TO THE HONORABLE SENATE:

The Committee on Health & Welfare to which was referred House Bill No. 812 entitled "An act relating to implementing an all-payer model and oversight of accountable care organizations" respectfully reports that it has considered the same and recommends that the Senate propose to the House that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * All-Payer Model * * *

Sec. 1. ALL-PAYER MODEL; MEDICARE AGREEMENT

The Green Mountain Care Board and the Agency of Administration shall only enter into an agreement with the Centers for Medicare and Medicaid Services to waive provisions under Title XVIII (Medicare) of the Social Security Act if the agreement:

(1) is consistent with the principles of health care reform expressed in 18 V.S.A. § 9371, to the extent permitted under Section 1115A of the Social Security Act and approved by the federal government;

(2) preserves the consumer protections set forth in Title XVIII of the Social Security Act, including not reducing Medicare covered services, not increasing Medicare patient cost sharing, and not altering Medicare appeals processes;

(3) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(4) allows Medicare patients to choose their providers;

(5) includes outcome measures for population health; and

(6) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont.

Sec. 2. 18 V.S.A. chapter 227 is added to read:

CHAPTER 227. ALL-PAYER MODEL

§ 9551. ALL-PAYER MODEL

**(a)** In order to implement a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, **other State-funded health care programs, (Richter)** and commercial insurance using a common methodology that may include population-based payments **and increased financial predictability for providers**, the Green Mountain Care Board and Agency of Administration shall ensure that the model:

(1) maintains consistency with the principles established in section 9371 of this title;

(2) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont;

(3) maximizes alignment between Medicare, Medicaid, **other State-funded health care programs, (Richter)** and commercial payers to the extent permitted under federal law and waivers from federal law, including:

(A) what is included in the calculation of the total cost of care;

(B) attribution and payment mechanisms;

(C) patient protections;

(D) care management mechanisms; and

(E) provider reimbursement processes;

(4) strengthens and invests in primary care;

(5) incorporates social determinants of health;

(6) adheres to federal and State laws on parity of mental health and substance abuse treatment~~,~~ **and** integrates mental health and substance abuse treatment systems into the overall health care system~~, and does not manage mental health or substance abuse care separately from other health care~~ **(Julie Tessler)**;

(7) includes a process for integration of community-based providers, including home health agencies, mental health agencies, development disability service providers, emergency medical service providers, and area agencies on aging, and their funding streams, into a transformed, fully integrated health care system **that may include transportation and housing**;

(8) continues to prioritize the use, where appropriate, of existing local and regional collaboratives of community health providers that develop integrated health care initiatives to address regional needs and evaluate best practices for replication and return on investment;

(9) pursues an integrated approach to data collection, analysis, exchange, and reporting to simplify communication across providers and drive quality improvement and access to care;

(10) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(11) evaluates access to care, quality of care, patient outcomes, and social determinants of health;

(12) requires processes and protocols for shared decision making between the patient and his or her health care providers that take into account a patient's unique needs, preferences, values, and priorities, including use of decision support tools and shared decision-making methods with which the patient may assess the merits of various treatment options in the context of his or her values and convictions, and by providing patients access to their medical records and to clinical knowledge so that they may make informed choices about their care;

(13) supports coordination of patients' care and care transitions through the use of technology, with patient consent, such as sharing electronic

summary records across providers and using telemedicine, home telemonitoring, and other enabling technologies; and

(14) ensures, in consultation with the Office of the Health Care Advocate, that robust patient grievance and appeal protections are available.

**(b) The Green Mountain Care Board shall convene stakeholder groups comprising accountable care organizations, community providers, and other interested stakeholders to ensure that any system established pursuant to this section maintains the appropriate allocation of resources and services to provide to Vermonters the right care at the right time in the right place.**

* * * Oversight of Accountable Care Organizations * * *

Sec. 3. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

* * *

(16) "Accountable care organization" and "ACO" means an organization of health care providers that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it.

Sec. 4. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

* * *

**(13) Manage the changes necessary to transform Vermont's health care system into one that provides seamless care, administration, and service delivery.**

(14) Adopt by rule pursuant to 3 V.S.A. chapter 25 standards for accountable care organizations, including reporting requirements, patient protections, solvency and ability to assume financial risk, and other matters the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter.

Sec. 5. 18 V.S.A. § 9382 is added to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a) In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization with 10,000 or more attributed lives in Vermont shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations, which may include consideration of acceptance of accreditation by the National Committee for Quality Assurance or another national accreditation organization for any of the criteria set forth in this

section. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

(1) the ACO's governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input;

(2) the ACO has established appropriate mechanisms to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO;

(3) the ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers;

(4) the ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination and are related to the needs of the ACO and the patient population served;

(5) the ACO has established mechanisms to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, and effective health care services;

(6) the ACO has the capacity for meaningful participation in health information exchanges;

(7) the ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers;

(8) the ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health;

(9) the ACO's participating health care providers engage their patients in shared decision making to ensure their awareness and understanding of their treatment options and the related risks and benefits of each;

(10) the ACO has an accessible mechanism for explaining how ACOs work; provides contact information for the Office of the Health Care Advocate; maintains a consumer telephone line for complaints and grievances from attributed patients; responds and makes best efforts to resolve complaints and grievance from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan; and share deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually;

(11) the ACO collaborates with providers not included in its financial model, including home- and community-based providers and dental health providers;

**(12) the ACO has developed a timeline for beginning integration into the ACO by January 1, 2018 of community-based providers, including home health agencies, mental health agencies, development disability service providers, emergency medical service providers, area agencies on aging, and potentially transportation and housing;**

**(13) the ACO links medical and community-based services across the continuum of health care in order to provide a seamless transition for patients moving from one care level to another and to reduce the administrative burden on all health care providers;**

**(14) the ACO has established a menu of flexible services to be provided based on the needs of the population served and the individual patients attributed to the ACO;**

(15) the ACO does not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the ACO; does not reduce covered services; and does not increase patient cost sharing;

(16) meetings of the ACO's governing body include a public session at which all business that is not confidential or proprietary is conducted and members of the public are provided an opportunity to comment;

(17) the impact of the ACO's establishment and operation does not diminish access to any health care service for the population and area it serves;

**(18) the ACO has in place appropriated mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities;** and

(19) the ACO has in place a financial guarantee sufficient to cover its potential losses.

(b)(1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving ACO budgets. In its review, the Board shall review and consider:

(A) information regarding utilization of the health care services delivered by health care providers participating in with the ACO;

(B) the goals and recommendations of the health resource allocation plan created in chapter 221 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

(E) any reports from professional review organizations;

(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area;

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

(H) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

**(I) the extent to which the ACO provides incentives for preventing adverse childhood experiences (ACEs), such as developing quality outcome measures for use by primary care providers working with**

**children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers as participating providers in the ACO;**

**(J) the extent to which the ACO uses any population-based prospective payments to provide flexible services to meet the needs of its attributed patients and the population it serves;**

(J) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(K) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(L) information on the ACO's administrative costs, as defined by the Board;

(M) the effect, if any, of Medicaid reimbursement rates on the rates for other payers; and

(N) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive.

(2) The Office of the Health Care Advocate shall have the right to intervene in any ACO budget review under this subsection. As an intervenor, the Office of the Health Care Advocate shall receive copies of all materials in the record and may:

(A) ask questions of any participant in the Board's ACO budget review;

(B) submit written comments for the Board's consideration; and

(C) provide testimony in any hearing held in connection with the Board's ACO budget review.

(c) The Board's rules shall include requirements for submission of information and data by ACOs and their participating providers as needed to evaluate an ACO's success. They may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

(d) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public upon request, provided that individual patients or health care providers shall not be directly or indirectly identifiable.

(e) To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board

determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

* * * Rulemaking * * *

Sec. 6. GREEN MOUNTAIN CARE BOARD; RULEMAKING

On or before January 1, 2018, the Green Mountain Care Board shall adopt rules governing the oversight of accountable care organizations pursuant to 18 V.S.A. § 9382. On or before January 15, 2017, the Board shall provide an update on its rulemaking process and its vision for implementing the rules to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

**Sec. 7. 18 V.S.A. § 9383 is added to read:**

**§ 9383. OVERSIGHT OF COMMUNITY-BASED PROVIDERS**

**(a) In order to participate in an all-payer model pursuant to chapter 227 of this title, a provider of community-based services shall obtain and maintain approval from the Green Mountain Care Board. The Board shall make available to accountable care organizations, commercial insurers, and the Department of Vermont Health Access a current list of approved community-based service providers.**

**(b) In order to receive approval to participate in an all-payer model, community-based service providers, including home health agencies, mental health agencies, developmental disability service providers, and area agencies on aging shall demonstrate to the Board that they provide high-quality services to Vermonters and contribute toward the State's goal of providing the right care at the right time in the right place.**

**(c) The Board shall adopt rules pursuant to 3 V.S.A. chapter 23 to establish standards and processes for approving community-based providers for participation in an all-payer model, which may include reviewing provider budgets, recommending modifications to organizational structures, and coordinating collaborative arrangements with accountable care organizations.**

Sec. 8. DENIAL OF SERVICE; RULEMAKING

The Department of Financial Regulation and the Department of Vermont Health Access shall ensure that their rules protect against wrongful denial of services under an insured's or Medicaid beneficiary's health benefit plan for an insured or Medicaid beneficiary attributed to an accountable care organization. The Departments may amend their rules as necessary to ensure that the grievance and appeals processes in Medicaid and commercial health benefit plans are appropriate to an accountable care organization structure.

* * * Implementation Provisions * * *

Sec. 9. TRANSITION; IMPLEMENTATION

(a) Prior to January 1, 2018, if the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, they shall develop and implement the model in a manner that works toward meeting the criteria established in 18 V.S.A. § 9551. Through its authority over payment reform pilot projects under 18 V.S.A. § 9377, the Board shall also oversee the development and operation of accountable care organizations in order to encourage them to achieve compliance with the criteria established in 18 V.S.A. § 9382(a) and to establish budgets that reflect the criteria set forth in 18 V.S.A. § 9382(b).

(b) On or before January 1, 2018, the Board shall begin certifying accountable care organizations that meet the criteria established in 18 V.S.A. § 9382(a) and shall only approve accountable care organization budgets after review and consideration of the criteria set forth in 18 V.S.A. § 9382(b). If the Green Mountain Care Board and the Agency of Administration pursue development and implementation of an all-payer model, then on and after January 1, 2018 they shall implement the all-payer model in accordance with 18 V.S.A. § 9551.

*** * * Resource Allocation * * ***

* * * **Reducing Administrative Burden on Health Care Professionals** * * *

**Sec. 10. 18 V.S.A. § 9374(e) is amended to read:**

(e)(1) The Board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the Board. Members of such advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The Board may establish additional advisory groups and subcommittees as needed to carry out its duties. The Board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

**(3) To the extent funds are available, the Board shall support research that examines the effectiveness of existing requirements for health care professionals, such as quality measures and prior authorization, and evaluates alternatives that improve quality, reduce costs, and reduce administrative burden.**

**Sec. 11. PRIMARY CARE PROFESSIONAL ADVISORY GROUP**

**(a) The Green Mountain Care Board** shall establish a primary care professional advisory group to provide input and recommendations to the Board. The Board shall seek input from the primary care professional advisory

group to address issues related to the administrative burden facing primary care professionals, including:

(1) identifying circumstances in which existing reporting requirements for primary care professionals may be replaced with more meaningful measures that require minimal data entry;

(2) creating opportunities to reduce requirements for primary care professionals to provide prior authorization for their patients to receive radiology, medication, and specialty services; and

(3) developing a uniform hospital discharge summary for use across the State.

**(b) The Green Mountain Care Board shall provide an update on the advisory group's work in the annual report the Board submits to the General Assembly in accordance with 18 V.S.A. § 9375(d).**

**(c)** The Board may seek assistance **with** the advisory group from organizations representing primary care professionals. Members of the advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year. **The advisory group shall cease to exist on July 1, 2018.**

*** * * Patient Benefits Packages * * ***

**Sec. 12. PATIENTS BENEFIT PACKAGES; REPORT**

**(a) The Green Mountain Care Board, in collaboration with the Agency of Human Services and its departments, shall convene working groups of interested stakeholders to develop models for patient benefits packages based on stages of life, disease diagnoses, and management practices for best outcomes. The benefit packages shall include types of medical and community-based services appropriate to the individual patient groups identified. The working groups may begin by extending the Blueprint for Health model to additional areas of care. The benefits packages shall identify specific groups of patients with medical and community-service needs analogous to those in the Blueprint for Health chronic care initiative, Choices for Care, Support and Services at Home (SASH) programs, the Hub and Spoke initiative, and other models.**

**(b) On or before January 15, 2017, the Green Mountain Care Board shall provide information to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare regarding the patient benefits packages designed by the working groups and the Board's recommendations for application of the benefits packages to accountable care organizations and other health care delivery system models.**

*** * * Improving Access to and Quality of Care * * ***

**Sec. 13. SEAMLESS PATIENT CARE AND CARE ADMINISTRATION**

**The Green Mountain Care Board, in collaboration with accountable care organizations and the Agency of Administration, shall identify areas that may require additional coordination or collaboration, or both, among health care and service providers in order to ensure that patient care and care administration are provided seamlessly across the continuum of care.**

*** * * Additional Reports * * ***

**Sec. 14. AGENCY OF HUMAN SERVICES' CONTRACTS; REPORT (from S.196)**

(a) On or before January 1, 2017, the Agency of Human Services, in consultation with Vermont Care Partners, the Green Mountain Care Board, and representatives from preferred providers, shall submit a report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services. The report shall address the following:

(1) the amount and type of performance measures and other evaluations used in fiscal year 2016 and 2017 Agency contracts with designated agencies, specialized service agencies, and preferred providers;

(2) how the Agency's funding levels of designated agencies, specialized service agencies, and preferred providers affect access to and quality of care; and

(3) how the Agency's funding levels for designated agencies, specialized service agencies, and preferred providers affect compensation levels for staff relative to private and public sector pay for the same services.

(b) The report shall contain a plan developed in conjunction with the Vermont Health Care Innovation Project and in consultation with the Vermont Care Network and the Vermont Council of Developmental and Mental Health Services to implement a value-based payment methodology for designated agencies, specialized service agencies, and preferred providers that shall improve access to and quality of care, including long-term financial sustainability. The plan shall describe the interaction of the value-based payment methodology for Medicaid payments made to designated agencies, specialized service agencies, and preferred providers by the Agency with any Medicaid payments made to designated agencies, specialized service agencies, and preferred providers by the accountable care organizations.

(c) As used in this section:

(1) "Designated agency" means the same as in 18 V.S.A. § 7252.

(2) "Preferred provider" means any substance abuse organization that has attained a certificate of operation from the Department of Health's Division of Alcohol and Drug Abuse Programs and has an existing contract or grant from the Division to provide substance abuse treatment.

(3) "Specialized service agency" means any community mental health and developmental disability agency or any public or private agency providing specialized services to persons with a mental condition or psychiatric disability or with developmental disabilities or children and adolescents with a severe emotional disturbance pursuant to 18 V.S.A. § 8912.

**Sec. 15. MEDICAID PATHWAY; REPORT (from S.196)**

(a) The Secretary of Human Services, in consultation with the Director of Health Care Reform**, the Green Mountain Care Board,** and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all Medicaid payments to affected providers ~~**and shall,**~~ focus on services not included in the Medicaid equivalent of Medicare Part A and Part B services**, and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives.**

(b) On or before January 15, 2017 and annually for five years thereafter, the Secretary of Human Services shall report on the results of this process to the Senate Committee on Health and Welfare **and** the House Committees on Health Care and on Human Services~~**, and the Green Mountain Care Board**~~. The Secretary's report shall address:

(1) all Medicaid payments to affected providers, including progress toward integration of services not included in the Medicaid equivalent of Medicare Part A and Part B services in the previous year;

(2) changes to reimbursement methodology and **the** services impacted;

**(3) efforts to integrate affected providers into the all-payer model and with other payment and delivery system reform initiatives;**

(4) changes to quality measure collection and identifying alignment efforts and analyses, if any; and

(5) the interrelationship of results-based accountability initiatives with the quality measures in subdivision (4) of this subsection.

**Sec. 16. MEDICAID PROGRAM REVIEW; REPORT**

**The Green Mountain Care Board shall review budgeting, reimbursement rates, and related issues in Vermont's Medicaid program to identify opportunities for improvement, increased integration of medical care and community services, and greater efficiency. On or before January 15, 2017, the Board shall report its findings and recommendations to the House Committees on Health Care and on Human Services, the Senate Committees on Health and Welfare and on Finance, and the Department of Vermont Health Access.**

**Sec. 17. MULTI-YEAR BUDGETS; REPORT**

**The Green Mountain Care Board, the Department of Vermont Health Access, and interested stakeholders shall consider the appropriate role, if any, of using multi-year budgets for ACOs, Medicaid, and other State-funded health care programs to reduce administrative burden, improve care quality, and ensure sustainable access to care. On or before January 15, 2017, the Green Mountain Care Board and the Department of Vermont Health Access shall report their findings and recommendations to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance.**

**Sec. 18. MULTI-PAYER ALIGNMENT; REPORT**

**The Green Mountain Care Board, the Agency of Administration, health insurers, and other interested stakeholders shall collaborate in identifying areas in which alignment may be achieved between Medicare, Medicaid, and commercial payers as required by 18 V.S.A. § 9551(a)(3). On or before January 15, 2017, the parties shall provide a progress report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on its work to date, which shall include noting areas in which alignment has been improved and areas in which continued work is needed, providing a projected timeline for completing the work, identifying any waivers needed to achieve alignment and the status of any applications for such waivers, and proposing any**

**necessary legislative changes. On or before January 15, 2017, the parties shall provide a final report to the same committees on its alignment efforts.**

* * * Universal Primary Care and Dr. Dynasaur 2.0 * * *

Sec. 19. UNIVERSAL PRIMARY CARE; DR. DYNASAUR 2.0

(a) It is the intent of the General Assembly to move forward with implementation of universal primary care for all Vermonters or expansion of Dr. Dynasaur to all Vermont residents up to 26 years of age, or both. **Regardless of any future developments in payment and delivery system reform, Vermont is likely to continue to have uninsured or underinsured residents. Expanding access to primary care services is a proven method for improving population health.**

(b) In order to determine a path forward toward implementing universal primary care in Vermont, the Agency of Administration**, in collaboration with the Joint Fiscal Office,** shall:

(1) create a menu of tax options available to fund universal primary care, based on the cost estimates included in the report entitled Cost Estimates of Universal Primary Care submitted to the General Assembly by the Agency of Administration on December 16, 2015;

(2) provide the results of a literature review of any savings realized by universal health care programs over time that are attributable to the availability of universal access to primary care;

**(3) incorporate the savings estimates into a multi-year cost model with utilization and trend assumptions;** and

(4) report on primary care payment models created through the development of the all-payer model in order to enable legislators to estimate appropriate reimbursement amounts for health care providers delivering primary care services.

(c) In order to determine a path forward toward expanding Dr. Dynasaur to all Vermont residents up to 26 years of age, the Agency of Administration**, in collaboration with the Joint Fiscal Office,** shall study:

(1) the incremental and administrative costs of expanding Dr. Dynasaur;

(2) the menu of tax options available to fund the Dr. Dynasaur expansion;

(3) the results of a literature review of the savings over time, if any, attributable to expanded health care coverage; and

**(4) the impacts of expansion of coverage for Vermont resident up to 26 years of age on individual and small group market commercial insurance rates.**

(d) On or before December 15, 2016, the Agency of Administration shall report the results of the universal primary care and Dr. Dynasaur 2.0 studies required by this section **in collaboration with the Joint Fiscal Office** to the House Committees on Appropriations, on Health Care, and on Ways and Means and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

* * * Exchange Sustainability Analysis * * *

Sec. 20. VERMONT HEALTH BENEFIT EXCHANGE TECHNOLOGY; SUSTAINABILITY ANALYSIS; REPORT **(from H.865)**

(a)(1) The Joint Fiscal Office, in collaboration with one or more independent third parties pursuant to contracts negotiated for that purpose, shall conduct an analysis and provide a report to the General Assembly on or before December 1, 2016 on the current functionality and long-term sustainability of the technology for Vermont's Health Benefit Exchange, including a review of the deficiencies in Vermont Health Connect functionality and the integration, connectivity, and business logic of each as they pertain to both the back-end systems and the user interface of Vermont Health Connect.

(2) The analysis shall provide recommendations for improving the function, efficiency, reliability, operations, and customer experience of the technology going forward.

(3) The report shall include an evaluation of the investment value of existing components of the Exchange technology and the contractor's assessment of the feasibility and cost-effectiveness of leveraging existing components of the Vermont Health Benefit Exchange as part of the technology for a larger, integrated eligibility system, including reviewing changes other states have made to the Exchange components of their technology infrastructure.

(4) The analysis and report shall provide a comparison of the investments required to ensure a sustainable State-based Exchange through further investment in Vermont Health Connect's current technology, including any opportunities to build on other states' Exchange technology **and opportunities to join with other states in a regional Exchange**, with the estimated investments that would be required to transition to a fully or partially federally facilitated Exchange.

(b) In conducting the analysis and report pursuant to this section, and in preparing any requests for proposals from independent third parties, the Joint Fiscal Office shall consult with health insurers offering qualified health plans on Vermont Health Connect.

(c) The General Assembly shall provide ongoing oversight and review of the analysis and report.

* * * Effective Dates * * *

Sec. **21**. EFFECTIVE DATES

(a) Secs. 2 (all-payer model) and 3–5 (ACOs) shall take effect on January 1, 2018.

(b) **The remaining sections shall take effect on passage**.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE