1 Introduced by Committee on Finance

2 Date:

3 Subject:

4 Statement of purpose of bill as introduced:

5 An act relating to health care reform priorities

6 It is hereby enacted by the General Assembly of the State of Vermont:

7 * * * Cost Containment Measures * * *

8 Sec. 1. ALL-PAYER WAIVER; SCOPE

9 In the course of negotiations with the Centers for Medicare and Medicaid
10 Services for an all-payer waiver, the Secretary of Administration or designee
11 and the Green Mountain Care Board shall concurrently explore pursuing a
12 waiver applicable to all health care services and a waiver applicable to hospital
13 services only.

14 Sec. 2. GLOBAL HOSPITAL BUDGETS; WAIVER AGREEMENT

15 On or before January 1, 2016, the Secretary of Administration or designee
16 shall apply to the Centers for Medicare and Medicaid Innovation for an
17 all-payer model agreement that enables the State to establish global hospital
18 budgets for each hospital licensed in this State.

19 Sec. 3. 18 V.S.A. chapter 44 is added to read:

20 CHAPTER 44. GLOBAL HOSPITAL BUDGETS

1 § 1951. GLOBAL HOSPITAL BUDGETS

2 (a) The Green Mountain Care Board shall enter into contracts and
3 operating agreements establishing a global hospital budget for each hospital
4 licensed in this State. It shall ensure hospitals are in compliance with their
5 global budgets by comparing each hospital's actual revenue to its approved
6 global budget.

7 (b) The global hospital budget for each hospital shall:

8 (1) include all inpatient and outpatient facility services, as well as
9 professional services provided by physicians employed by the hospital;

10 (2) cover all patients seeking care at the hospital, regardless of whether
11 they reside in Vermont, with services provided to out-of-state residents
12 reimbursed directly through traditional fee-for-service arrangements;

13 (3) apply to all payers, including commercial payers, Medicare,
14 Medicaid, and uninsured patients;

15 (4) be developed based on the hospital's historical costs and net patient
16 revenue from hospital fiscal year 2014, then adjusted for future hospital fiscal
17 years based on trend factors that account for inflation, demand fluctuation
18 based on the demographics of the hospital's patient population, and growth at a
19 rate commensurate with the growth in the State's gross domestic product;

20 (5) initially set the rates to be paid by each payer at the level in effect for
21 the year prior to implementation of the global budget plus an inflationary

1 factor, with rates increased or decreased in the future at levels approved by the
2 Green Mountain Care Board based on whether the hospital is successful in
3 reducing unnecessary hospital utilization or exceeds its budgeted amounts; and
4 (6) be adjusted if necessary to account for significant shifts in patient
5 volume and impacts on market share.
6 (c) The Green Mountain Care Board, in consultation with the Agencies of
7 Administration and of Human Services, shall implement pay-for-performance
8 quality initiatives for hospitals in addition to the global budgets to ensure that
9 clinical standards are achieved and maintained. The Green Mountain Care
10 Board and the Agency of Human Services shall also monitor delivery system
11 changes to ensure that providers do not reduce access, inappropriately shift
12 care to other providers, or otherwise avoid costly patients.
13 § 1952. RULEMAKING
14 The Green Mountain Care Board may adopt rules pursuant to 3 V.S.A.
15 chapter 25 as needed to carry out the purposes of this chapter.
16 Sec. 4. RESERVED
17 Sec. 5. RESERVED
18 Sec. 6. RESERVED
19 Sec. 7. 18 V.S.A. § 9375(b) is amended to read:
20 (b) The Board shall have the following duties:
21 * * *

1 (2)(A) Review and approve Vermont's statewide Health Information
2 Technology Plan pursuant to section 9351 of this title to ensure that the
3 necessary infrastructure is in place to enable the State to achieve the principles
4 expressed in section 9371 of this title.
5 (B) Review and approve the criteria required for health care
6 providers and health care facilities to create or maintain connectivity to the
7 State's health information exchange as set forth in section 9352 of this title.
8 (C) Annually review and approve the core activities and budget,
9 consistent with available funds and to the extent the activities are funded with
10 State dollars, of the Vermont Information Technology Leaders, Inc., which
11 shall include establishing the interconnectivity of electronic medical records
12 held by health care professionals and health care systems for the purpose of
13 improving the quality and efficiency of health care provided to Vermonters.
14 This review shall be conducted according to a process established by the Board
15 by rule pursuant to 3 V.S.A. chapter 25.
16 * * *
17 Sec. 8. 18 V.S.A. § 9352 is amended to read:
18 § 9352. VERMONT INFORMATION TECHNOLOGY LEADERS
19 * * *
20 (c)(1) Health information exchange operation. VITL shall be designated in
21 the Health Information Technology Plan pursuant to section 9351 of this title

1 to operate the exclusive statewide health information exchange network for
2 this State. ~~The~~ After the Green Mountain Care Board approves VITL's core
3 activities and budget pursuant to chapter 220 of this title, the Secretary of
4 Administration or designee shall enter into procurement grant agreements with
5 VITL pursuant to 8 V.S.A. § 4089k. Nothing in this chapter shall impede local
6 community providers from the exchange of electronic medical data.
7 (2) Notwithstanding any provision of 3 V.S.A. § 2222 or 2283b to the
8 contrary, upon request of the Secretary of Administration, the Department of
9 Information and Innovation shall review VITL's technology for security,
10 privacy, and other appropriate technical issues.
11 * * *
12 (f) Funding authorization. VITL is authorized to seek matching funds to
13 assist with carrying out the purposes of this section. In addition, it may accept
14 any and all donations, gifts, and grants of money, equipment, supplies,
15 materials, and services from the federal or any local government, or any
16 agency thereof, and from any person, firm, foundation, or corporation for any
17 of its purposes and functions under this section and may receive and use the
18 same, subject to the terms, conditions, and regulations governing such
19 donations, gifts, and grants. VITL shall not use any State funds for
20 advertising, marketing, or similar services.
21 * * *

1 Sec. 9. RESERVED

2 * * * Care Improvement * * *

3 Sec. 10. 8 V.S.A. § 4100k(g) is amended to read:

4 (g) As used in this subchapter:

5 (1) "Health insurance plan" means any health insurance policy or health
6 benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402~~, as well~~
7 ~~as Medicaid and any other public health care assistance program offered or~~
8 ~~administered by the State or by any subdivision or instrumentality of the State~~.
9 The term does not include policies or plans providing coverage for specified
10 disease or other limited benefit coverage.

11 * * *

12 Sec. 11. 33 V.S.A. § 1901i is added to read:

13 § 1901i. MEDICAID COVERAGE FOR TELEMEDICINE

14 (a) Beginning on July 1, 2015, the Agency of Human Services shall
15 provide coverage for primary care consultations delivered through
16 telemedicine to Medicaid beneficiaries in a residential setting. The Agency
17 shall ensure that coverage for the telemedicine consultations is budget-neutral
18 by reimbursing treating health care professionals in the same manner as if the
19 services were provided through in-person consultation.

1 (b) The Agency shall not impose limitations on the number of telemedicine
2 consultations a Medicaid beneficiary may receive or on which Medicaid
3 beneficiaries may receive primary care consultations through telemedicine.
4 (c) As used in this section, "telemedicine" means the delivery of health care
5 services such as diagnosis, consultation, or treatment through the use of live
6 interactive audio and video over a secure connection that complies with the
7 requirements of the Health Insurance Portability and Accountability Act of
8 1996, Public Law 104-191. Telemedicine does not include the use of
9 audio-only telephone, e-mail, or facsimile.
10 Sec. 12. RESERVED
11 Sec. 13. RESERVED
12 Sec. 14. RESERVED
13 * * * Increased Coverage * * *
14 Sec. 15. 33 V.S.A. § 1803(b)(4) is amended to read:
15 (4)(A) To the extent permitted by the U.S. Department of Health and
16 Human Services, the Vermont Health Benefit Exchange shall permit qualified
17 employers to purchase qualified health benefit plans through the Exchange
18 website, through navigators, by telephone, or directly from a health insurer
19 under contract with the Vermont Health Benefit Exchange.
20 (B) To the extent permitted by the U.S. Department of Health and
21 Human Services, the Vermont Health Benefit Exchange shall permit qualified

1 individuals who are not eligible for or do not wish to receive federal or State
2 Exchange financial assistance to purchase qualified benefit plans through the
3 Exchange website, through navigators, by telephone, or directly from a health
4 insurer under contract with the Vermont Health Benefit Exchange. Prior to
5 enrolling an individual directly in an Exchange plan, a health insurer shall:
6 (i) notify the applicant of the income thresholds for receiving
7 federal and State Exchange premium tax credits and cost-sharing subsidies;
8 (ii) inform the applicant that the premium tax credits and
9 cost-sharing subsidies are available only when purchasing a plan through the
10 Exchange website, through a navigator, or by telephone communication with
11 an Exchange employee; and
12 (iii) recommend that the applicant determine his or her eligibility
13 for the premium tax credits and cost-sharing subsidies prior to purchasing a
14 plan through the insurer.
15 Sec. 16. RESERVED
16 Sec. 17. RESERVED
17 * * * Assignment of Payment for Dental Benefits * * *
18 Sec. 18. REDESIGNATION
19 (a) 8 V.S.A. chapter 107, subchapter 13 (tobacco cessation) is redesignated
20 as 8 V.S.A. chapter 107, subchapter 15.

1 (b) 8 V.S.A. § 4100j (coverage for tobacco cessation programs) is
2 redesignated as 8 V.S.A. § 4100l.
3 Sec. 19. 8 V.S.A. § 4100j is added in chapter 107, subchapter 12 to read:
4 § 4100j. ASSIGNMENT OF PAYMENT FOR BENEFITS
5 (a) As used in this section, "dental plan" means any insurance policy that is
6 issued by a health care service contractor, health maintenance organization,
7 health insurer, dental insurer, or any similar entity subject to regulation by the
8 Department of Financial Regulation, which provides coverage for dental
9 services as a stand-alone dental plan or in connection with a health insurance
10 plan as defined in section 4088h of this title.
11 (b) A subscriber of a dental plan may direct the payment for a dental
12 service covered under the plan to a dentist outside of the dental plan's provider
13 network who provided the covered dental service to the subscriber. If the
14 subscriber's authority to assign payment for a covered dental service to a
15 dentist outside of the dental plan's provider network is exercised, the dental
16 plan shall submit payment directly to the dentist providing the covered dental
17 service.
18 (c) An assignment of payment for a covered dental service pursuant to this
19 section shall not limit or otherwise affect the payment of benefits or coverage
20 provided under the dental plan.
21 * * * Claims Edit Standards * * *

1 Sec. 20. VERMONT CLAIMS EDIT REVIEW PANEL

2 (a) There is created a Vermont Claims Edit Review Panel. The Panel shall
3 comprise health care providers, health insurers, and other interested
4 stakeholders and shall include representatives from Blue Cross Blue Shield of
5 Vermont, MVP Health Care, Cigna, the Vermont Association of Hospitals and
6 Health Systems, the Vermont Medical Society, the Department of Vermont
7 Health Access, and the Green Mountain Care Board. These representatives
8 and other interested stakeholder participants shall be individuals who have the
9 appropriate knowledge, experience, and authority to perform the work of the
10 Panel.

11 (b) On or before September 1, 2015, the Panel shall establish a process by
12 which it will develop a set of standardized edits and payment rules appropriate
13 for use in Vermont beginning on January 1, 2017.

14 (c) On or before January 15, 2016, the Panel shall:

15 (1) Identify a set of common edits and payment rules for use by
16 commercial payers in Vermont for the payment of health care provider claims
17 based on the edits and payment rules currently used by the commercial payers
18 on the Panel and any other edits and payment rules the Panel deems
19 appropriate.

20 (2) Develop a process for determining whether and how to modify the
21 set of common edits and payment rules identified pursuant to subdivision (1)

1 of this subsection. The process shall include a mechanism by which health
2 care providers may request that the Panel review one or more edits or payment
3 rules.
4 (3) Identify any differences between the set of common edits and
5 payment rules and those used by Medicaid, and minimize those difference to
6 the greatest extent practicable.
7 (4) Submit a report to the House Committee on Health Care and the
8 Senate Committees on Health and Welfare and on Finance setting forth the
9 Panel's progress under this subsection.
10 (d) On or before January 1, 2017, health care providers, health insurances,
11 and other payers shall use the set of common edits and payment rules
12 developed pursuant to this section to edit claims submitted by Vermont health
13 care providers.
14 (e) To the extent necessary to avoid violations of federal antitrust laws, the
15 Green Mountain Care Board shall facilitate and supervise the participation of
16 members of the Vermont Claims Edit Review Panel.
17 Sec. 21. 2013 Acts and Resolves No. 79, Sec. 5b, as amended by 2014 Acts
18 and Resolves No. 144, Sec. 10, is further amended to read:
19 Sec. 5b. STANDARDIZED HEALTH INSURANCE CLAIMS AND
20 EDITS

1 (a)(1) As part of moving away from fee-for-service and toward other models
2 of payment for health care services in Vermont, the Green Mountain Care Board,
3 in consultation with the Department of Vermont Health Access, health care
4 providers, health insurers, and other interested stakeholders, shall develop a
5 complete set of standardized edits and payment rules based on Medicare or on
6 another set of standardized edits and payment rules appropriate for use in
7 Vermont. The Board ~~and the Department~~ shall adopt by rule the standards and
8 payment rules that health care providers, health insurers, and other payers shall
9 use beginning on January 1, ~~2016~~ 2017 ~~and that Medicaid shall use beginning on~~
10 ~~January 1, 2017~~.

11 * * *

12 Sec. 22. RESERVED

13 Sec. 23. RESERVED

14 * * * Effective Dates * * *

15 Sec. 24. EFFECTIVE DATES