Act 54 (S.139) – An act relating to health care

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All-Payer Model

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

Pharmacy Benefit Managers

- Requires pharmacy benefit managers (PBMs) to:
  - make available to pharmacists the actual maximum allowable cost (MAC) for each drug and the source used to determine the MAC
  - update the MAC at least every 7 calendar days
  - have a reasonable appeals process to contest a MAC
  - respond in writing to an appealing pharmacy within 10 calendar days, provided pharmacy must file appeal within 10 calendar days from date its claim for reimbursement was adjudicated

Notice of hospital observation status

- Requires hospitals to provide oral and written notices to Medicare beneficiaries placed in observation status
- Notice must tell people:
  - that they are on observation status and not admitted as an inpatient
  - that observation status may affect their Medicare coverage for hospital services and nursing home stays
  - whom they may contact for more information
- Interested stakeholders will consider the appropriate notice of hospital observation status for patients with commercial insurance
  - Report due by January 15, 2016

Green Mountain Care Board (GMCB) 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

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, or similar services, unless a grant or contract requires a contribution of State funds

Ambulance reimbursement

- Requires DVHA to evaluate the way it calculates ambulance and emergency medical services reimbursements in Medicaid to determine the basis for the current reimbursement amounts and rationale
- DVHA must consider adjustments to change the methodology if they will be budget neutral or of minimal fiscal impact in FY 2016
- Report due December 1, 2015

Direct enrollment for Exchange

- Allows individuals to purchase Exchange plans directly from the health insurers beginning with 2016 open enrollment
- Continues to allow small group market (1-100 employees for 2016 plan year) to purchase Exchange plans directly from the health insurers

Large group insurance market

- Delays until 2018 the ability of the large group market (101+ employees) 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

Universal primary care

- Directs Secretary of Administration or designee to estimate costs of providing universal primary care to all Vermont residents, with and without cost-sharing, beginning in 2017
  - Draft estimate due to JFO by October 15, 2015
  - JFO must conduct an independent review, provide feedback by December 2, 2015
  - Final report due to General Assembly by December 16, 2015
  - JFO must present independent review to General Assembly by January 6, 2016
- Requires Secretary of Administration or designee to arrange for actuarial services
- Appropriates up to $100,000 to Agency of Administration for actuarial work

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
- The Internet tool must reflect cost-sharing applicable to a member's specific plan and reflect up-to-date deductible information

Consumer information and price transparency

- Directs GMCB to evaluate potential models for allowing consumers to compare information about the cost and quality of health care services across Vermont
- Requires GMCB to report findings and proposal by October 1, 2015

Public employee 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
- Director must consult with stakeholders
- Coverage must be cost-effective and not trigger the excise ("Cadillac") tax
- Report due by November 1, 2015

Payment reform/differential payments to providers

- In implementing an all-payer model and provider rate-setting, the Green Mountain Care Board must consider:
  - the benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service
  - the impact of hospital acquisitions of independent physicians on health system costs
  - the effects of differential reimbursement for professional services provided by health care providers employed by academic medical centers and by others and methods to reduce or eliminate the differences
  - the effects of different reimbursements for different types of providers for the same services billed under the same codes
  - the advantages and disadvantages of allowing health care providers to continue setting their own rates for uninsured customers

Payment reform/differential payments to providers (cont.)

- Requires insurers with more than 5,000 covered lives to submit to GMCB by July 1, 2016 a plan to provide fair and equitable reimbursement to providers at academic medical centers and other providers
  - Plan must not increase premiums or public funding
  - GMCB must approve, modify, or reject plans
- When GMCB approves a plan, GMCB must require academic medical centers to accept the reimbursements provided in the plan
- GMCB will provide progress update in its annual report

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
- Department and Division must report findings and recommendations by December 1, 2015

Designated agency budget review

- 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 GMCB's ongoing role in designated agency budget review and the designated and specialized service agencies' inclusion in the all-payer model

Presuit mediation in medical malpractice claims

- Reenacts until July 1, 2020 a subchapter on presuit mediation, which expired on February 1, 2015
- 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 request
- If mediation unsuccessful, plaintiff can bring 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

Transfer of DFR duties

- Transfers or eliminates certain health care-related duties of the Department of Financial Regulation (DFR)
- Prohibits DFR from modifying existing common forms, procedures, or rules prior to January 1, 2017
- Requires Director of Health Care Reform to evaluate:
  - need to maintain certain provisions in health insurance statutes
  - need to maintain provisions requiring DFR to review and examine aspects of MCO administration
  - need to maintain provisions related to mental health quality assurance
  - appropriate entity to assume responsibility for any function that should be retained
  - requirements of federal law applicable to DVHA in its role as public MCO
- Report due by December 15, 2015

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
- By April 15, 2016, DVHA must provide a report on the first six months of implementation

Repurposing excess hospital funds

- Describes reductions in rate of uninsured with no corresponding reduction in Disproportionate Share Hospital (DSH) payments and hospital “free care” charges
- Directs GMCB to identify “stranded” dollars in hospital budgets, report findings to General Assembly by October 15, 2015
- Expresses legislative intent to repurpose those dollars for increases to the Blueprint for Health

Cigarette and tobacco taxes

- Increases cigarette and other tobacco product taxes, including floor stock, by an amount equivalent to $0.33 per pack beginning on July 1, 2015

Appropriations - GMCB

- Appropriates and adjusts funds to GMCB for positions and operating expenses related to GMCB's provider rate-setting authority, all-payer model, and Medicaid cost shift
- Adds three new positions to GMCB
- Appropriates $60,000 for GMCB oversight of VITL's budget and activities

Appropriations - Blueprint

- Blueprint for Health - $2,446,075 (gross) to increase payments to patient-centered medical homes and community health teams participating in the Blueprint beginning on July 1, 2015
- Requires Blueprint to begin including family-centered approaches and adverse childhood experience screenings

Appropriations - Medicaid

- **Primary provider rate increase** - $1,000,667 (gross) beginning on July 1, 2015
- **Other Medicaid providers**- $833,969 (gross) for rate increases beginning on July 1, 2015 for providers under contract with departments in AHS to provide services to Medicaid beneficiaries
- **Home- and community-based services** - $175,818 (gross) for Medicaid rate increases beginning on July 1, 2015
- **Independent mental health and substance abuse professionals** - $111,185 (gross) for Medicaid rate increases beginning on July 1, 2015

Additional Appropriations

- **Cost-sharing subsidies** - $761,308 (State) for base spending
- **Area Health Education Centers (AHEC)** - $667,111.00 (gross) for repayment of educational loans for health care providers and health care educators
- **Office of Health Care Advocate (HCA)** - $40,000.00 (State)
  - Expresses legislative intent that Governor's budget proposals include a line item showing the aggregate sum to be appropriated to the HCA from all State sources

Additional reports

- **SIM Grant** - Requires updates at least quarterly on Project implementation and use of State Innovation Model (SIM) grant funds
- **Human services** - Directs AHS to evaluate services offered by each entity licensed, administered, or funded by the State to provide home- and community-based long-term care services or providing services to people with developmental disabilities, mental health needs, or substance use disorder
  - AHS must identify gaps in services, overlapping or duplicative services
  - Report due January 15, 2016
- **Blueprint for Health** - 2016 annual report must include analysis of value-added benefits and return on investment to Medicaid of new funds appropriated in fiscal year 2016 budget
  - Blueprint must explore and report to General Assembly by January 15, 2016 on potential wellness incentives

Act 58 (Big Bill) VHC provisions

- Requires monthly Vermont Health Connect (VHC) reports to committees of jurisdiction beginning June 1
- Requires Joint Fiscal Office to analyze and provide information about VHC information technology systems in July, September, and October 2015
- Describes VHC milestones relating to change of circumstance/information and automated renewal of qualified health plans
- If VHC fails to meet any milestone(s), the Administration must identify and begin exploring all feasible alternatives to VHC

Act 58 VHC provisions (cont.)

- If Joint Fiscal Committee (JFC) requests it, Chief of Health Care Reform must prepare analysis and potential implementation plan for transition to new model
- By November 15, 2015, Chief of Health Care Reform must provide recommendation of future of VHC, including proposed timeline for 2016
  - If Chief recommends transition to federally supported State-based marketplace (FSSBM), JFC has until December 1, 2015 to decide whether to concur
    - If JFC concurs, Chief must request federal approval before December 31, 2015 and provide statutory changes necessary by January 15, 2016
  - If Chief does not recommend FSSBM and/or JFC does not concur, Chief must submit alternative options to General Assembly by January 15, 2016

SFY'16 Estimates - Act 54 (S.139) as passed

Sec.	*Proposed Revenue Sources*	
49, 51	Cigarette Tax Increases	2.60
50, 51	Other Tobacco Products (snuff/snuz)	0.70
	ESTIMATED REVENUES	**3.20**

** Note: additional $122,000 will come from General Fund.*

Sec.	*Cost Estimates*	State	Gross
	Cost sharing subsidies	**0.76**	**0.76**
54	Current Cost Sharing subsidy	0.76	0.76
	Targeted Medicaid Rate Increases	**0.96**	**2.13**
57	Primary Care	0.45	1.00
58	Other Medcaid Providers & Home and Community-Based Services*	0.45	1.01
59	Independent Mental Health Providers	0.05	0.12
56	**Blueprint for Health**	**1.10**	**2.45**
	Green Mountain Care Board	**0.07**	**0.34**
55	All Payer Model / Rate setting / VITL Oversight	0.07	0.34
	Other	**0.44**	**0.81**
52	Loan Repayment (AHEC)	0.30	0.67
16-19	Universal Primary Care Study	0.10	0.10
53	Health Care Advocate	0.04	0.04
	TOTAL TO BE FINANCED	**3.32**	**6.48**

** Note: preliminary estimates are that this increase translates to a roughly 0.22% increase.*

Any questions?