TO THE HONORABLE SENATE:

The Committee on Health and 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 among 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

In order to implement a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, 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, 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;

(7) includes a process for integration of community-based providers, including home health agencies, mental health agencies, developmental disability service providers, emergency medical service providers, and area agencies on aging, and their funding streams to the extent permitted under federal law, 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.

* * * 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:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

* * *

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

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 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. To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. 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 and care models 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 and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care, where feasible;

(6) the ACO's participating providers have 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 inform them of their treatment options and the related risks and benefits of each;

(10) the ACO offers assistance to health care consumers, including:

(A) maintaining a consumer telephone line for complaints and grievances from attributed patients;

(B) responding and making best efforts to resolve complaints and grievances from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan;

(C) providing an accessible mechanism for explaining how ACOs work;

(D) providing contact information for the Office of the Health Care Advocate; and

(E) sharing 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 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;

(13) 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;

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

(15) the ACO has in place appropriate mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities; and

(16) 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 the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. 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 the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;

(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 by payer;

(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, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

(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 integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

(I) 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;

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of 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 and designated agencies as participating providers in the ACO;

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

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

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

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

(O) 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. 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. 8. 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. 9. 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 may examine, on its own or through collaboration or contracts with third parties, the effectiveness of existing requirements for health care professionals, such as quality measures and prior authorization, and evaluate alternatives that improve quality, reduce costs, and reduce administrative burden.

Sec. 10. 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 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.

* * * Additional Reports * * *

Sec. 11. AGENCY OF HUMAN SERVICES' CONTRACTS; REPORT

(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. 12. MEDICAID PATHWAY; REPORT

(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, 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. 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. 13. MEDICAID ADVISORY RATE CASE FOR ACO SERVICES

On or before December 31, 2016, the Green Mountain Care Board shall review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access and an accountable care organization for calendar year 2017. The Board's review shall include the number of

attributed lives, eligibility groups, covered services, elements of the per-member, per-month payment, and any other nonclaims payments. The review shall be nonbinding on the Agency of Human Services, and nothing in this section shall be construed to abrogate the designation of the Agency of Human Services as the single State agency as required by 42 C.F.R. § 431.10.

Sec. 14. MULTI-YEAR BUDGETS; ACOS; REPORT

The Green Mountain Care Board shall consider the appropriate role, if any, of using multi-year budgets for ACOs 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 provide 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. 15. MULTI-YEAR BUDGETS; MEDICAID; REPORT

The Joint Fiscal Office and the Department of Finance and Management, in collaboration with the Agency of Human Services Central Office and the Department of Vermont Health Access, shall consider the appropriate role, if any, of using multi-year budgets for Medicaid and other State-funded health care programs to reduce administrative burden, improve care quality, and ensure sustainable access to care. On or before March 1, 2017, the Joint Fiscal Office and the Department of Finance and Management shall provide their

findings and any recommendations for statutory change to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

Sec. 16. ALL-PAYER MODEL; ALIGNMENT; REPORT

On or before January 15, 2017, the Green Mountain Care Board shall present information to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on the status of its efforts to achieve alignment between Medicare, Medicaid, and commercial payers in the all-payer model as required by 18 V.S.A. § 9551(a)(3).

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

Sec. 17. UNIVERSAL PRIMARY CARE; DR. DYNASAUR 2.0

(a) 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. 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.

(b)(1) In order to determine a path forward toward implementing universal primary care in Vermont, on or before**,** the Secretary of Administration shall:

(A) 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;

(B) determine the impacts on the individual, small group, and large group health insurance markets of providing primary care through a universal, publicly funded program; and

(C) 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.

(2) On or before November 15, 2016, the Secretary of Administration shall provide to the Joint Fiscal Office a summary of its findings on the topics described in subdivision (1) of this subsection. The Joint Fiscal Office shall conduct an independent review of the assumptions underlying the Secretary's findings and shall provide its comments and feedback to the Secretary on or before December 1, 2016. On or before December 15, 2016, the Secretary shall provide to the Health Reform Oversight Committee, the Joint Fiscal Committee, the House Committees on Health Care, on Appropriations, and on Ways and Means, and the Senate Committees on Health and Welfare, on Appropriations, and on Finance a final report on the literature review, market

impacts, and primary care models required by subdivision (1) of this subsection.

(c)(1) In order to determine a path forward toward expanding Dr. Dynasaur to all Vermont residents up to 26 years of age, the Secretary of Administration shall analyze the financial implications of expanding Dr. Dynasaur, the State's children's Medicaid and Children's Health Insurance Program, to all Vermont residents up to 26 years of age.

(2)(A) Estimated program costs shall include the cost of coverage, one-time and ongoing operating costs, administrative costs, and reserves or reinsurance to the extent they are deemed advisable.

(B) The cost estimates shall be for a period of five years beginning on January 1, 2019, and shall assume a reasonable rate of health care spending growth.

(C) Estimated costs shall be offset by any cost reductions to State government spending and by any avoided State or federal tax liability that the State of Vermont would otherwise incur as an employer.

(D) The cost estimates shall include an analysis of any cost increases or reductions anticipated for municipalities and school districts, including impacts on projected education spending.

(E) The cost estimates shall project increasing provider reimbursement rates at regular intervals from 100 percent of Medicare rates up

to commercial rates. Medicare and commercial rates shall be determined based on claims data from the Vermont's all-payer claims database.

(3)(A) On or before January 15, 2017, the Secretary shall submit a report to the House Committees on Health Care, on Appropriations, and on Ways and Means and the Senate Committees on Health and Welfare, on Appropriations, and on Finance comprising its analysis of the costs of expanding Dr. Dynasaur to all Vermont residents up to 26 years of age and potential plans for financing the expansion. The financing plans shall be consistent with the principles of equity expressed in 18 V.S.A. § 9371(11), which states that financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably. In developing the financing plans, the Secretary shall consider the following:

(i) all current sources of funding for State government, including taxes, fees, and assessments;

(ii) existing health care revenue sources, including the claims tax levied pursuant to 32 V.S.A. chapter 243, the provider assessments imposed pursuant to 33 V.S.A. chapter 19, subchapter 2, and the employer assessment required pursuant to 21 V.S.A. chapter 25, to determine whether they are suitable for preservation or expansion to fund the program expansion;

(iii) new revenue sources such as a payroll tax, gross receipts tax, or business enterprise tax, or a combination of these;

(iv) expansion or reform of existing taxes;

(v) opportunities and challenges presented by federal law, including the Internal Revenue Code; Section 1332 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and Titles XIX (Medicaid) and XXI (SCHIP) of the Social Security Act, and by State tax law; and

(vi) anticipated federal funds that may be used for health care services, including consideration of methods to maximize receipt of federal funds available for this purpose.

(B) The Secretary's report shall also include information on the impacts of the coverage and proposed tax changes on individuals, households, businesses, public sector entities, and the nonprofit community, including migration of coverage, insurance market impacts, financial impacts, federal tax implications, and other economic effects. The impact assessment shall cover the same five-year period as the cost estimates.

(4) Agencies, departments, boards, and similar units of State government, including the Agency of Human Services, Department of Financial Regulation, Department of Labor, Director of Health Care Reform, and Green Mountain Care Board, shall provide information and assistance

requested by the Secretary and the Secretary's contractors to enable them to conduct the analysis required by this act.

(5) The Secretary shall to the Joint Fiscal Office provide periodic updates on the estimates and analysis required by this subsection and their underlying fiscal assumptions.

(d)(1) The Secretary may contract with other individuals and entities as needed to provide actuarial services, economic modeling, and any other assistance the Secretary requires in carrying out the analyses described in subsections (b) and (c) of this section.

(2) To the extent necessary to conduct the analyses required by subsections (b) and (c) of this section and consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, a health insurer licensed to do business in Vermont shall provide information requested by the Secretary or the Secretary's contractors within 30 days of the request, to the extent feasible and upon receipt by the health insurer of a non-disclosure agreement from the State and its contractors. The Secretary may enter into a confidentiality agreement with an insurer if the data requested includes proprietary or other confidential material. No health insurer shall be required to provide protected health information.

* * * Exchange Sustainability Analysis * * *

Sec. 18. VERMONT HEALTH BENEFIT EXCHANGE

TECHNOLOGY; SUSTAINABILITY ANALYSIS; REPORT

(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 functionality, 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 Health Reform Oversight Committee and the Joint Fiscal Committee shall provide ongoing oversight and review of the analysis and report.

* * * Health Research Commission * * *

Sec. 19. 2 V.S.A. chapter 27 is added to read:

CHAPTER 27. HEALTH RESEARCH COMMISSION

§ 961. CREATION OF COMMISSION

(a) There is established the Health Research Commission to coordinate and provide oversight over legislative policy research, studies, and evaluations related to health care delivery, regulation, and reform.

(b) Members of the Commission shall include two members of the House of Representatives appointed by the Speaker of the House, two members of the

Senate appointed by the Senate Committee on Committees, and one member appointed by the Governor.

(c) The Commission may meet as needed. For attendance at meetings during adjournment of the General Assembly, legislative members of the Commission shall be entitled to per diem compensation and reimbursement of expenses pursuant to section 406 of this title. The member appointed by the Governor shall be entitled to per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010 if he or she is not a full-time State employee.

§ 962. EMPLOYEES; BUDGET

(a) The Commission shall meet promptly following the appointment of its members in order to organize and begin conducting its business. The Commission may adopt its own rules for the operation of its personnel.

(b)(1) The Commission shall employ professional and secretarial staff as needed to carry out its functions and shall determine their compensation subject to legislative appropriation.

(2)(A) All requests for assistance, information, and advice from the Commission and all information the Commission receives in connection with research or related studies is exempt from public inspection and copying under the Public Records Act and shall be kept confidential unless the party requesting assistance or providing information specifies otherwise. All

Commission reports, documents, and transcripts or minutes of Commission meetings, including written testimony submitted to the Commission, are not confidential under this subdivision.

(B) The staff of the Commission may sign data use agreements and confidentiality agreements on the Commission's behalf in order to collect the data, including health care claims and tax information, needed to carry out the duties of the Commission. Data collected by Commission staff may be used only for the purposes of studies and evaluation. Appropriate data standards shall be maintained to ensure confidentiality.

(c) The Commission shall prepare a budget as part of the Joint Fiscal Committee's budget.

(d) The Commission shall receive administrative, fiscal, and legal support from the Joint Fiscal Office and the Legislative Council. In addition, the Commission may retain the services of one or more consultants or experts knowledgeable in health care systems, financing, or delivery to assist in its work within the amounts appropriated in its budget.

§ 963. FUNCTIONS

The Commission shall direct, supervise, and coordinate the work of its staff, which shall include:

(1) furnishing policy research and evaluation services, including coordinating contracts with consultants, related to health care for studies required by legislation enacted by the General Assembly;

(2) engaging in a continuing review of the State's health care reform initiatives;

(3) monitoring the activities of the Green Mountain Care Board on behalf of the General Assembly; and

(4) keeping and maintaining minutes of its meetings.

Sec. 20. POSITIONS

On or before July 1, 2016, up to three positions and appropriate amounts for personal services and operating expenses shall be transferred from the Agency of Administration to the General Assembly to provide staff for the Health Research Commission established in Sec. 19 of this act.

Sec. 21. APPOINTMENTS TO THE HEALTH RESEARCH COMMISSION

The Speaker of the House of Representatives, the Senate Committee on Committees, and the Governor shall appoint the first members of the Health Research Commission established pursuant to 2 V.S.A. chapter 27 on or before August 15, 2016.

* * * Appropriations * * *

Sec. 22. APPROPRIATIONS

(a) The sum of $240,000.00 is appropriated from the General Fund to the Secretary of Administration in fiscal year 2017 to support the universal primary care and Dr. Dynasaur expansion studies and reports pursuant to Sec. 17 of this act.

(b) The sum of $250,000.00 is appropriated from the General Fund to the General Assembly in fiscal year 2017 for purposes of the Health Research Commission established pursuant to 2 V.S.A. chapter 27.

Sec. 23. FISCAL YEAR 2016; REVERSIONS; APPROPRIATIONS

(a) Notwithstanding any provision of law to the contrary, and in addition to any other reversions in fiscal year 2016, the following amounts appropriated in fiscal year 2016 to the following sources shall revert to the General Fund:

(1) from the Office of the State Treasurer, the amount of $115,000.00;

(2) from the Green Mountain Care Board, the amount of $109,320.00.

(b) The amount of $224,320.00 is appropriated in fiscal year 2016 from the General Fund to the Joint Fiscal Office for the purpose of implementing Sec. 18 of this act.

Sec. 24. FISCAL YEAR 2017; APPROPRIATION; ALLOCATION

(a) Of the amounts appropriated in fiscal year 2017 from the General Fund to the Agency of Agriculture, Food and Markets, the amount of $175,680.00 is appropriated from the Agency to the Joint Fiscal Office for the purpose of implementing Sec. 18 of this act.

(b) The Commissioner of Finance and Management shall exercise his or her authority pursuant to 32 V.S.A. § 511 (allocation of excess receipts) to allocate $175,680.00 to the Agency of Agriculture, Food and Markets.

* * * Repeal * * *

Sec. 25. REPEAL

2 V.S.A. chapter 20 (Health Reform Oversight Committee) is repealed on January 1, 2017.

* * * Effective Dates * * *

Sec. 26. EFFECTIVE DATES

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

(b) Secs. 22 and 24 (FY17 appropriations) shall take effect on July 1, 2016.

(c) This section and the remaining sections shall take effect on passage.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE