S.139 - Section by section summary of *CONFERENCE COMMITTEE REPORT*
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Sec. 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

Secs. 2-3. 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

Secs. 4-6. 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
- Requests that interested stakeholders consider the appropriate notice of hospital observation status for patients with commercial insurance
  - Report due by January 15, 2016

Sec. 7. 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. 8. Green Mountain Care Board rate-setting authority

- Specifies that nothing about GMCB's rate-setting authority should be construed to reduce or limit covered services offered by Medicare or Medicaid

Sec. 9. 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

Sec. 10. 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

Secs. 11-12. Direct enrollment in Exchange plans

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

Secs. 13-15. 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

Secs. 16-19. Universal primary care

- Introduces concept of universal primary care for all Vermonters
- 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 $100,000.00 to Agency of Administration for actuarial work

Sec. 20. 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

Sec. 21. 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

Sec. 22. 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. 23. Payment reform and differential payments to providers

- In implementing an all-payer model and provider rate-setting, the Green Mountain Care Board must consider:
    - benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service
    - impact of hospital acquisitions of independent physicians on health system costs
    - 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
    - effects of different reimbursements for different types of providers for the same services billed under the same codes
    - advantages and disadvantages of allowing health care providers to continue setting their own rates for uninsured customers
- 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 center to accept the reimbursements provided in the plan
- GMCB will provide progress update in its annual report

Sec. 24. Vermont Health Care Innovation Project updates

- Requires the Vermont Health Care Innovation Project to provide updates at least quarterly on Project implementation and use of federal State Innovation Model (SIM) grant funds

Sec. 25. Reducing duplication of services; report

- Directs Agency of Human Services (AHS) to evaluate the 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 and overlapping or duplicative services
- Report due January 15, 2016

Sec. 26. Blueprint for Health report

- Requires 2016 Blueprint for Health annual report to include an analysis of the value-added benefits and return on investment to Medicaid of the new funds appropriated in the fiscal year 2016 budget
- Requires Blueprint to explore and report to General Assembly by January 15, 2016 on potential wellness incentives

Sec. 27. 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. 28. 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. 29-30. 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

Secs. 31–44. Transferring Department of Financial Regulation (DFR) duties

- Sec. 31 - 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. 32 - 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. 33 - 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. 34 - 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. 35 - 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. 36 - 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. 37 - deletes references to rules adopted by DFR
- Sec. 38 - deletes references to rules adopted by DFR
- Sec. 39 - GMCB replaces DFR as entity with authority over conversion of nonprofit hospitals
- Sec. 40 - makes changes to the public notice requirements for certificate of need applications
- Sec. 41 - clarifies GMCB's authority in enforcing certificate of need laws
- Sec. 42 - makes conforming change in hospital budget review statute
- Sec. 43 - 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. 44 - 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 need to maintain provisions related to mental health quality assurance, 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

Sec. 45. 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. 46. 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

Sec. 47. 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

Sec. 48. Green Mountain Care Board positions

- Adds three positions to the GMCB

Secs. 49-51. 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

Sec. 52 Area Health Education Centers (AHEC)

- Appropriates $667,111 (gross) to AHEC for repayment of educational loans for health care providers and health care educators

Sec. 53. Office of the Health Care Advocate

- Appropriates $40,000.00 (State) for the Office of the Health Care Advocate (HCA)
- 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

Sec. 54. Cost-sharing subsidies

- Appropriates $761,308 (State) for base spending for cost-sharing subsidies

Sec. 55. All-payer waiver, rate-setting

- Appropriates and adjusts funds to GMCB for positions and operating expenses related to GMCB's provider rate-setting authority, the all-payer model, and Medicaid cost shift
- Appropriates $60,000.00 for oversight of VITL's budget and activities

Sec. 56. Blueprint for Health increases

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

Sec. 57. Increase for Medicaid primary care providers

- Appropriates $1,000,667 (gross) to increase Medicaid reimbursement rates for primary care providers beginning on July 1, 2015

Sec. 58. Rate increases for other Medicaid providers

- Appropriates $833,969 (gross) to AHS to increase reimbursement rates beginning on July 1, 2015 for providers under contract with departments within AHS to provide services to Medicaid beneficiaries:
  - $290,186 to DMH
  - $69,875 to Dept. of Health, Division of ADAP
  - $358,480 to DAIL for developmental disability services
  - $115,427 to other departments' line items
- Appropriates $175,818 (gross) to DVHA to increase Medicaid reimbursement rates for home-and community-based services in Global Commitment and Choices for Care beginning on July 1, 2015

Sec. 59. Rate increases for independent mental health and substance abuse treatment professionals

- Appropriates $111,185 (gross) to DVHA to increase Medicaid reimbursement rates on July 1, 2015 to mental health and substance abuse treatment professionals not affiliated with a designated agency

Sec. 60. Global Commitment appropriation

- Makes appropriations and adjustments to ensure that the AHS Global Commitment budget line item matches the appropriations made in Secs. 52-59

Sec. 61. 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

Sec. 62. Effective dates