriations and adjustments are made to the Green
17 Mountain Care Board in fiscal year 2016 for positions, contracts, and operating
18 expenses related to the Board’s provider rate-setting authority, the all-payer
19 model, and the Medicaid cost shift:

20 (1) \$83,054.00 is appropriated from the General Fund;

21 (2) \$268,524.00 is appropriated from special funds;

1 (3) \$97,968.00 is appropriated from federal funds;

2 (4) a negative adjustment in the amount of –\$35,919.00 is made to the
3 Global Commitment funds appropriated; and

4 (5) a negative adjustment in the amount of –\$128,693.00 is made to the
5 interdepartmental transfer funds appropriated.

6 (b) The sum of \$60,000.00 is appropriated from the Health-IT Fund to the
7 Green Mountain Care Board in fiscal year 2016 to provide oversight of the
8 budget and activities of the Vermont Information Technology Leaders, Inc.

9 Sec. 52. BLUEPRINT FOR HEALTH INCREASES

10 The sum of \$1,402,900.00 in Global Commitment funds is appropriated to
11 the Department of Vermont Health Access in fiscal year 2016 to increase
12 payments to patient-centered medical homes and community health teams
13 pursuant to 18 V.S.A. § 702 beginning on January 1, 2016.

14 Sec. 53. INVESTING IN PRIMARY CARE SERVICES

15 The sum of \$2,732,677.00 in Global Commitment funds is appropriated to
16 the Department of Vermont Health Access in fiscal year 2016 to increase
17 reimbursement rates to primary care providers beginning on January 1, 2016
18 for services provided to Medicaid beneficiaries. It is the intent of the General
19 Assembly that these amounts shall be increased on July 1, 2016 by an amount
20 sufficient to provide a cumulative annualized increase of \$7,500,000.00.

21 Sec. 54. RATE INCREASES FOR OTHER MEDICAID PROVIDERS

1 (a) The sum of \$3,394,058.00 in Global Commitment funds is appropriated
2 to the Agency of Human Services in fiscal year 2016 for the purpose of
3 increasing reimbursement rates beginning on January 1, 2016 for providers
4 under contract with the Departments of Disabilities, Aging, and Independent
5 Living, of Mental Health, of Corrections, of Health, and for Children and
6 Families to provide services to Vermont Medicaid beneficiaries. In allocating
7 the Global Commitment funds appropriated pursuant to this section, the
8 Agency shall direct:

9 (1) \$1,180,989.00 to the Department of Mental Health;

10 (2) \$284,376.00 to the Department of Health, Division of Alcohol and
11 Drug Abuse Programs;

12 (3) \$1,458,931.00 to the Department of Disabilities, Aging, and
13 Independent Living for developmental disability services; and

14 (4) the remaining \$469,763.00 for distribution to other departments'
15 appropriation line items within the Agency for Medicaid-eligible services from
16 contract providers.

17 (b) The sum of \$569,543.00 in Global Commitment funds is appropriated
18 to the Department of Vermont Health Access in fiscal year 2016 for the
19 purpose of increasing reimbursement rates for home- and community-based
20 services in the Choices for Care program beginning on January 1, 2016.

21 Sec. 55. INDEPENDENT MENTAL HEALTH PROFESSIONALS

1 The sum of \$421,591.00 in Global Commitment funds is appropriated to the
2 Department of Vermont Health Access in fiscal year 2016 for the purpose of
3 increasing Medicaid reimbursement rates beginning on January 1, 2016 to
4 mental health professionals not affiliated with a designated agency who
5 provide mental health services to Medicaid beneficiaries.

6 Sec. 56. RATE INCREASES FOR DENTAL SERVICES; INTENT

7 It is the intent of the General Assembly that Medicaid reimbursement rates
8 for providers of dental services to Medicaid beneficiaries shall be increased by
9 an amount estimated to be equivalent to \$485,000.00 beginning on July 1,
10 2016.

11 Sec. 57. AGENCY OF HUMAN SERVICES; GLOBAL COMMITMENT
12 APPROPRIATION

13 (a) The following appropriations and adjustments are made to ensure that
14 the Agency of Human Services' Global Commitment budget line item
15 comports with the appropriations made in Secs. 39–47 of this act:

16 (1) the sum of \$5,100,000.00 is appropriated from the State Health Care
17 Resources Fund in fiscal year 2016;

18 (2) the sum of \$5,016,557.00 is appropriated from federal funds in fiscal
19 year 2016; and

20 (3) a negative adjustment in the amount of –\$968,210.00 to the General
21 Funds appropriated in fiscal year 2016.

1 11 (VITL), 12 (ambulance reimbursement), 13 and 14 (direct enrollment in
2 Exchange plans), 15–17 (large group market), 18–20 (universal primary care
3 study), 23 (public employees’ health benefits), 24 (provider payment parity),
4 25 (Green Mountain Care Board; payment reform), 26–28 (reports), 29
5 (provider rate setting), 30 (designated agency budgets), 32 and 33 (presuit
6 mediation), and this section shall take effect on passage.

7 (b) Secs. 21 (universal primary care appropriation), 31 (effect of designated
8 agency rate increase), 34–45 (transfer of DFR duties), 46 and 47 (suspension
9 and review of uniform forms), 48–57 (appropriations), 58 (positions), and 59
10 (repeals) shall take effect on July 1, 2015.

11 (c) Secs. 7 and 8 (telemedicine) shall take effect on October 1, 2015.

12 (d) Secs. 4 and 5 (notice of hospital observation status) shall take effect on
13 December 1, 2015.

14 (e) Sec. 22 (consumer price comparison) shall take effect on July 1, 2016.

15 and that after passage the title of the bill be amended to read: “An act relating
16 to health care”

17
18
19
20 (Committee vote: _____)

1

2

Senator _____

3

FOR THE COMMITTEE