Introduced by Committee on Health and Welfare

Date:

Subject: Health; health care reform; pharmacy benefit managers; hospitals; Green Mountain Care Board

Statement of purpose of bill as introduced: This bill proposes to establish specific parameters by which pharmacy benefit managers would set the maximum allowable cost for prescription drug reimbursement. It would require hospitals to provide notice to individuals placed in observation status and to alert individuals receiving observation services about the potential financial implications. It would also direct the Department of Vermont Health Access to adopt a prospective payment system for home health agencies. The bill would reinstate the Health Care Oversight Committee permanently and the Mental Health Oversight Committee for one year and it would establish a long-term care evaluation task force to assess and catalogue in-home, long-term care programs operated or subsidized by the State. The bill would require updates on the Vermont Health Care Innovation Project and direct the Agency of Human Services to identify overlap and duplication in the delivery of services. It would also modify the circumstances under which the Commissioner of Health may adopt a rule regulating the sale or distribution of a children's product containing a chemical of high concern to children.

An act relating to pharmacy benefit managers, hospital observation status, and chemicals of high concern to children

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

* * * Pharmacy Benefit Managers * * *

~~Sec. 1. 18 V.S.A. chapter 79 is amended to read:~~

~~CHAPTER 79. PHARMACY AUDITS~~ BENEFIT MANAGERS

~~Subchapter 1. General~~

~~§ 3801. DEFINITIONS~~

~~As used in this subchapter~~ chapter~~:~~

~~(1)(A) "Health insurer" shall have the same meaning as in section 9402 of this title and shall include:~~

~~(i) a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations;~~

~~(ii) an employer, a labor union, or another group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont; and~~

~~(iii) except as otherwise provided in section 3805 of this title, the State of Vermont and any agent or instrumentality of the State that offers, administers, or provides financial support to State government.~~

~~(B) The term "health insurer" shall not include Medicaid or any other Vermont public health care assistance program.~~

~~(2) "Health plan" means a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont.~~

~~(3) "Maximum allowable cost" means the per unit drug product reimbursement amount, excluding dispensing fees, for a group of therapeutically and pharmaceutically equivalent multisource generic drugs.~~

~~(4) "Pharmacy" means any individual or entity licensed or registered under 26 V.S.A. chapter 36.~~

~~(4)~~(5) ~~"Pharmacy benefit management" means an arrangement for the procurement of prescription drugs at a negotiated rate for dispensation within this State to beneficiaries, the administration or management of prescription drug benefits provided by a health plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits:~~

~~(A) mail service pharmacy;~~

~~(B) claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;~~

~~(C) clinical formulary development and management services;~~

~~(D) rebate contracting and administration;~~

~~(E) certain patient compliance, therapeutic intervention, and generic substitution programs; and~~

~~(F) disease or chronic care management programs.~~

~~(5)~~**(6)** ~~"Pharmacy benefit manager" means an entity that performs pharmacy benefit management. The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.~~

~~(7) "Price index" means any variable, including average wholesale price, wholesale acquisition cost, or average manufacturer's price, used by a pharmacy benefit manager in determining drug product reimbursement.~~

~~(6)~~**(8)** ~~"Responsible party" means the entity, including a health insurer or pharmacy benefit manager, responsible for payment of claims for health care services other than:~~

~~(A) the individual to whom the health care services were rendered;~~

~~(B) that individual's guardian or legal representative; or~~

~~(C) the agency of human services~~ **Agency of Human Services**~~, its agents, and contractors.~~

~~Subchapter 2. Pharmacy Audits~~

~~§ 3802. PHARMACY RIGHTS DURING AN AUDIT~~

*** * ***

~~Subchapter 3. Maximum Allowable Cost~~

§ 3811. CONTRACT PROVISIONS

Each contract between a pharmacy benefit manager and a contracted pharmacy shall include:

(1) the sources used by the pharmacy benefit manager to calculate the drug product reimbursement rate paid for all covered drugs available under the pharmacy health benefit plan administered by the pharmacy benefit manager;

(2) the price index methodology used to establish the drug product reimbursement rate; and

(3) the process to appeal, investigate, and resolve disputes regarding the drug product reimbursement rate.

§ 3812. MAXIMUM ALLOWABLE COST

For each drug for which a pharmacy benefit manager establishes a maximum allowable cost in order to determine the reimbursement rate, the pharmacy benefit manager shall do all of the following:

(1) Ensure that the drug is available nationwide from at least three manufacturers of Food and Drug Administration Orange Book "AB" rated equivalent multisource drugs.

(2) Ensure that maximum allowable cost applies only when a drug is available for purchase without limitations by all pharmacists in the State

~~from licensed national or regional wholesalers, and that it will not apply if the drug is unavailable for a period of 14 calendar days or more.~~

~~(3) Make available, in a format that is readily accessible and understandable by a pharmacist, a list of the drugs subject to maximum allowable cost, the actual maximum allowable cost for each drug, and the source used to determine the maximum allowable cost.~~

~~(4) Update the maximum allowable cost list at least once every seven calendar days.~~

~~(5) Establish or maintain a reasonable process for an administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable cost as:~~

~~(A) not meeting the requirements of this section; or~~

~~(B) being below the cost at which the pharmacy obtained or may obtain the drug.~~

~~(6)(A) Respond in writing to any appealing pharmacy provider as to the merits of the dispute within seven calendar days after receipt of an appeal. If, upon appeal, the pharmacy benefit manager finds in favor of the appealing pharmacy, the pharmacy benefit manager shall adjust the maximum allowable cost to no less than the actual acquisition cost retroactive to the dispensing date of the original claim and make adjustments to all similar claims in all pharmacies in the pharmacy~~

~~benefit manager's network. If, upon appeal, the pharmacy benefit manager finds against the appealing pharmacy, the pharmacy benefit manager shall provide the appealing pharmacy with the National Drug Code of an alternative product on the maximum allowable cost list that is available for purchase without limitations.~~

~~(B) If an appealing pharmacy can prove that its actual acquisition cost exceeded the pharmacy benefit manager's maximum allowable cost, the pharmacy benefit manager shall adjust the maximum allowable cost to no less than the actual acquisition cost retroactive to the dispensing date of the original claim. If no maximum allowable cost is available for a drug, the pharmacy benefit manager shall reimburse the pharmacy no less than the proven actual acquisition cost.~~

~~Subchapter 4. Benefit Administration~~

~~§ 3821. CHOICE OF PHARMACY~~

~~(a) A health insurer or pharmacy benefit manager shall permit a plan beneficiary to fill a prescription at the pharmacy of his or her choice and shall not impose differential cost-sharing requirements based on the choice of pharmacy or otherwise promote the use of one pharmacy over another.~~

~~(b) A health insurer or pharmacy benefit manager shall not condition the reimbursement for dispensing prescription drugs in any way based on~~

~~**whether a pharmacy or pharmacist participates in the health insurer's or pharmacy benefit manager's network or other contractual agreement.**~~

Sec. 1. 18 V.S.A. § 9471 is amended to read:

§ 9471. DEFINITIONS

As used in this subchapter:

*** * ***

(6) "Maximum allowable cost" means the per unit drug product reimbursement amount, excluding dispensing fees, for a group of therapeutically and pharmaceutically equivalent multisource generic drugs.

Sec. 2. 18 V.S.A. § 9473 is amended to read:

§ 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO PHARMACIES

* * *

(c) For each drug for which a pharmacy benefit manager establishes a maximum allowable cost in order to determine the reimbursement rate, the pharmacy benefit manager shall do all of the following:

(1) make available, in a format that is readily accessible and understandable by a pharmacist, a list of the drugs subject to maximum allowable cost, the actual maximum allowable cost for each drug, and the source used to determine the maximum allowable cost;

(2) update the maximum allowable cost list at least once every seven calendar days; and

(3) establish or maintain a reasonable **~~process for an~~** administrative appeals **~~procedure~~** process to allow a dispensing pharmacy provider to contest a listed maximum allowable cost.

* * * Notice of Hospital Observation Status * * *

Sec. 3. 18 V.S.A. § 1905 is amended to read:

§ 1905. LICENSE REQUIREMENTS

Upon receipt of an application for license and the license fee, the licensing agency shall issue a license when it determines that the applicant and hospital facilities meet the following minimum standards:

* * *

(22) All hospitals shall provide oral and written notice to each individual that the hospital places in observation status as required by section 1911a of this title.

Sec. 4. 18 V.S.A. § 1911a is added to read:

1911a. NOTICE OF HOSPITAL OBSERVATION STATUS

(a) Each hospital shall provide oral and written notice to each individual that the hospital places in observation status as soon as possible but no later than 24 hours following such placement, unless the individual is discharged or leaves the hospital before the 24-hour period expires. The written notice shall

be a uniform form developed by the Department of Health for use in all hospitals.

(b) Each oral and written notice shall include:

(1) a statement that the individual is under observation as an outpatient and is not admitted to the hospital as an inpatient;

(2) a statement that observation status may affect the individual's Medicare, Medicaid, or private insurance coverage for hospital services, including medications and pharmaceutical supplies, and for rehabilitative **or skilled nursing services** at a skilled nursing facility if needed upon discharge from the hospital; and

(3) a statement that the individual may contact his or her health insurance provider, the Office of the Health Care Advocate, or the Vermont State Health Insurance Assistance Program to understand better the implications of placement in observation status.

(c) Each written notice shall include the name and title of the hospital representative who gave oral notice, the date and time oral notice was given, and contact information for the Office of the Health Care Advocate and the Vermont State Health Insurance Assistance Program.

(d) Oral and written notice shall be provided in a manner that is ~~understood~~ **understandable** by the individual placed in observation status or by his or her legal guardian or authorized representative.

(e) Each written notice shall be signed and dated by the individual placed in observation status, or if applicable by his or her legal guardian or authorized representative, to verify receipt and an understanding of the oral and written notice.

* * * Prospective Payments for Home Health Services * * *

~~**Sec. 4. FINDINGS**~~

~~**The General Assembly finds that:**~~

~~**(1) In Vermont, the State reimburses home health agencies over $34 million annually in Medicaid fee-for-service payments.**~~

~~**(2) In October 2000, the federal Centers for Medicare and Medicaid Services adopted a prospective payment system for Medicare that pays home health agencies a predetermined rate for each 60-day episode of home health care regardless of the number of visits the patient receives during that period.**~~

~~**(3) Medicare's prospective payment system provides home health agencies with incentives to provide the appropriate level of care to achieve positive outcomes for Medicare patients.**~~

~~**(4) Vermont Medicaid's fee-for-service model encourages more services instead of more efficient services.**~~

~~(5) Home health services reimbursed under the Vermont Medicaid program are currently delivered in a manner that limits the services clients may receive.~~

~~(6) Losses at Vermont's home health agencies are becoming unsustainable because Medicaid reimbursement rates are far below the cost of delivering services.~~

~~(7) A Medicaid prospective payment system model will support Vermont's payment reform efforts by providing more flexible, integrated, and improved services to clients, reducing administrative costs at home health agencies, and containing costs while providing greater financial predictability to home health agencies and to the State.~~

Sec. 5. 33 V.S.A. § 1901h is added to read:

§ 1901h. PROSPECTIVE PAYMENT; HOME HEALTH SERVICES

(a) On or before January 1, 2016 **and upon approval from the Centers for Medicare and Medicaid Services**, the ~~Agency of Human Services~~ **Department of Vermont Health Access** shall **modify reimbursement methodologies to home health agencies, as defined in section 1951 of this title, in order to** implement ~~a~~ prospective payment**s** ~~system~~ **for the medical services paid for by the Department and** to replace ~~the~~ fee-for-service ~~system for home health agencies that provide services under Medicaid, including nursing, therapies, licensed nursing assistants, nutritionists, and~~

~~hospice care; that provide pediatric rehabilitation services, including physical therapy, occupational therapy, and speech-language pathology; and that provide services under the Choices for Care program~~ payment methodologies.

~~(b) The prospective payment system shall:~~

~~(1) pay home health agencies a predetermined rate for each 60-day episode of home health care, which shall be adjusted annually for inflation;~~

~~(2) be budget neutral;~~

~~(3) not adjust payments based on patient acuity;~~

~~(4) not limit the number of episodes of care;~~

~~(5) eliminate the need for prior authorization for pediatric rehabilitation services;~~

~~(6) establish risk corridors of three percent, such that if a home health agency's profits exceed three percent, the excess shall be paid to the Agency of Human Services or placed in a flexible fund for new or noncovered services, while if a home health agency's losses exceed three percent, the Agency of Human Services shall pay the difference to the home health agency; and~~

~~(7) require home health agencies to report data to the Agency of Human Services to evaluate the prospective payment system payment methodology, including:~~

~~(A) details of each episode, including identifying patient visits by discipline and providing the name of the certifying physician, the date on which care began, and the primary diagnosis;~~

~~(B) costs reflecting revenue from services rendered under the prospective payment system, the home health agency's total expenses, and gains and losses;~~

~~(C) information regarding health outcomes; and~~

~~(D) monitoring and reporting on acute care hospitalization, emergency care, and nursing home admissions using existing internal and external resources.~~

~~(c) As used in this section, "home health agency" means an entity that has received a certificate of need from the State to provide home health services and is certified to provide services pursuant to 42 U.S.C. § 1395x(o).~~

(b) The Department shall develop the payment methodology in collaboration with representatives of home health agencies. If practicable, the Department:

(1) shall align the methodology with Medicare to reduce the administrative burden on the agencies; and

(2) may include a quality payment in the methodology.

~~*** * * Consumer Access to Health Care Cost Information * * ***~~

~~**Sec. 6. 18 V.S.A. § 9410a is added to read:**~~

~~**§ 9410a. HEALTH CARE QUALITY AND PRICE COMPARISON**~~

~~**(a)(1) The Green Mountain Care Board shall establish a website allowing health care consumers to compare the price of medical care in Vermont by insurance plan and by service or procedure, including office visits, emergency care, radiologic services, and preventive care such as mammography and colonoscopy, as well as comparing the cost of prescription drugs. The website shall also enable consumers to compare quality across providers. The Board may develop and administer the comparison website itself or through a contract with a third party.**~~

~~**(2) The website shall allow a consumer to compare price by selecting a specific service or procedure, insurance plan, and geographic region of the State. Based on the criteria specified, the website shall provide the consumer with an estimate for each provider of the amount the consumer would pay for the service or procedure, an estimate of the amount the insurance would pay, and an estimate of the combined payments.**~~

~~(3) For consumers without health insurance or who choose to compare costs without selecting an insurance plan, the website shall provide the average cost for the service or procedure in the specified geographic region.~~

~~(b) Cost data for the comparison website shall be derived from the unified health care database established in section 9410 of this title.~~

~~(c) The Department of Vermont Health Access shall ensure that the website for the Vermont Health Benefit Exchange includes a prominently placed link to the comparison website established by this section to allow health care consumers to make informed decisions about the health care services they receive.~~

~~Sec. 7. 18 V.S.A. § 4634 is amended to read:~~

~~§ 4634. PRESCRIPTION DRUG PRICE DISCLOSURE~~

~~(a) Upon request, a pharmacy shall disclose to any consumer or health care provider the usual and customary retail price of a prescription drug.~~

~~(b) With each prescription dispensed, a pharmacy shall disclose to the consumer, in writing,.~~

~~(c)~~ Each pharmacy ~~the price of the prescription and any payment toward the price required of the consumer~~ shall display on or near the pharmacy counter and on the pharmacy website, if any, the usual and customary retail price of the 20 most commonly prescribed prescription

~~medications dispensed at that pharmacy, as well as the average price for each of those prescription medications.~~

~~(d) For purposes of~~ As used in ~~this section:~~

~~(1) "Price of the prescription" means the amount charged by the pharmacy to the consumer or, if applicable, to the consumer's health benefit plan.~~

~~(2) "Usual and customary retail price" means the total price charged to a consumer who does not have prescription drug coverage under a health benefit plan.~~

~~(d)~~(e) ~~In addition to any other remedy provided by law, the attorney general~~ Attorney General ~~may file an action in superior court~~ Superior Court ~~for a violation of this section. In any such action, the attorney general~~ Attorney General ~~shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Protection Act, 9 V.S.A. chapter 63. Each violation of this section constitutes a separate civil violation for which the attorney general~~ Attorney General ~~may obtain relief.~~

*** * * Oversight Committees * * ***

Sec. 6. 2 V.S.A. chapter 24 is added to read:

CHAPTER 24. HEALTH CARE OVERSIGHT COMMITTEE

§ 851. CREATION OF COMMITTEE

(a) There is created a legislative Health Care Oversight Committee. The Committee shall be appointed biennially and consist of ten members: five members of the House appointed by the Speaker, not all from the same political party, and five members of the Senate appointed by the Senate Committee on Committees, not all from the same political party. The House appointees shall include one member from the House Committee on Human Services, one member from the House Committee on Health Care, one member from the House Committee on Appropriations, and two at-large members. The Senate appointees shall include one member from the Senate Committee on Health and Welfare, one member from the Senate Committee on Finance, one member from the Senate Committee on Appropriations, and two at-large members.

(b) The Committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The Health Care Oversight Committee shall monitor, oversee, and provide a continuing review of health care and human services programs in Vermont when the General Assembly is not in session; provided, however, that review of matters related to mental health and health care reform shall remain in the jurisdiction of the Mental Health Oversight

and Health Reform Oversight Committees, respectively, for as long as each Committee is authorized by law.

(b) In conducting its oversight and in order to fulfill its duties, the Committee may consult with consumers, providers, advocates, administrative agencies and departments, and other interested parties.

(c) The Committee shall work with, assist, and advise other committees of the General Assembly, members of the Executive Branch, and the public on matters relating to health care and human services programs.

(d) Annually, on or before January 15, the Committee shall report its findings and any recommendations to the Governor and the committees of jurisdiction.

§ 853. MEETINGS AND STAFF SUPPORT

(a) For attendance at meetings during adjournment of the General Assembly, legislative members of the Committee shall be entitled to per diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 406.

(b) The Office of Legislative Council and the Joint Fiscal Office shall provide professional and administrative support to the Committee. The Department of Financial Regulation, the Agency of Human Services, and other agencies of the State shall provide information, assistance, and support upon request of the Committee.

Sec. 7. MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The Mental Health Oversight Committee is created to ensure that consumers have access to a comprehensive and adequate continuum of mental health services. The Committee shall be composed of one member from each of the House Committees on Human Services, on Corrections and Institutions, and on Appropriations and a member-at-large to be appointed by the Speaker of the House, not all from the same party, and one member from each of the Senate Committees on Health and Welfare, on Institutions, and on Appropriations and one member-at-large to be appointed by the Committee on Committees, not all from the same party. Initial appointments shall be made upon passage of this act.

(b) Members of the Committee shall serve as the liaison to their respective legislative standing committees with primary jurisdiction over the various components of Vermont's mental health system. The Committee shall work with, assist, and advise the other committees of the General Assembly, members of the Executive Branch, and the public on matters related to Vermont's mental health system.

(c) The Committee is authorized to meet up to six times per year while the General Assembly is not in session to perform its functions under this section.

(d) The Commissioner of Mental Health shall report to the Committee

as required by the Committee.

(e) For attendance at meetings during adjournment of the General Assembly, legislative members of the Committee shall be entitled to per diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 406.

(f) The Committee shall have the administrative, technical, and legal assistance of the Office of Legislative Council and the Joint Fiscal Office.

(g) The Mental Health Oversight Committee shall provide a progress report to each of the committees represented thereon on or before January 1, 2016.

(h) The Committee shall cease to exist after January 1, 2016.

*** * * Long-Term Care Evaluation Task Force * * ***

Sec. 8. LONG-TERM CARE EVALUATION TASK FORCE

(a) Creation. There is created a Long-Term Care Evaluation Task Force to assess and catalogue those in-home, long-term care programs that are either operated by the State or subsidized by the State.

(b) Membership. The Task Force shall be composed of the following 10 members:

(1) the Chair of the Senate Committee on Health and Welfare or designee, appointed by the Committee on Committees;

(2) the Chair of the House Committee on Human Services or designee, appointed by the Speaker of the House;

(3) the Commissioner of Disabilities, Aging, and Independent Living or designee;

(4) the Long-Term Care Ombudsman;

(5) a representative of elders, appointed by the Community of Vermont Elders;

(6) a representative of retired persons, appointed by the American Association of Retired Persons;

(7) a representative of the Area Agencies on Aging;

(8) a representative of home health care providers, appointed by the Vermont Association of Home Health Agencies;

(9) a representative of the Support and Services at Home (SASH) program; and

(10) a representative of private home health care providers, appointed by Bayada Home Health Care.

(c) Powers and duties. The Task Force shall assess the availability and effectiveness of in-home, long-term care services in Vermont that are either State-operated or State-subsidized and create a catalogue of existing services to determine where overlapping services or gaps in service may exist.

(d) Assistance. The Task Force shall have the administrative, technical, and legal assistance of the Department of Disabilities, Aging, and Independent Living. For purposes of preparing any recommended legislation, the Task Force shall have the assistance of the Office of Legislative Council.

(e) Report. On or before January 15, 2016, the Task Force shall submit a written report to the House Committee on Human Services and to the Senate Committee on Health and Welfare with its findings and any recommendations for rules or legislative action.

(f) Meetings.

(1) The Commissioner of Disabilities, Aging, and Independent Living or designee shall call the first meeting of the Task Force to occur on or before August 1, 2015.

(2) The Commissioner of Disabilities, Aging, and Independent Living or designee shall serve as chair of the Task Force.

(3) A majority of the membership shall constitute a quorum.

(4) The Task Force shall cease to exist on February 1, 2016.

(g) Reimbursement.

(1) For attendance at meetings during adjournment of the General Assembly, legislative members of the Task Force shall be entitled to per

diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 406 for no more than four meetings.

(2) Other members of the Task Force who are not employees of the State of Vermont and who are not otherwise compensated or reimbursed for their attendance shall be entitled to per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010 for no more than four meetings.

* * * Reports * * *

Sec. 9. VERMONT HEALTH CARE INNOVATION PROJECT; UPDATES

The Project Director of the Vermont Health Care Innovation Project (VHCIP) shall provide an update at least quarterly to the House Committees on Health Care and on Ways and Means, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee regarding VHCIP implementation and the use of the federal State Innovation Model (SIM) grant funds. The Project Director's update shall include information regarding:

(1) the VHCIP pilot projects and other initiatives undertaken using SIM grant funds, including a description of the projects and initiatives, the timing of their implementation, the results achieved, and the replicability of the results;

(2) how the VHCIP projects and initiatives fit with other payment and delivery system reforms planned or implemented in Vermont;

(3) how the VHCIP projects and initiatives meet the goals of improving health care access and quality and reducing costs;

(4) how the VHCIP projects and initiatives will reduce administrative costs;

(5) how the VHCIP projects and initiatives compare to the principles expressed in 2011 Acts and Resolves No. 48;

(6) what will happen to the VHCIP projects and initiatives when the SIM grant funds are no longer available; and

(7) how to protect the State's interest in any health information technology and security functions, processes, or other intellectual property developed through the VHCIP.

~~**Sec. 11. REDUCING PAPERWORK; WORKING GROUP**~~

~~**(a) The Green Mountain Care Board, in coordination with the Agency of Human Services, shall convene a working group to evaluate the information requirements of the quality and satisfaction surveys and other forms required by:**~~

~~**(1) Medicare;**~~

~~**(2) Medicaid;**~~

~~**(3) rules adopted by the Department of Financial Regulation, the Green Mountain Care Board, and the Agency of Human Services;**~~

~~**(4) the Blueprint for Health;**~~

~~(5) designated agencies;~~

~~(6) accountable care organizations;~~

~~(7) the federal Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant;~~

~~(8) the National Committee for Quality Assurance (NCQA);~~

~~(9) 2000 Acts and Resolves No. 129;~~

~~(10) adverse childhood experience surveys; and~~

~~(11) other programs and initiatives.~~

~~(b) The working group shall recommend strategies for aligning survey questions and other required forms across programs and initiatives in order to reduce the administrative burden on health care providers in completing all of the required surveys and forms. It shall also establish a process to ensure that future surveys and forms are aligned across programs and initiatives, to the extent that doing so is within the State's control.~~

~~(c) On or before December 1, 2015, the working group shall report its recommendations to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee.~~

Sec. 10. REDUCING DUPLICATION OF SERVICES; REPORT

(a) The Agency of Human Services shall evaluate the services offered by each entity licensed, administered, or funded by the State, including the designated agencies, to provide services to individuals receiving home- and community-based long-term care services or who have developmental disabilities, mental health needs, or substance use disorder. The Agency shall determine areas in which **there are gaps in services and areas in which** programs or services **are inconsistent with the Health Resource Allocation Plan or are** overlapping, duplicative, or otherwise not delivered in the most efficient, ~~**and**~~ cost-effective**, and high-quality** manner and shall develop recommendations for consolidation or other modification to maximize high-quality services, efficiency, **service integration,** and appropriate use of public funds.

(b) On or before January 15, 2016, the Agency shall report its findings and recommendations to the House Committee on Human Services and the Senate Committee on Health and Welfare.

*** * * Chemicals of Concern to Children * * ***

Sec. 11. 18 V.S.A. § 1774(d) is amended to read:

(d) Commissioner of Health recommendation; assistance.

(1) Beginning on July 1, 2017, and biennially thereafter, the Commissioner of Health shall recommend at least two chemicals of high concern to children in children's products for review by the Working

Group. The Commissioner's recommendations shall be based on the ~~degree of~~ human health risks, exposure pathways, and impact on sensitive populations presented by a chemical of high concern to children.

(2) The Working Group shall have the administrative, technical, and legal assistance of the Department of Health and the Agency of Natural Resources.

Sec. 12. 18 V.S.A. § 1776 is amended to read:

§ 1776. RULEMAKING; ADDITIONAL CHEMICALS OF CONCERN TO CHILDREN; PROHIBITION OF SALE

(a) Rulemaking authority. The Commissioner shall, after consultation with the Secretary of Natural Resources, adopt rules as necessary for the purposes of implementing, administering, or enforcing the requirements of this chapter.

(b) Additional chemicals of concern to children. The Commissioner may by rule add additional chemicals to the list of chemicals of high concern to children, provided that the Commissioner of Health, on the basis of ~~the weight of~~ credible, scientific evidence, has determined that a chemical proposed for addition to the list meets both of the following criteria in subdivisions (1) and (2) of this subsection:

(1) The Commissioner of Health has determined that an authoritative governmental entity or accredited research university has demonstrated that the chemical:

(A) harms the normal development of a fetus or child or causes other developmental toxicity;

(B) causes cancer, genetic damage, or reproductive harm;

(C) disrupts the endocrine system;

(D) damages the nervous system, immune system, or organs or causes other systemic toxicity; or

(E) is a persistent bioaccumulative toxic.

(2) The chemical has been found through:

(A) biomonitoring to be present in human blood, umbilical cord blood, breast milk, urine, or other bodily tissues or fluids;

(B) sampling and analysis to be present in household dust, indoor air, drinking water, or elsewhere in the home environment; or

(C) monitoring to be present in fish, wildlife, or the natural environment.

(c) Removal of chemical from list. The Commissioner may by rule remove a chemical from the list of chemicals of high concern to children established under section 1773 of this title or rules adopted under this

section if the Commissioner determines that the chemical no longer meets both of the criteria of subdivisions (b)(1) and (2) of this section.

(d) Rule to regulate sale or distribution.

(1) The Commissioner~~, upon the recommendation of~~ after consultation with the Chemicals of High Concern to Children Working Group, may adopt a rule to regulate the sale or distribution of a children's product containing a chemical of high concern to children upon a determination that:

(A) ~~children will be exposed to a chemical of high concern to children in the children's product~~ there is potential for exposure of children to the chemical of high concern; and

(B) ~~there is a probability that, due to the degree of exposure or frequency of exposure of a child to a chemical of high concern to children in a children's product, exposure could cause or contribute to one or more of the adverse health impacts listed under subdivision (b)(1) of this section~~ one or more safer alternatives to the chemical of high concern to children are available.

(2) In determining whether children will be exposed to a chemical of high concern in a children's product, the Commissioner shall review available, credible information regarding:

(A) the market presence of the children's product in the State; or

(B) ~~the type or occurrence of exposures to the relevant chemical of high concern to children in the children's product;~~

~~(C) the household and workplace presence of the children's product; or~~

~~(D) the potential and frequency of exposure of children to the chemical of high concern to children in the children's product~~ the amounts of the chemical of high concern contained in the children's product as reported under section 1775 of this title.

*** * ***

*** * * Appropriation * * ***

Sec. 13. APPROPRIATION

The sum of $1,250,000.00 in Global Commitment funds is appropriated from the General Fund to the Department of Vermont Health Access in fiscal year 2016 to increase Medicaid reimbursement rates for home health agencies and for implementation of the prospective payment methodologies set forth in Sec. 5 of this act.

* * * Effective Dates * * *

Sec. 14. EFFECTIVE DATES

(a) Secs. 1 and 2 (pharmacy benefit managers), 9 and 10 (reports), and this section shall take effect on passage.

(b) Secs. 3 and 4 (notice of hospital observation status), 5 (prospective payments for home health services), **6 and 7 (reinstating oversight committees), 8 (Long-Term Care Evaluation Task Force), 11 and 12 (chemicals of concern to children), and 13 (appropriation)** shall take effect on July 1, 2015.