S.135 - Section by section summary as passed by Senate Finance

Prepared by Jennifer Carbee, Legislative Counsel, Vermont Legislative Council

May 4, 2015

Section 1. All-payer model

- Secretary of Administration or designee and Green Mountain Care Board (GMCB) must jointly explore all-payer model
- Must consider the following models:
  - including payment for broad array of health services
  - hospitals only
  - allowing for global hospital budgets for all Vermont hospitals

Sec. 2. St. Johnsbury accountable care community

- Directs the FQHC in St. Johnsbury to convene interested stakeholders to create a concept paper and implementation plan for an accountable care community program for the St. Johnsbury health service area
- Upon completion of implementation plan, it must be submitted to Agency of Human Services to determine feasibility of implementation

Sec. 3. Green Mountain Care Board duties

- Requires GMCB's payment reform and cost containment methodologies to involve collaboration with providers, include a transition plan, take into consideration current Medicare designations and payment methodologies, and encourage regional coordination and planning
- Requires GMCB to consult with VITL when reviewing the statewide Health Information Technology Plan
- Requires GMCB to review and approve criteria for health care providers and facilities to create or maintain connectivity to health information exchange
- Requires GMCB to annually review and approve VITL's budget and its core activities associated with public funding

Sec. 4. Vermont Information Technology Leaders (VITL)

- Specifies makeup of VITL's Board of Directors, including one member of the General Assembly
- Allows Department of Information and Innovation to review VITL's technology
- Prohibits VITL from using any State funds for health care consumer advertising, marketing, lobbying, or similar services

Sec. 5. Medicaid coverage for primary care telemedicine

- Requires Medicaid coverage for primary care consultations delivered to Medicaid beneficiaries outside a health care facility beginning on October 1, 2015
- Coverage is only for services that have been determined by the Department of Vermont Health Access's (DVHA) Chief Medical Officer to be clinically appropriate

Sec. 6. Telemedicine implementation report

- By April 15, 2016, DVHA must provide a report on the first six months of implementation of Medicaid coverage for primary care consultations delivered through telemedicine outside a health care facility

Secs. 7-8. Direct enrollment in Exchange plans

- Allows individuals to purchase Exchange plans directly from the health insurers beginning with 2016 open enrollment

Secs. 9-11. Large group insurance market

- Delays until 2018 the ability of large group market to purchase Exchange plans
- Directs GMCB to analyze projected impact on rates in the large group market if large employers are allowed to buy Exchange plans beginning in 2018, including impact on premiums of the transition from experience rating to community rating

Sec. 12. Health care quality and price comparison website

- Requires each health insurer with more than 200 covered lives in Vermont to establish an Internet-based tool to allow its members to compare the price of medical care by service or procedure
- Must reflect cost-sharing applicable to a member's specific plan and reflect up-to-date deductible information

Sec. 13. Public employees' health benefits

- Director of Health Care Reform must identify options and considerations for providing health care coverage to all public employees, including State and judiciary employees, school employees, municipal employees, and State and teacher retirees
- Coverage must be cost-effective and not trigger the excise ("Cadillac") tax
- Report due by November 1, 2015

Sec. 14-15. Provider payment parity

- Health plans must reimburse participating physicians, podiatrists, chiropractors, naturopathic physicians, psychologists, clinical social workers, advanced practice registered nurses, and physician assistants the same professional fee as applied to other participating providers providing same covered service
- Health plans must adjust reimbursement rates to ensure that parity is attained without increasing premiums
- GMCB must convene group of interested stakeholders to develop implementation plan for parity in 2017, which must be provided to committees of jurisdiction by January 15, 2016

Secs. 16–29. Transferring Department of Financial Regulation (DFR) duties

- Sec. 16 - requires public hearing in insurance rate review cases within 90-day period for the GMCB's review, rather than within 30 days after making rate filing available to public; maintains DFR's authority over Medicare supplemental rates

- Sec. 17 - eliminates requirement that insurers to file with DFR an annual report card regarding the plan's performance with respect to care and treatment for mental and substance abuse conditions, as well as its revenue loss and expense ratio relating to care and treatment of mental conditions under the plan
- Sec. 18 - deletes DFR's Division of Health Care Administration from definition section, makes conforming change with respect to GMCB's authority over health resource allocation plan
- Sec. 19 - makes conforming changes reflecting GMCB's role over procedures in 18 V.S.A. chapter 221; eliminates the special fund DFR used when it regulated health care
- Sec. 20 - makes conforming changes reflecting GMCB's authority over VHCURES; deletes requirement that VHCURES include a consumer health care price and quality information system and deletes DFR's authority to require health insurers to file consumer health care price and quality information plans; transfers household health insurance survey to Department of Health, with next survey due by January 15, 2018
- Sec. 21 - allows DFR to resolve certain consumer complaints about managed care organizations (MCOs) as though the MCO was an insurer; eliminates a requirement that DFR review an MCO's performance at least once every three years
- Sec. 22 - deletes references to rules adopted by DFR
- Sec. 23 - deletes references to rules adopted by DFR
- Sec. 24 - GMCB replaces DFR as entity with authority over conversion of nonprofit hospitals
- Sec. 25 - makes changes to the public notice requirements for certificate of need applications
- Sec. 26 - clarifies GMCB's authority in enforcing certificate of need laws
- Sec. 27 - makes conforming change in hospital budget review statute
- Sec. 28 - prohibits DFR from modifying existing common forms, procedures, and rules prior to January 1, 2017; allows DFR to review and examine aspects of MCO administration
- Sec. 29 - requires Director of Health Care Reform to evaluate the need to maintain certain provisions in health insurance statutes, the need to maintain provisions requiring DFR to review and examine aspects of MCO administration, the appropriate entity to assume responsibility for any function that should be retained, and the requirements of federal law applicable to DVHA in its role as public MCO; report due by December 15, 2015

Secs. 30-31. Presuit mediation in medical malpractice claims

- Reenacts subchapter on presuit mediation, which expired on February 1, 2015, until July 1, 2020
- Allows potential plaintiffs to serve on potential defendants in medical malpractice cases a request to participate in presuit mediation before filing the lawsuit

- Request would name all known potential defendants, contain a brief statement of the facts the plaintiff believes are grounds for relief, and include a certificate of merit
- Sets forth process for potential defendants to accept or reject the request for presuit mediation
- If mediation is unsuccessful, plaintiff can bring the medical malpractice lawsuit
- Presuit mediation is confidential
- Secretary of Administration or designee must report by December 1, 2019 on the impacts of certificates of merit and presuit mediation

Sec. 32. Provider rate setting in Medicaid

- Directs Department of Disabilities, Aging, and Independent Living and AHS Division of Rate Setting to review current reimbursement rates for providers of certain long term home- and community-based care services and report findings and recommendations by December 1, 2015

Sec. 33. Green Mountain Care Board review of designated agency budgets

- Directs GMCB to analyze the budget and Medicaid rates of one or more designated agencies using criteria similar to hospital budget review
- Directs GMCB to consider whether designated and specialized service agencies should be included in the all-payer model
- Report due by January 31, 2016 regarding Board's ongoing role in designated agency budget review and the designated and specialized service agencies' inclusion in the all-payer model

Secs. 34-38. Universal Primary Care

- Introduces concept of universal primary care for all Vermonters
- Directs Joint Fiscal Office to estimate costs of providing universal primary care to all Vermont residents, with and without cost-sharing, beginning in 2017
    - Estimate due October 15, 2015
- Requires Secretary of Administration or designee to arrange for actuarial services
- Appropriates up to $100,000.00 to Agency of Administration for actuarial work

Sec. 39. Repeals

- Repeals statute on other powers and duties of DFR Commissioner
- Repeals statute on DFR bill-back authority
- Prospective repeal of presuit mediation on July 1, 2020