

1 TO THE HONORABLE SENATE:

2 The Committee on Finance to which was referred Senate Bill No. 135
3 entitled “An act relating to expanding the responsibilities of the Green
4 Mountain Care Board” respectfully reports that it has considered the same and
5 recommends that the bill be amended by striking out all after the enacting
6 clause and inserting in lieu thereof the following:

7 * * * Cost Containment Measures * * *

8 Sec. 1. ALL-PAYER MODEL; SCOPE

9 The Secretary of Administration or designee and the Green Mountain Care
10 Board shall jointly explore an all-payer model, which may be achieved through
11 a waiver from the Centers for Medicare and Medicaid Services. The Secretary
12 or designee and the Board shall consider a model that includes payment for a
13 broad array of health services, a model applicable to hospitals only, and a
14 model that enables the State to establish global hospital budgets for each
15 hospital licensed in Vermont.

16 Sec. 2. ST. JOHNSBURY HEALTH SERVICE AREA; ACCOUNTABLE
17 CARE COMMUNITY DEVELOPMENT

18 (a) In order to create an accountable care community program in the St.
19 Johnsbury health service area, the federally qualified health center located in
20 St. Johnsbury shall convene interested health care providers, community
21 partners, representatives from accountable care organizations, and health care

1 consumers to develop a concept paper and an implementation plan. The
2 implementation plan shall include:

3 (1) a description of the scope of the project;

4 (2) a methodology for creating a community-wide budget, which may
5 include a global budget for the community, individual budgets for each
6 participating organization, or fees for services performed;

7 (3) a legal analysis of the regulatory flexibility requested by the
8 community or by each participating provider, including an analysis of whether
9 the requested regulatory change is allowed under the Medicaid Section 1115
10 Global Commitment to Health waiver or if a waiver modification must be
11 requested;

12 (4) descriptions of any other requested program modifications in
13 Medicaid or any other State program;

14 (5) sufficient detail in the program design to allow the Department of
15 Vermont Health Access to create a State Plan amendment, if needed; and

16 (6) an analysis of how the program fits with current statewide payment
17 for initiatives, such as the Medicaid Shared Savings Program.

18 (b) Upon request by the participating providers, the Director of Health Care
19 Reform in the Agency of Administration shall facilitate the acquisition of
20 necessary information, data, or other assistance from State agencies and
21 departments.

1 (c) The participating providers shall consult with or solicit funding from
2 the Populations Health Work Group and the Payment Models Work Group of
3 the Vermont Health Care Innovation Project.

4 (d) Upon completion, the participating providers shall submit the
5 implementation plan to the Agency of Human Services for review and a
6 determination of its completeness. The Agency shall consider the request and
7 determine the feasibility of implementation by the Agency within 30 days
8 following the date of submission.

9 * * * Green Mountain Care Board; Duties * * *

10 Sec. 3 18 V.S.A. § 9375(b) is amended to read:

11 (b) The Board shall have the following duties:

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

17 (A) Implement by rule, pursuant to 3 V.S.A. chapter 25,
18 methodologies for achieving payment reform and containing costs that include
19 the participation of Medicare and Medicaid, which may include the creation of
20 health care professional cost-containment targets, global payments, bundled
21 payments, global budgets, risk-adjusted capitated payments, or other uniform

1 payment methods and amounts for integrated delivery systems, health care
2 professionals, or other provider arrangements.

3 (i) The Board shall work in collaboration with providers to
4 develop payment models that preserve access to care and quality in each
5 community and shall not compel a provider to participate in a new payment
6 model or to accept insurance risk.

7 (ii) The rule shall include a plan for the transition from current
8 payment models to new payment models that preserves access to care and
9 quality of care in each community.

10 (iii) The rule shall take into consideration current Medicare
11 designations and payment methodologies, including critical access hospitals,
12 prospective payment system hospitals, graduate medical education payments,
13 Medicare dependent hospitals, and federally qualified health centers.

14 (iv) The payment reform methodologies developed by the Board
15 shall encourage coordination and planning on a regional basis, taking into
16 account existing local relationships between providers and human services
17 organizations.

18 * * *

19 (2)(A) Review and approve Vermont's statewide Health Information
20 Technology Plan pursuant to section 9351 of this title to ensure that the
21 necessary infrastructure is in place to enable the State to achieve the principles

1 expressed in section 9371 of this title. In performing its review, the Board
2 shall consult with and consider any recommendations regarding the plan
3 received from the Vermont Information Technology Leaders, Inc. (VITL).

4 (B) Review and approve the criteria required for health care
5 providers and health care facilities to create or maintain connectivity to the
6 State’s health information exchange as set forth in section 9352 of this title.
7 Within 90 days following this approval, the Board shall issue an order
8 explaining its decision.

9 (C) Annually review the budget and all activities of VITL and
10 approve the budget, consistent with available funds, and the core activities
11 associated with public funding, which shall include establishing the
12 interconnectivity of electronic medical records held by health care
13 professionals and the storage, management, and exchange of data received
14 from such health care professionals, for the purpose of improving the quality of
15 and efficiently providing health care to Vermonters. This review shall take
16 into account VITL’s responsibilities pursuant to 18 V.S.A. § 9352 and the
17 availability of funds needed to support those responsibilities.

18 * * *

19 * * * Vermont Information Technology Leaders * * *

20 Sec. 4. 18 V.S.A. § 9352 is amended to read:

21 § 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

1 (a)(1) Governance. ~~The General Assembly and the Governor shall each~~
2 ~~appoint one representative to the~~ Vermont Information Technology Leaders,
3 Inc. (VITL) Board of Directors shall consist of no fewer than nine nor more
4 than 14 members. The term of each member shall be two years, except that of
5 the members first appointed, approximately one-half shall serve a term of one
6 year and approximately one-half shall serve a term of two years, and members
7 shall continue to hold office until their successors have been duly appointed.
8 The Board of Directors shall comprise the following:

9 (A) one member of the General Assembly, appointed jointly by the
10 Speaker of the House and the President Pro Tempore of the Senate, who shall
11 be entitled to the same per diem compensation and expense reimbursement
12 pursuant to 2 V.S.A. § 406 as provided for attendance at sessions of the
13 General Assembly;

14 (B) one individual appointed by the Governor;

15 (C) one representative of the business community;

16 (D) one representative of health care consumers;

17 (E) one representative of Vermont hospitals;

18 (F) one representative of Vermont physicians;

19 (G) one practicing clinician licensed to practice medicine
20 in Vermont;

1 (H) one representative of a health insurer licensed to do business
2 in Vermont;

3 (I) the President of VITL, who shall be an ex officio, nonvoting
4 member;

5 (J) two individuals familiar with health information technology,
6 at least one of whom shall be the chief technology officer for a health care
7 provider; and

8 (K) two at-large members, at least one of whom shall be a health care
9 consumer who is not affiliated with a consumer advocacy or consumer
10 protection organization.

11 (2) Except for the members appointed pursuant to subdivisions (1)(A)
12 and (B) of this subsection, whenever a vacancy on the Board occurs, the
13 members of the Board of Directors then serving shall appoint a new member
14 who shall meet the same criteria as the member he or she replaces.

15 * * *

16 (c)(1) Health information exchange operation. VITL shall be designated
17 in the Health Information Technology Plan pursuant to section 9351 of this
18 title to operate the exclusive statewide health information exchange network
19 for this State. ~~The~~ After the Green Mountain Care Board approves VITL's
20 core activities and budget pursuant to chapter 220 of this title, the Secretary of
21 Administration or designee shall enter into procurement grant agreements with

1 VITL pursuant to 8 V.S.A. § 4089k. Nothing in this chapter shall impede local
2 community providers from the exchange of electronic medical data.

3 (2) Notwithstanding any provision of 3 V.S.A. § 2222 or 2283b to the
4 contrary, upon request of the Secretary of Administration, the Department of
5 Information and Innovation shall review VITL’s technology for security,
6 privacy, and interoperability with State government information technology
7 consistent with the State’s health information technology plan requirement by
8 section 9351 of this title.

9 * * *

10 (f) Funding authorization. VITL is authorized to seek matching funds to
11 assist with carrying out the purposes of this section. In addition, it may accept
12 any and all donations, gifts, and grants of money, equipment, supplies,
13 materials, and services from the federal or any local government, or any
14 agency thereof, and from any person, firm, foundation, or corporation for any
15 of its purposes and functions under this section and may receive and use the
16 same, subject to the terms, conditions, and regulations governing such
17 donations, gifts, and grants. VITL shall not use any State funds for health care
18 consumer advertising, marketing, lobbying, or similar services.

19 * * *

20 * * * Telemedicine * * *

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

1 § 1901i. MEDICAID COVERAGE FOR PRIMARY CARE

2 TELEMEDICINE

3 (a) Beginning on October 1, 2015, the Department of Vermont Health
4 Access shall provide reimbursement for Medicaid-covered primary care
5 consultations delivered through telemedicine to Medicaid beneficiaries outside
6 a health care facility. The Department shall reimburse health care
7 professionals for telemedicine consultations in the same manner as if the
8 services were provided through in-person consultation. Coverage provided
9 pursuant to this section shall comply with all federal requirements imposed by
10 the Centers for Medicare and Medicaid Services.

11 (b) Medicaid shall only provide coverage for services delivered through
12 telemedicine outside a health care facility that have been determined by the
13 Department’s Chief Medical Officer to be clinically appropriate. The
14 Department shall not impose limitations on the number of telemedicine
15 consultations a Medicaid beneficiary may receive or on which Medicaid
16 beneficiaries may receive primary care consultations through telemedicine that
17 exceed limitations otherwise placed on in-person Medicaid covered services.

18 (c) As used in this section:

19 (1) “Health care facility” shall have the same meaning as in 18 V.S.A.

20 § 9402.

1 (2) “Health care provider” means a physician licensed pursuant to
2 26 V.S.A. chapter 23 or 33, a naturopathic physician licensed pursuant to 26
3 V.S.A. chapter 81, an advanced practice registered nurse licensed pursuant to
4 26 V.S.A. chapter 28, subchapter 3, or a physician assistant licensed pursuant
5 to 26 V.S.A. chapter 31.

6 (3) “Telemedicine” means the delivery of health care services such as
7 diagnosis, consultation, or treatment through the use of live interactive audio
8 and video over a secure connection that complies with the requirements of the
9 Health Insurance Portability and Accountability Act of 1996, Public Law 104-
10 191. Telemedicine does not include the use of audio-only telephone, e-mail, or
11 facsimile.

12 Sec. 6. **TELEMEDICINE; IMPLEMENTATION REPORT**

13 On or before April 15, 2016, the Department of Vermont Health Access
14 shall submit to the House Committee on Health Care and the Senate
15 Committees on Health and Welfare and on Finance a report providing data
16 regarding the first six months of implementation of Medicaid coverage for
17 primary care consultations delivered through telemedicine outside a health care
18 facility. The report shall include demographic information regarding Medicaid
19 beneficiaries receiving the telemedicine services, the types of services
20 received, and an analysis of the effects of providing primary care consultations

1 through telemedicine outside a health care facility on health care costs, quality,
2 and access.

3 * * * Direct Enrollment for Individuals * * *

4 Sec. 7. 33 V.S.A. § 1803(b)(4) is amended to read:

5 (4) To the extent permitted by the U.S. Department of Health and
6 Human Services, the Vermont Health Benefit Exchange shall permit qualified
7 individuals and qualified employers to purchase qualified health benefit plans
8 through the Exchange website, through navigators, by telephone, or directly
9 from a health insurer under contract with the Vermont Health Benefit
10 Exchange.

11 Sec. 8. 33 V.S.A. § 1811(b) is amended to read:

12 (b)(1) ~~No person may provide a health benefit plan to an individual unless~~
13 ~~the plan is offered through the Vermont Health Benefit Exchange~~ To the extent
14 permitted by the U.S. Department of Health and Human Services, an
15 individual may purchase a health benefit plan through the Exchange website,
16 through navigators, by telephone, or directly from a registered carrier under
17 contract with the Vermont Health Benefit Exchange, if the carrier elects to
18 make direct enrollment available. A registered carrier enrolling individuals in
19 health benefit plans directly shall comply with all open enrollment and special
20 enrollment periods applicable to the Vermont Health Benefit Exchange.

1 (2) To the extent permitted by the U.S. Department of Health and
2 Human Services, a small employer or an employee of a small employer may
3 purchase a health benefit plan through the Exchange website, through
4 navigators, by telephone, or directly from a ~~health insurer~~ registered carrier
5 under contract with the Vermont Health Benefit Exchange.

6 (3) No person may provide a health benefit plan to an individual or
7 small employer unless the plan complies with the provisions of this subchapter.

8 * * * Large Group Insurance Market * * *

9 Sec. 9. 33 V.S.A. § 1802 is amended to read:

10 § 1802. DEFINITIONS

11 As used in this subchapter:

12 * * *

13 (5) “Qualified employer”:

14 (A) means an entity which employed an average of not more than 50
15 employees on working days during the preceding calendar year and which:

16 (i) has its principal place of business in this State and elects to
17 provide coverage for its eligible employees through the Vermont Health
18 Benefit Exchange, regardless of where an employee resides; or

19 (ii) elects to provide coverage through the Vermont Health Benefit
20 Exchange for all of its eligible employees who are principally employed in this
21 State.

1 (B) on and after January 1, 2016, shall include an entity which:

2 (i) employed an average of not more than 100 employees on
3 working days during the preceding calendar year; and

4 (ii) meets the requirements of subdivisions (A)(i) and (A)(ii) of
5 this subdivision (5).

6 (C) on and after January 1, ~~2017~~ 2018, shall include all employers
7 meeting the requirements of subdivisions (A)(i) and (ii) of this subdivision (5),
8 regardless of size.

9 * * *

10 Sec. 10. 33 V.S.A. § 1804(c) is amended to read:

11 (c) On and after January 1, ~~2017~~ 2018, a qualified employer shall be an
12 employer of any size which elects to make all of its full-time employees
13 eligible for one or more qualified health plans offered in the Vermont Health
14 Benefit Exchange, and the term “qualified employer” includes self-employed
15 persons. A full-time employee shall be an employee who works more than 30
16 hours per week.

17 Sec. 11. LARGE GROUP MARKET; IMPACT ANALYSIS

18 The Green Mountain Care Board, in consultation with the Department of
19 Financial Regulation, shall analyze the projected impact on rates in the large
20 group health insurance market if large employers are permitted to purchase
21 qualified health plans through the Vermont Health Benefit Exchange beginning

1 in 2018. The analysis shall estimate the impact on premiums for employees in
2 the large group market if the market were to transition from experience rating
3 to community rating beginning with the 2018 plan year.

4 * * * Consumer Information * * *

5 Sec. 12. 18 V.S.A. § 9413 is added to read:

6 § 9413. HEALTH CARE QUALITY AND PRICE COMPARISON

7 Each health insurer with more than 200 covered lives in this State shall
8 establish an Internet-based tool to enable its members to compare the price of
9 medical care in Vermont by service or procedure, including office visits,
10 emergency care, radiologic services, and preventive care such as
11 mammography and colonoscopy. The tool shall include provider quality
12 information as available and to the extent consistent with other applicable laws
13 and regulations. The tool shall allow members to compare price by selecting a
14 specific service or procedure and a geographic region of the State. Based on
15 the criteria specified, the tool shall provide the member with an estimate for
16 each provider of the amount the member would pay for the service or
17 procedure, an estimate of the amount the insurance plan would pay, and an
18 estimate of the combined payments. The price information shall reflect the
19 cost-sharing applicable to a member's specific plan, as well as any remaining
20 balance on the member's deductible for the plan year.

1 * * * Public Employees' Health Benefits * * *

2 Sec. 13. PUBLIC EMPLOYEES' HEALTH BENEFITS; REPORT

3 (a) The Director of Health Care Reform in the Agency of Administration
4 shall identify options and considerations for providing health care coverage to
5 all public employees, including State and judiciary employees, school
6 employees, municipal employees, and State and teacher retirees, in a cost-
7 effective manner that will not trigger the excise tax on high-cost, employer-
8 sponsored health insurance plans imposed pursuant to 26 U.S.C. § 4980I. One
9 of the options to be considered shall be an intermunicipal insurance agreement,
10 as described in 24 V.S.A. chapter 121, subchapter 6.

11 (b) The Director shall consult with representatives of the Vermont-NEA,
12 the Vermont School Boards Association, the Vermont Education Health
13 Initiative, the Vermont State Employees' Association, the Vermont Troopers
14 Association, the Department of Human Resources, the Office of the Treasurer,
15 and the Joint Fiscal Office.

16 (c) On or before November 1, 2015, the Director shall report his or her
17 findings and recommendations to the House Committees on Appropriations, on
18 Education, on General, Housing, and Military Affairs, on Government
19 Operations, on Health Care, and on Ways and Means; the Senate Committees
20 on Appropriations, on Education, on Economic Development, Housing, and

1 General Affairs, on Government Operations, on Health and Welfare, and on
2 Finance; and the Health Reform Oversight Committee.

3 * * * Provider Payment Parity * * *

4 Sec. 14. 18 V.S.A. § 9418(n) is added to read:

5 (n)(1) A health plan shall reimburse a participating provider who is
6 licensed as a physician pursuant to 26 V.S.A. chapter 23 or 33, as a podiatric
7 physician pursuant to 26 V.S.A. chapter 7, as a chiropractic physician pursuant
8 to 26 V.S.A. chapter 10, as a naturopathic physician pursuant to 26 V.S.A.
9 chapter 81, as a psychologist pursuant to 26 V.S.A. chapter 55, as a clinical
10 social worker pursuant to 26 V.S.A. chapter 61, as an advanced practice
11 registered nurse pursuant to 26 V.S.A. chapter 28, subchapter 3, or as a
12 physician assistant pursuant to 26 V.S.A. chapter 31 and who is providing a
13 covered health care service that is within his or her scope of practice the same
14 professional fee as applied to other licensed participating providers providing
15 the same covered service. Health plans shall adjust reimbursement rates in a
16 manner that ensures that parity is attained without increasing premium rates.

17 (2) Subdivision (1) of this subsection shall not be construed to affect a
18 health plan's:

19 (A) implementation of a health care quality improvement program
20 offering separately identifiable enhanced payments designed to promote
21 cost-effective and clinically efficacious health care services, including

1 pay-for-performance payment methodologies, if they are fairly applied,
2 designed to promote evidence-based and research-based practices, and
3 available to all providers licensed pursuant to 26 V.S.A. chapters 7, 10, 23, 33,
4 and 81; or

5 (B) authority to pay in-network providers differently than
6 out-of-network providers.

7 Sec. 15. PROVIDER PAYMENT PARITY IMPLEMENTATION

8 The Green Mountain Care Board shall convene a group of interested
9 stakeholders to develop a plan for implementation of the provider payment
10 parity provisions set forth in Sec. 14 of this act. On or before January 15,
11 2016, the Board shall provide the implementation plan to the House
12 Committee on Health Care and the Senate Committees on Health and Welfare
13 and on Finance, which shall detail the process by which the health plans will
14 attain parity in the reimbursement for all of the licensed providers included in
15 18 V.S.A. § 9418(n) by January 1, 2017.

16 * * * Transferring Department of Financial Regulation Duties * * *

17 Sec. 16. 8 V.S.A. § 4062 is amended to read:

18 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

19 * * *

1 (e) ~~Within 30 calendar days after making the rate filing and analysis~~
2 ~~available to the public pursuant to subsection (d)~~ the time period set forth in
3 subdivision (a)(2)(A) of this section, the Board shall:

4 (1) conduct a public hearing, at which the Board shall:

5 (A) call as witnesses the Commissioner of Financial Regulation or
6 designee and the Board's contracting actuary, if any, unless all parties agree to
7 waive such testimony; and

8 (B) provide an opportunity for testimony from the insurer; the Office
9 of the Health Care Advocate; and members of the public;

10 (2) at a public hearing, announce the Board's decision of whether to
11 approve, modify, or disapprove the proposed rate; and

12 (3) issue its decision in writing.

13 * * *

14 (h)(1) The authority of the Board under this section shall apply only to the
15 rate review process for policies for major medical insurance coverage and shall
16 not apply to the policy forms for major medical insurance coverage or to the
17 rate and policy form review process for policies for specific disease, accident,
18 injury, hospital indemnity, dental care, vision care, disability income,
19 long-term care, student health insurance coverage, Medicare supplemental
20 coverage, or other limited benefit coverage, or to benefit plans that are paid
21 directly to an individual insured or to his or her assigns and for which the

1 amount of the benefit is not based on potential medical costs or actual costs
2 incurred. Premium rates and rules for the classification of risk for Medicare
3 supplemental insurance policies shall be governed by sections 4062b and
4 4080e of this title.

5 * * *

6 (3) ~~Medicare supplemental insurance policies shall be exempt only from~~
7 ~~the requirement in subdivisions (a)(1) and (2) of this section for the Green~~
8 ~~Mountain Care Board's approval on rate requests and shall be subject to the~~
9 ~~remaining provisions of this section. [Repealed.]~~

10 * * *

11 Sec. 17. 8 V.S.A. § 4089b(g) is amended to read:

12 (g) ~~On or before July 15 of each year, health insurance companies doing~~
13 ~~business in Vermont whose individual share of the commercially insured~~
14 ~~Vermont market, as measured by covered lives, comprises at least five percent~~
15 ~~of the commercially insured Vermont market, shall file with the~~
16 ~~Commissioner, in accordance with standards, procedures, and forms approved~~
17 ~~by the Commissioner:~~

18 (1) ~~A report card on the health insurance plan's performance in relation~~
19 ~~to quality measures for the care, treatment, and treatment options of mental and~~
20 ~~substance abuse conditions covered under the plan, pursuant to standards and~~
21 ~~procedures adopted by the Commissioner by rule, and without duplicating any~~

1 ~~reporting required of such companies pursuant to Rule H 2009-03 of the~~
2 ~~Division of Health Care Administration and regulation 95-2, “Mental Health~~
3 ~~Review Agents,” of the Division of Insurance, as amended, including:~~

4 ~~(A) the discharge rates from inpatient mental health and substance~~
5 ~~abuse care and treatment of insureds;~~

6 ~~(B) the average length of stay and number of treatment sessions for~~
7 ~~insureds receiving inpatient and outpatient mental health and substance abuse~~
8 ~~care and treatment;~~

9 ~~(C) the percentage of insureds receiving inpatient and outpatient~~
10 ~~mental health and substance abuse care and treatment;~~

11 ~~(D) the number of insureds denied mental health and substance abuse~~
12 ~~care and treatment;~~

13 ~~(E) the number of denials appealed by patients reported separately~~
14 ~~from the number of denials appealed by providers;~~

15 ~~(F) the rates of readmission to inpatient mental health and substance~~
16 ~~abuse care and treatment for insureds with a mental condition;~~

17 ~~(G) the level of patient satisfaction with the quality of the mental~~
18 ~~health and substance abuse care and treatment provided to insureds under the~~
19 ~~health insurance plan; and~~

20 ~~(H) any other quality measure established by the Commissioner.~~

1 ~~(2) The health insurance plan’s revenue loss and expense ratio relating~~
2 ~~to the care and treatment of mental conditions covered under the health~~
3 ~~insurance plan. The expense ratio report shall list amounts paid in claims for~~
4 ~~services and administrative costs separately. A managed care organization~~
5 ~~providing or administering coverage for treatment of mental conditions on~~
6 ~~behalf of a health insurance plan shall comply with the minimum loss ratio~~
7 ~~requirements pursuant to the Patient Protection and Affordable Care Act of~~
8 ~~2010, Public Law 111-148, as amended by the Health Care and Education~~
9 ~~Reconciliation Act of 2010, Public Law 111-152, applicable to the underlying~~
10 ~~health insurance plan with which the managed care organization has contracted~~
11 ~~to provide or administer such services. The health insurance plan shall also~~
12 ~~bear responsibility for ensuring the managed care organization’s compliance~~
13 ~~with the minimum loss ratio requirement pursuant to this subdivision.~~

14 ~~[Repealed.]~~

15 Sec. 18. 18 V.S.A. § 9402 is amended to read:

16 § 9402. DEFINITIONS

17 As used in this chapter, unless otherwise indicated:

18 * * *

19 ~~(4) “Division” means the division of health care administration.~~

20 ~~[Repealed.]~~

21 * * *

1 (10) “Health resource allocation plan” means the plan adopted by the
2 ~~commissioner of financial regulation~~ Green Mountain Care Board under
3 section 9405 of this title.

4 * * *

5 Sec. 19. 18 V.S.A. § 9404 is amended to read:

6 § 9404. ADMINISTRATION

7 (a) The Commissioner and the Green Mountain Care Board shall supervise
8 and direct the execution of all laws vested in the Department and the Board,
9 respectively, by this chapter, and shall formulate and carry out all policies
10 relating to this chapter.

11 (b) The Commissioner and the Board may:

12 (1) apply for and accept gifts, grants, or contributions from any person
13 for purposes consistent with this chapter;

14 (2) adopt rules necessary to implement the provisions of this
15 chapter; and

16 (3) enter into contracts and perform such acts as are necessary to
17 accomplish the purposes of this chapter.

18 (c) ~~There is hereby created a fund to be known as the Health Care~~
19 ~~Administration Regulatory and Supervision Fund for the purpose of providing~~
20 ~~the financial means for the Commissioner of Financial Regulation to~~
21 ~~administer this chapter and 33 V.S.A. § 6706. All fees and assessments~~

1 ~~received by the Department pursuant to such administration shall be credited to~~
2 ~~this Fund. All fines and administrative penalties, however, shall be deposited~~
3 ~~directly into the General Fund.~~

4 ~~(1) All payments from the Health Care Administration Regulatory and~~
5 ~~Supervision Fund for the maintenance of staff and associated expenses,~~
6 ~~including contractual services as necessary, shall be disbursed from the State~~
7 ~~Treasury only upon warrants issued by the Commissioner of Finance and~~
8 ~~Management, after receipt of proper documentation regarding services~~
9 ~~rendered and expenses incurred.~~

10 ~~(2) The Commissioner of Finance and Management may anticipate~~
11 ~~receipts to the Health Care Administration Regulatory and Supervision Fund~~
12 ~~and issue warrants based thereon. [Repealed.]~~

13 Sec. 20. 18 V.S.A. § 9410 is amended to read:

14 § 9410. HEALTH CARE DATABASE

15 (a)(1) The Board shall establish and maintain a unified health care database
16 to enable the ~~Commissioner and the~~ Board to carry out ~~their~~ its duties under
17 this chapter, chapter 220 of this title, and Title 8, including:

18 (A) determining the capacity and distribution of existing resources;

19 (B) identifying health care needs and informing health care policy;

20 (C) evaluating the effectiveness of intervention programs on
21 improving patient outcomes;

1 (D) comparing costs between various treatment settings and
2 approaches;

3 (E) providing information to consumers and purchasers of health
4 care; and

5 (F) improving the quality and affordability of patient health care and
6 health care coverage.

7 ~~(2)(A) The program authorized by this section shall include a consumer~~
8 ~~health care price and quality information system designed to make available to~~
9 ~~consumers transparent health care price information, quality information, and~~
10 ~~such other information as the Board determines is necessary to empower~~
11 ~~individuals, including uninsured individuals, to make economically sound and~~
12 ~~medically appropriate decisions.~~

13 ~~(B) The Commissioner may require a health insurer covering at least~~
14 ~~five percent of the lives covered in the insured market in this State to file with~~
15 ~~the Commissioner a consumer health care price and quality information plan in~~
16 ~~accordance with rules adopted by the Commissioner. [Repealed.]~~

17 ~~(C) The Board shall adopt such rules as are necessary to carry out the~~
18 ~~purposes of this subdivision. The Board's rules may permit the gradual~~
19 ~~implementation of the consumer health care price and quality information~~
20 ~~system over time, beginning with health care price and quality information that~~
21 ~~the Board determines is most needed by consumers or that can be most~~

1 ~~practically provided to the consumer in an understandable manner. The rules~~
2 ~~shall permit health insurers to use security measures designed to allow~~
3 ~~subscribers access to price and other information without disclosing trade~~
4 ~~secrets to individuals and entities who are not subscribers. The rules shall~~
5 ~~avoid unnecessary duplication of efforts relating to price and quality reporting~~
6 ~~by health insurers, health care providers, health care facilities, and others,~~
7 ~~including activities undertaken by hospitals pursuant to their community report~~
8 ~~obligations under section 9405b of this title.~~

9 * * *

10 (i) On or before January 15, 2008 2018 and every three years thereafter, the
11 Commissioner of Health shall submit a recommendation to the General
12 Assembly for conducting a survey of the health insurance status of Vermont
13 residents. The provisions of 2 V.S.A. § 20(d) (expiration of required reports)
14 shall not apply to the report to be made under this subsection.

15 * * *

16 Sec. 21. 18 V.S.A. § 9414 is amended to read:

17 § 9414. QUALITY ASSURANCE FOR MANAGED CARE

18 ORGANIZATIONS

19 (a) The ~~commissioner~~ Commissioner shall have the power and
20 responsibility to ensure that each managed care organization provides quality
21 health care to its members, in accordance with the provisions of this section.

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* * *

(4) The Commissioner or designee may resolve any consumer complaint arising out of this subsection as though the managed care organization were an insurer licensed pursuant to Title 8.

* * *

(d)(1) In addition to its internal quality assurance program, each managed care organization shall evaluate the quality of health and medical care provided to members. The organization shall use and maintain a patient record system which will facilitate documentation and retrieval of statistically meaningful clinical information.

(2) A managed care organization may evaluate the quality of health and medical care provided to members through an independent accreditation organization, ~~provided that the commissioner has established criteria for such independent evaluations.~~

~~(e) The commissioner shall review a managed care organization's performance under the requirements of this section at least once every three years and more frequently as the commissioner deems proper. If upon review the commissioner determines that the organization's performance with respect to one or more requirements warrants further examination, the commissioner shall conduct a comprehensive or targeted examination of the organization's performance. The commissioner may designate another organization to~~

1 ~~conduct any evaluation under this subsection. Any such independent designee~~
2 ~~shall have a confidentiality code acceptable to the commissioner, or shall be~~
3 ~~subject to the confidentiality code adopted by the commissioner under~~
4 ~~subdivision (f)(3) of this section. In conducting an evaluation under this~~
5 ~~subsection, the commissioner or the commissioner's designee shall employ,~~
6 ~~retain, or contract with persons with expertise in medical quality assurance.~~

7 [Repealed.]

8 (f)(1) For the purpose of evaluating a managed care organization's
9 performance under the provisions of this section, the ~~commissioner~~
10 Commissioner may examine and review information protected by the
11 provisions of the patient's privilege under 12 V.S.A. § 1612(a), or otherwise
12 required by law to be held confidential, ~~except that the commissioner's access~~
13 ~~to and use of minutes and records of a peer review committee established~~
14 ~~under subsection (e) of this section shall be governed by subdivision (2) of this~~
15 ~~subsection.~~

16 (2) ~~Notwithstanding the provisions of 26 V.S.A. § 1443, for the sole~~
17 ~~purpose of reviewing a managed care organization's internal quality assurance~~
18 ~~program, and enforcing compliance with the provisions of subsection (e) of~~
19 ~~this section, the commissioner or the commissioner's designee shall have~~
20 ~~reasonable access to the minutes or records of any peer review or comparable~~
21 ~~committee required by subdivision (c)(6) of this section, provided that such~~

1 ~~access shall not disclose the identity of patients, health care providers, or other~~
2 ~~individuals. [Repealed.]~~

3 * * *

4 (i) ~~Upon review of the managed care organization's clinical data, or after~~
5 ~~consideration of claims or other data, the commissioner may:~~

6 (1) ~~identify quality issues in need of improvement; and~~

7 (2) ~~direct the managed care organization to propose quality~~
8 ~~improvement initiatives to remediate those issues. [Repealed.]~~

9 Sec. 22. 18 V.S.A. § 9418(1) is amended to read:

10 (1) Nothing in this section shall be construed to prohibit a health plan from
11 applying payment policies that are consistent with applicable federal or State
12 laws and regulations, or to relieve a health plan from complying with payment
13 standards established by federal or State laws and regulations, ~~including rules~~
14 ~~adopted by the Commissioner pursuant to section 9408 of this title relating to~~
15 ~~claims administration and adjudication standards, and rules adopted by the~~
16 ~~Commissioner pursuant to section 9414 of this title and 8 V.S.A. § 4088h~~
17 ~~relating to pay for performance or other payment methodology standards.~~

18 Sec. 23. 18 V.S.A. § 9418b(f) is amended to read:

19 (f) Nothing in this section shall be construed to prohibit a health plan from
20 applying payment policies that are consistent with applicable federal or State
21 laws and regulations, or to relieve a health plan from complying with payment

1 standards established by federal or State laws and regulations, ~~including rules~~
2 ~~adopted by the Commissioner pursuant to section 9408 of this title, relating to~~
3 ~~claims administration and adjudication standards, and rules adopted by the~~
4 ~~Commissioner pursuant to section 9414 of this title and 8 V.S.A. § 4088h,~~
5 ~~relating to pay for performance or other payment methodology standards.~~

6 Sec. 24. 18 V.S.A. § 9420 is amended to read:

7 § 9420. CONVERSION OF NONPROFIT HOSPITALS

8 (a) Policy and purpose. The ~~state~~ State has a responsibility to assure that
9 the assets of nonprofit entities, which are impressed with a charitable trust, are
10 managed prudently and are preserved for their proper charitable purposes.

11 (b) Definitions. As used in this section:

12 * * *

13 (2) ~~“Commissioner” is the commissioner of financial regulation.~~

14 [Repealed.]

15 * * *

16 (10) “Green Mountain Care Board” or “Board” means the Green
17 Mountain Care Board established in chapter 220 of this title.

18 (c) Approval required for conversion of qualifying amount of charitable
19 assets. A nonprofit hospital may convert a qualifying amount of charitable
20 assets only with the approval of the ~~commissioner~~ Green Mountain Care
21 Board, and either the ~~attorney general~~ Attorney General or the ~~superior court~~

1 Superior Court, pursuant to the procedures and standards set forth in this
2 section.

3 (d) Exception for conversions in which assets will be owned and controlled
4 by a nonprofit corporation:

5 (1) Other than subsection (q) of this section and subdivision (2) of this
6 subsection, this section shall not apply to conversions in which the party
7 receiving assets of a nonprofit hospital is a nonprofit corporation.

8 (2) In any conversion that would have required an application under
9 subsection (e) of this section but for the exception set forth in subdivision (1)
10 of this subsection, notice to or written waiver by the ~~attorney general~~ Attorney
11 General shall be given or obtained as if required under 11B V.S.A. § 12.02(g).

12 (e) Application. Prior to consummating any conversion of a qualifying
13 amount of charitable assets, the parties shall submit an application to the
14 ~~attorney general~~ Attorney General and the ~~commissioner~~ Green Mountain Care
15 Board, together with any attachments complying with subsection (f) of this
16 section. If any material change occurs in the proposal set forth in the filed
17 application, an amendment setting forth such change, together with copies of
18 all documents and other material relevant to such change, shall be filed with
19 the ~~attorney general~~ Attorney General and the ~~commissioner~~ Board within two
20 business days, or as soon thereafter as practicable, after any party to the
21 conversion learns of such change. If the conversion involves a hospital

1 system, and one or more of the hospitals in the system desire to convert
2 charitable assets, the ~~attorney general~~ Attorney General, in consultation with
3 the ~~commissioner~~ Board, shall determine whether an application shall be
4 required from the hospital system.

5 (f) Completion and contents of application.

6 (1) Within 30 days of receipt of the application, or within 10 days of
7 receipt of any amendment thereto, whichever is longer, the ~~attorney general~~
8 Attorney General, with the ~~commissioner's~~ Green Mountain Care Board's
9 agreement, shall determine whether the application is complete. The Attorney
10 General shall promptly notify the parties of the date the application is deemed
11 complete, or of the reasons for a determination that the application is
12 incomplete. A complete application shall include the following:

13 * * *

14 (N) any additional information the ~~attorney general~~ Attorney General
15 or ~~commissioner~~ Green Mountain Care Board finds necessary or appropriate
16 for the full consideration of the application.

17 (2) The parties shall make the contents of the application reasonably
18 available to the public prior to any hearing for public comment described in
19 subsection (g) of this section to the extent that they are not otherwise exempt
20 from disclosure under 1 V.S.A. § 317(b).

21 (g) Notice and hearing for public comment on application.

1 (1) The ~~attorney general~~ Attorney General and ~~commissioner~~ the Green
2 Mountain Care Board shall hold one or more public hearings on the transaction
3 or transactions described in the application. A record shall be made of any
4 hearing. The hearing shall commence within 30 days of the determination by
5 the ~~attorney general~~ Attorney General that the application is complete. If a
6 hearing is continued or multiple hearings are held, any hearing shall be
7 completed within 60 days of the ~~attorney general's~~ Attorney General's
8 determination that an application is complete. In determining the number,
9 location, and time of hearings, the ~~attorney general~~ Attorney General, in
10 consultation with the ~~commissioner~~ Board, shall consider the geographic areas
11 and populations served by the nonprofit hospital and most affected by the
12 conversion and the interest of the public in commenting on the application.

13 (2) The ~~attorney general~~ Attorney General shall provide reasonable
14 notice of any hearing to the parties, the ~~commissioner~~ Board, and the public,
15 and may order that the parties bear the cost of notice to the public. Notice to
16 the public shall be provided in newspapers having general circulation in the
17 region affected and shall identify the applicants and the proposed conversion.
18 A copy of the public notice shall be sent to the ~~state~~ State health care and long-
19 term care ombudspersons and to the ~~senators~~ Senators and members of the
20 ~~house of representatives~~ House of Representatives representing the county and
21 district and to the ~~clerk, chief municipal officer~~ Clerk, Chief Municipal

1 Officer, and legislative body, of the municipality in which the nonprofit
2 hospital is principally located. Upon receipt, the ~~clerk~~ Clerk shall post notice
3 in or near the ~~clerk's~~ Clerk's office and in at least two other public places in
4 the municipality. Any person may testify at a hearing under this section and,
5 within such reasonable time as the ~~attorney general~~ Attorney General may
6 prescribe, file written comments with the ~~attorney general~~ Attorney General
7 and ~~commissioner~~ Board concerning the proposed conversion.

8 (h) Determination by ~~commissioner~~ the Green Mountain Care Board.

9 (1) The ~~commissioner~~ Green Mountain Care Board shall consider the
10 application, together with any report and recommendations from the Board's
11 staff ~~of the department~~ requested by the ~~commissioner~~ Board, and any other
12 information submitted into the record, and approve or deny it within 50 days
13 following the last public hearing held pursuant to subsection (g) of this section,
14 unless the ~~commissioner~~ Board extends such time up to an additional 60 days
15 with notice prior to its expiration to the ~~attorney general~~ Attorney General and
16 the parties.

17 (2) The ~~commissioner~~ Board shall approve the proposed transaction if
18 the ~~commissioner~~ Board finds that the application and transaction will satisfy
19 the criteria established in section 9437 of this title. For purposes of applying
20 the criteria established in section 9437, the term "project" shall include a
21 conversion or other transaction subject to the provisions of this subchapter.

1 (3) A denial by the ~~commissioner~~ Board may be appealed to the
2 ~~supreme court~~ Supreme Court pursuant to ~~the procedures and standards set~~
3 ~~forth in 8 V.S.A. § 16~~ section 9381 of this title. If no appeal is taken or if the
4 ~~commissioner's~~ Board's order is affirmed by the ~~supreme court~~ supreme court,
5 the application shall be terminated. A failure of the ~~commissioner~~ Board to
6 approve of an application in a timely manner shall be considered a final order
7 in favor of the applicant.

8 (i) Determination by ~~attorney general~~ Attorney General. The ~~attorney~~
9 ~~general~~ Attorney General shall make a determination as to whether the
10 conversion described in the application meets the standards provided in
11 subsection (j) of this section.

12 (1) If the ~~attorney general~~ Attorney General determines that the
13 conversion described in the application meets the standards set forth in
14 subsection (j) of this section, the ~~attorney general~~ Attorney General shall
15 approve the conversion and so notify the parties in writing.

16 (2) If the ~~attorney general~~ Attorney General determines that the
17 conversion described in the application does not meet such standards, the
18 ~~attorney general~~ Attorney General may not approve the conversion and shall so
19 notify the parties of such disapproval and the basis for it in writing, including
20 identification of the standards listed in subsection (j) of this section that the
21 ~~attorney general~~ Attorney General finds not to have been met by the proposed

1 conversion. Nothing in this subsection shall prevent the parties from amending
2 the application to meet any objections of the ~~attorney general~~ Attorney
3 General.

4 (3) The notice of approval or disapproval by the ~~attorney general~~
5 Attorney General under this subsection shall be provided no later than either
6 60 days following the date of the last hearing held under subsection (g) of this
7 section or ten days following approval of the conversion by the ~~commissioner~~
8 Board, whichever is later. The ~~attorney general~~ Attorney General, for good
9 cause, may extend this period an additional 60 days.

10 (j) Standards for ~~attorney general's~~ Attorney General's review. In
11 determining whether to approve a conversion under subsection (i) of this
12 section, the ~~attorney general~~ Attorney General shall consider whether:

13 * * *

14 (7) the application contains sufficient information and data to permit the
15 ~~attorney general~~ Attorney General and ~~commissioner~~ the Green Mountain Care
16 Board to evaluate the conversion and its effects on the public's interests in
17 accordance with this section; and

18 (8) the conversion plan has made reasonable provision for reports, upon
19 request, to the ~~attorney general~~ Attorney General on the conduct and affairs of
20 any person that, as a result of the conversion, is to receive charitable assets or

1 proceeds from the conversion to carry on any part of the public purposes of the
2 nonprofit hospital.

3 (k) Investigation by ~~attorney general~~ Attorney General. The ~~attorney~~
4 ~~general~~ Attorney General may conduct an investigation relating to the
5 conversion pursuant to the procedures set forth generally in 9 V.S.A. § 2460.
6 The ~~attorney general~~ Attorney General may contract with such experts or
7 consultants the ~~attorney general~~ Attorney General deems appropriate to assist
8 in an investigation of a conversion under this section. The ~~attorney general~~
9 Attorney General may order any party to reimburse the ~~attorney general~~
10 Attorney General for all reasonable and actual costs incurred by the ~~attorney~~
11 ~~general~~ Attorney General in retaining outside professionals to assist with the
12 investigation or review of the conversion.

13 (l) Superior ~~court~~ Court action. If the ~~attorney general~~ Attorney General
14 does not approve the conversion described in the application and any
15 amendments, the parties may commence an action in the ~~superior court~~
16 Superior Court of Washington County, or with the agreement of the ~~attorney~~
17 ~~general~~ Attorney General, of any other county, within 60 days of the ~~attorney~~
18 ~~general's~~ Attorney General's notice of disapproval provided to the parties
19 under subdivision (i)(2) of this section. The parties shall notify the
20 ~~commissioner~~ Green Mountain Care Board of the commencement of an action
21 under this subsection. The ~~commissioner~~ Board shall be permitted to request

1 that the ~~court~~ Court consider the ~~commissioner's~~ Board's determination under
2 subsection (h) of this section in its decision under this subsection.

3 (m) Court determination and order.

4 * * *

5 (4) Nothing herein shall prevent the ~~attorney general~~ Attorney General,
6 while an action brought under subsection (l) of this section is pending, from
7 approving the conversion described in the application, as modified by such
8 terms as are agreed between the parties, the ~~attorney general~~ Attorney General,
9 and the ~~commissioner~~ Green Mountain Care Board to bring the conversion into
10 compliance with the standards set forth in subsection (j) of this section.

11 (n) Use of converted assets or proceeds of a conversion approved pursuant
12 to this section. If at any time following a conversion, the ~~attorney general~~
13 Attorney General has reason to believe that converted assets or the proceeds of
14 a conversion are not being held or used in a manner consistent with
15 information provided to the ~~attorney general~~ Attorney General, the
16 ~~commissioner~~ Board, or a court in connection with any application or
17 proceedings under this section, the ~~attorney general~~ Attorney General may
18 investigate the matter pursuant to procedures set forth generally in 9 V.S.A.
19 § 2460 and may bring an action in Washington ~~superior court~~ Superior Court
20 or in the ~~superior court~~ Superior Court of any county where one of the parties
21 has a principal place of business. The ~~court~~ Court may order appropriate relief

1 in such circumstances, including avoidance of the conversion or transfer of the
2 converted assets or proceeds or the amount of any private inurement to a
3 person or party for use consistent with the purposes for which the assets were
4 held prior to the conversion, and the award of costs of investigation and
5 prosecution under this subsection, including the reasonable value of legal
6 services.

7 (o) Remedies and penalties for violations.

8 (1) The ~~attorney general~~ Attorney General may bring or maintain a civil
9 action in the Washington ~~superior court~~ Superior Court, or any other county in
10 which one of the parties has its principal place of business, to enjoin, restrain,
11 or prevent the consummation of any conversion which has not been approved
12 in accordance with this section or where approval of the conversion was
13 obtained on the basis of materially inaccurate information furnished by any
14 party to the ~~attorney general~~ Attorney General or the ~~commissioner~~ Board.

15 * * *

16 (p) Conversion of less than a qualifying amount of assets.

17 (1) The ~~attorney general~~ Attorney General may conduct an investigation
18 relating to a conversion pursuant to the procedures set forth generally in
19 9 V.S.A. § 2460 if the ~~attorney general~~ Attorney General has reason to believe
20 that a nonprofit hospital has converted or is about to convert less than a
21 qualifying amount of its assets in such a manner that would:

1 (A) if it met the qualifying amount threshold, require an application
2 under subsection (e) of this section; and

3 (B) constitute a conversion that does not meet one or more of the
4 standards set forth in subsection (j) of this section.

5 (2) The ~~attorney general~~ Attorney General, in consultation with the
6 ~~commissioner~~ Green Mountain Care Board, may bring an action with respect
7 to any conversion of less than a qualifying amount of assets, according to the
8 procedures set forth in subsection (n) of this section. The ~~attorney general~~
9 Attorney General shall notify the ~~commissioner~~ Board of any action
10 commenced under this subsection. The ~~commissioner~~ Board shall be permitted
11 to investigate and determine whether the transaction satisfies the criteria
12 established in subdivision (g)(2) of this section, and to request that the ~~court~~
13 Court consider the ~~commissioner's~~ Board's recommendation in its decision
14 under this subsection. In such an action, the ~~superior court~~ Superior Court may
15 enjoin or void any transaction and may award any other relief as provided
16 under subsection (n) of this section.

17 (3) In any action brought by the ~~attorney general~~ Attorney General
18 under this subdivision, the ~~attorney general~~ Attorney General shall have the
19 burden to establish that the conversion:

20 (A) violates one or more of the standards listed in subdivision (j)(1),
21 (3), (4), or (6); or

1 (B) substantially violates one or more of the standards set forth in
2 subdivisions (j)(2) and (5) of this section.

3 (q) Other preexisting authority.

4 (1) Nothing in this section shall be construed to limit the authority of the
5 ~~commissioner~~ Green Mountain Care Board, ~~attorney general~~ Attorney General,
6 ~~department of health~~ Department of Health, or a court of competent
7 jurisdiction under existing law, or the interpretation or administration of a
8 charitable gift under 14 V.S.A. § 2328.

9 (2) This section shall not be construed to limit the regulatory and
10 enforcement authority of the ~~commissioner~~ Board, or exempt any applicant or
11 other person from requirements for licensure or other approvals required
12 by law.

13 Sec. 25. 18 V.S.A. § 9440 is amended to read: (proposed by GMCB)

14 § 9440. PROCEDURES

15 * * *

16 (c) The application process shall be as follows:

17 (1) Applications shall be accepted only at such times as the Board shall
18 establish by rule.

19 (2)(A) Prior to filing an application for a certificate of need, an applicant
20 shall file an adequate letter of intent with the Board no less than 30 days or, in
21 the case of review cycle applications under section 9439 of this title, no less

1 than 45 days prior to the date on which the application is to be filed. The letter
2 of intent shall form the basis for determining the applicability of this
3 subchapter to the proposed expenditure or action. A letter of intent shall
4 become invalid if an application is not filed within six months of the date that
5 the letter of intent is received or, in the case of review cycle applications under
6 section 9439 of this title, within such time limits as the Board shall establish by
7 rule. ~~Except for requests for expedited review under subdivision (5) of this~~
8 ~~subsection,~~ The Board shall post public notice of such letters of intent ~~shall be~~
9 ~~provided in newspapers having general circulation in the region of the State~~
10 ~~affected by the letter of intent~~ on its website electronically within five business
11 days of receipt. The public notice shall identify the applicant, the proposed
12 new health care project, and the date by which a competing application or
13 petition to intervene must be filed. ~~In addition, a copy of the public notice~~
14 ~~shall be sent to the clerk of the municipality in which the health care facility is~~
15 ~~located. Upon receipt, the clerk shall post the notice in or near the clerk's~~
16 ~~office and in at least two other public places in the municipality.~~

17 (B) Applicants who agree that their proposals are subject to
18 jurisdiction pursuant to section 9434 of this title shall not be required to file a
19 letter of intent pursuant to subdivision (A) of this subdivision (2) and may file
20 an application without further process. Public notice of the application shall be

1 ~~provided upon filing~~ posted electronically on the Board's website as provided
2 for in subdivision (A) of this subdivision (2) for letters of intent.

3 * * *

4 (5) An applicant seeking expedited review of a certificate of need
5 application may simultaneously file ~~a letter of intent and~~ with the Board a
6 request for expedited review and an application with the Board. ~~Upon~~ After
7 receiving the request and an application, the Board shall issue public notice of
8 the request and application in the manner set forth in subdivision (2) of this
9 subsection. At least 20 days after the public notice was issued, if no competing
10 application has been filed and no party has sought and been granted, nor is
11 likely to be granted, interested party status, the Board, upon making a
12 determination that the proposed project may be uncontested and does not
13 substantially alter services, as defined by rule, or upon making a determination
14 that the application relates to a health care facility affected by bankruptcy
15 proceedings, ~~the Board shall issue public notice of the application and the~~
16 ~~request for expedited review and identify a date by which a competing~~
17 ~~application or petition for interested party status must be filed. If a competing~~
18 ~~application is not filed and no person opposing the application is granted~~
19 ~~interested party status, the Board~~ may formally declare the application
20 uncontested and may issue a certificate of need without further process, or with
21 such abbreviated process as the Board deems appropriate. If a competing

1 application is filed or a person opposing the application is granted interested
2 party status, the applicant shall follow the certificate of need standards and
3 procedures in this section, except that in the case of a health care facility
4 affected by bankruptcy proceedings, the Board after notice and an opportunity
5 to be heard may issue a certificate of need with such abbreviated process as the
6 Board deems appropriate, notwithstanding the contested nature of the
7 application.

8 * * *

9 Sec. 26. 18 V.S.A. § 9445 is amended to read:

10 § 9445. ENFORCEMENT

11 (a) Any person who offers or develops any new health care project within
12 the meaning of this subchapter without first obtaining a certificate of need as
13 required herein, or who otherwise violates any of the provisions of this
14 subchapter, may be subject to the following administrative sanctions by the
15 Board, after notice and an opportunity to be heard:

16 (1) The Board may order that no license or certificate permitted to be
17 issued by ~~the Department or any other~~ State agency may be issued to any
18 health care facility to operate, offer, or develop any new health care project for
19 a specified period of time, or that remedial conditions be attached to the
20 issuance of such licenses or certificates.

1 (2) The Board may order that payments or reimbursements to the entity
2 for claims made under any health insurance policy, subscriber contract, or
3 health benefit plan offered or administered by any public or private health
4 insurer, including the Medicaid program and any other health benefit program
5 administered by the State be denied, reduced, or limited, and in the case of a
6 hospital that the hospital’s annual budget approved under subchapter 7 of this
7 chapter be adjusted, modified, or reduced.

8 (b) In addition to all other sanctions, if any person offers or develops any
9 new health care project without first having been issued a certificate of need or
10 certificate of exemption for the project, or violates any other provision of this
11 subchapter or any lawful rule adopted pursuant to this subchapter, the Board,
12 ~~the Commissioner~~, the Office of the Health Care Advocate, the State
13 Long-Term Care Ombudsman, and health care providers and consumers
14 located in the State shall have standing to maintain a civil action in the
15 Superior Court of the county in which such alleged violation has occurred, or
16 in which such person may be found, to enjoin, restrain, or prevent such
17 violation. Upon written request by the Board, it shall be the duty of the
18 Vermont Attorney General to furnish appropriate legal services and to
19 prosecute an action for injunctive relief to an appropriate conclusion, which
20 shall not be reimbursed under subdivision (a)(2) of this section.

21

* * *

1 Sec. 27. 18 V.S.A. § 9456(h) is amended to read:

2 (h)(1) If a hospital violates a provision of this section, the Board may
3 maintain an action in the Superior Court of the county in which the hospital is
4 located to enjoin, restrain, or prevent such violation.

5 * * *

6 (3)(A) The Board shall require the officers and directors of a hospital to
7 file under oath, on a form and in a manner prescribed by the ~~Commissioner~~
8 Board, any information designated by the Board and required pursuant to this
9 subchapter. The authority granted to the Board under this subsection is in
10 addition to any other authority granted to the Board under law.

11 (B) A person who knowingly makes a false statement under oath or
12 who knowingly submits false information under oath to the Board or to a
13 hearing officer appointed by the Board or who knowingly testifies falsely in
14 any proceeding before the Board or a hearing officer appointed by the Board
15 shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

16 Sec. 28. SUSPENSION; PROHIBITION ON MODIFICATION OF
17 UNIFORM FORMS

18 The Department of Financial Regulation shall not modify the existing
19 common forms, procedures, and rules based on 18 V.S.A. §§ 9408, 9408a(b),
20 9408a(e), and 9418(f) prior to January 1, 2017. The Commissioner of
21 Financial Regulation may review and examine, at his or her own discretion or

1 in response to a complaint, a managed care organization’s administrative
2 policies and procedures, quality management and improvement procedures,
3 credentialing practices, members’ rights and responsibilities, preventive health
4 services, medical records practices, member services, financial incentives or
5 disincentives, disenrollment, provider contracting, and systems and data
6 reporting capacities described in 18 V.S.A. § 9414(a)(1).

7 Sec. 29. UNIFORM FORMS; EVALUATION

8 The Director of Health Care Reform in the Agency of Administration, in
9 collaboration with the Green Mountain Care Board and the Department of
10 Financial Regulation, shall evaluate:

11 (1) the necessity of maintaining provisions regarding common claims
12 forms and procedures, uniform provider credentialing, and suspension of
13 interest accrual for failure to pay claims if the failure was not within the
14 insurer’s control, as those provisions are codified in 18 V.S.A. §§ 9408,
15 9408a(b), 9408a(e), and 9418(f);

16 (2) the necessity of maintaining provisions requiring the Commissioner
17 to review and examine a managed care organization’s administrative policies
18 and procedures, quality management and improvement procedures,
19 credentialing practices, members’ rights and responsibilities, preventive health
20 services, medical records practices, member services, financial incentives or

1 disincentives, disenrollment, provider contracting, and systems and data
2 reporting capacities, as those provisions are codified in 18 V.S.A. § 9414(a)(1);

3 (3) the appropriate entity to assume responsibility for any such function
4 that should be retained and the appropriate enforcement process; and

5 (4) the requirements in federal law applicable to the Department of
6 Vermont Health Access in its role as a public managed care organization in
7 order to identify opportunities for greater alignment between federal law and
8 18 V.S.A. § 9414(a)(1).

9 (b) In performing the evaluation required by subsection (a) of this section,
10 the Director shall consult regularly with interested stakeholders, including
11 health insurance and managed care organizations, as defined in 18 V.S.A.
12 9402; health care providers; and the Office of the Health Care Advocate.

13 (c) On or before December 15, 2015, the Director shall provide his or her
14 findings and recommendations to the House Committee on Health Care, the
15 Senate Committees on Health and Welfare and on Finance, and the Health
16 Reform Oversight Committee.

17 * * * Presuit Mediation for Medical Malpractice Claims * * *

18 Sec. 30. 12 V.S.A. chapter 215, subchapter 2 is added to read:

19 Subchapter 2. Mediation Prior to Filing a Complaint of Malpractice

20 § 7011. PURPOSE

1 The purpose of mediation prior to filing a medical malpractice case is to
2 identify and resolve meritorious claims and reduce areas of dispute prior to
3 litigation, which will reduce the litigation costs, reduce the time necessary to
4 resolve claims, provide fair compensation for meritorious claims, and reduce
5 malpractice-related costs throughout the system.

6 § 7012. PRESUIT MEDIATION; SERVICE

7 (a) A potential plaintiff may serve upon each known potential defendant a
8 request to participate in presuit mediation prior to filing a civil action in tort or
9 in contract alleging that an injury or death resulted from the negligence of a
10 health care provider and to recover damages resulting from the personal injury
11 or wrongful death.

12 (b) Service of the request required in subsection (a) of this section shall be
13 in letter form and shall be served on all known potential defendants by certified
14 mail. The date of mailing such request shall toll all applicable statutes of
15 limitations.

16 (c) The request to participate in presuit mediation shall name all known
17 potential defendants, contain a brief statement of the facts that the potential
18 plaintiff believes are grounds for relief, and be accompanied by a certificate of
19 merit prepared pursuant to section 1051 of this title, and may include other
20 documents or information supporting the potential plaintiff's claim.

1 (d) Nothing in this chapter precludes potential plaintiffs and defendants
2 from presuit negotiation or other presuit dispute resolution to settle potential
3 claims.

4 § 7013. MEDIATION RESPONSE

5 (a) Within 60 days of service of the request to participate in presuit
6 mediation, each potential defendant shall accept or reject the potential
7 plaintiff's request for presuit mediation by mailing a certified letter to counsel
8 or if the party is unrepresented to the potential plaintiff.

9 (b) If the potential defendant agrees to participate, within 60 days of the
10 service of the request to participate in presuit mediation, each potential
11 defendant shall serve a responsive certificate on the potential plaintiff by
12 mailing a certified letter indicating that he or she, or his or her counsel, has
13 consulted with a qualified expert within the meaning of section 1643 of this
14 title and that expert is of the opinion that there are reasonable grounds to
15 defend the potential plaintiff's claims of medical negligence. Notwithstanding
16 the potential defendant's acceptance of the request to participate, if the
17 potential defendant does not serve such a responsive certificate within the
18 60-day period, then the potential plaintiff need not participate in the presuit
19 mediation under this title and may file suit. If the potential defendant is willing
20 to participate, presuit mediation may take place without a responsive certificate
21 of merit from the potential defendant at the plaintiff's election.

1 § 7014. PROCESS; TIME FRAMES

2 (a) The mediation shall take place within 60 days of the service of all
3 potential defendants' acceptance of the request to participate in presuit
4 mediation. The parties may agree to an extension of time. If in good faith the
5 mediation cannot be scheduled within the 60-day time period, the potential
6 plaintiff need not participate and may proceed to file suit.

7 (b) If presuit mediation is not agreed to, the mediator certifies that
8 mediation is not appropriate, or mediation is unsuccessful, the potential
9 plaintiff may initiate a civil action as provided in the Vermont Rules of Civil
10 Procedure. The action shall be filed:

11 (1) within 90 days of the potential plaintiff's receipt of the potential
12 defendant's letter refusing mediation, the failure of the potential defendant to
13 file a responsive certificate of merit within the specified time period, or the
14 mediator's signed letter certifying that mediation was not appropriate or that
15 the process was complete; or

16 (2) prior to the expiration of the applicable statute of limitations,
17 whichever is later.

18 (c) If presuit mediation is attempted unsuccessfully, the parties shall not be
19 required to participate in mandatory mediation under Rule 16.3 of the Vermont
20 Rules of Civil Procedure.

1 § 7015. CONFIDENTIALITY

2 All written and oral communications made in connection with or during the
3 mediation process set forth in this chapter shall be confidential. The mediation
4 process shall be treated as a settlement negotiation under Rule 408 of the
5 Vermont Rules of Evidence.

6 Sec. 31. REPORT

7 On or before December 1, 2019, the Secretary of Administration or
8 designee shall report to the Senate Committees on Health and Welfare and on
9 Judiciary and the House Committees on Health Care and on Judiciary on the
10 impacts of 12 V.S.A. § 1042 (certificate of merit) and 12 V.S.A. chapter 215,
11 subchapter 2 (presuit mediation). The report shall address the impacts that
12 these reforms have had on:

13 (1) consumers, physicians, and the provision of health care services;

14 (2) the rights of consumers to due process of law and to access to the
15 court system; and

16 (3) any other service, right, or benefit that was or may have been
17 affected by the establishment of the medical malpractice reforms in 12 V.S.A.
18 § 1042 and 12 V.S.A. chapter 215, subchapter 2.

19 * * * Medicaid Rates * * *

20 Sec. 32. PROVIDER RATE SETTING; MEDICAID

1 (a) The Department of Disabilities, Aging, and Independent Living and the
2 Division of Rate Setting in the Agency of Human Services shall review current
3 reimbursement rates for providers of enhanced residential care, assistive
4 community care, and other long term home-and community-based services and
5 shall consider ways to:

6 (1) ensure that rates are reviewed regularly and are sustainable,
7 reasonable, and adequately reflect economic conditions, new home- and
8 community-based services rules, and health system reforms; and

9 (2) encourage providers to accept residents without regard to their
10 source of payment.

11 (b) On or before December 1, 2015, the Department and the Agency shall
12 provide their findings and recommendations to the House Committee on
13 Human Services, the Senate Committees on Health and Welfare and on
14 Finance, and the Health Reform Oversight Committee.

15 * * * Designated Agency Budgets * * *

16 Sec. 33. GREEN MOUNTAIN CARE BOARD; DESIGNATED AGENCY
17 BUDGETS

18 The Green Mountain Care Board shall analyze the budget of one or more
19 designated agencies providing services to Vermont residents using criteria
20 similar to the Board's review of hospital budgets pursuant to 18 V.S.A. § 9456.
21 The Board shall also consider whether to include designated and specialized

1 service agencies in the all-payer model. On or before January 31, 2016, the
2 Board shall recommend to the House Committees on Appropriations, on
3 Health Care, and on Human Services and the Senate Committees on
4 Appropriations, on Health and Welfare, and on Finance whether the Board
5 should be responsible for the annual review of all designated agency budgets
6 and whether designated and specialized service agencies should be included in
7 the all-payer model.

8 * * * Universal Primary Care * * *

9 Sec. 34. PURPOSE

10 The purpose of Secs. 34 through 38 of this act is to establish the
11 administrative framework and reduce financial barriers as preliminary steps to
12 the implementation of the principles set forth in 2011 Acts and Resolves
13 No. 48 to enable Vermonters to receive necessary health care and examine the
14 cost of providing primary care to all Vermonters without deductibles,
15 coinsurance, or co-payments or, if necessary, with limited cost-sharing.

16 Sec. 35. FINDINGS

17 The General Assembly finds that:

18 (1) Research has shown that universal access to primary care enhances
19 the quality of care, improves patient outcomes, and reduces overall health care
20 spending.

1 (2) Universal access to primary care will advance the health of
2 Vermonters by preventing disease and by reducing the need for emergency
3 room visits and hospital admissions.

4 (3) Vermonters face financial barriers to accessing primary care because
5 of the widespread cost-sharing requirements, including deductibles,
6 coinsurance, and co-payments.

7 (4) The cost of providing universal primary care to Vermonters should
8 be estimated to determine whether universal primary care should be the first
9 step in implementing the principles and intent set forth in 2011 Acts and
10 Resolves No. 48, Secs. 1 and 1a.

11 Sec. 36. DEFINITION OF PRIMARY CARE

12 As used in Secs. 34 through 38 of this act, “primary care” means health
13 services provided by health care professionals who are specifically trained for
14 and skilled in first-contact and continuing care for individuals with signs,
15 symptoms, or health concerns, not limited by problem origin, organ system, or
16 diagnosis, and includes pediatrics, internal and family medicine, gynecology,
17 primary mental health services, and other health services commonly provided
18 at federally qualified health centers. Primary care does not include dental
19 services.

20 Sec. 37. COST ESTIMATES FOR UNIVERSAL PRIMARY CARE

1 (a) No later than October 15, 2015, the Joint Fiscal Office, in consultation
2 with the Green Mountain Care Board and the Secretary of Administration or
3 designee, shall provide to the Joint Fiscal Committee, the Health Reform
4 Oversight Committee, the House Committees on Appropriations, on Health
5 Care, and on Ways and Means, and the Senate Committees on Appropriations,
6 on Health and Welfare, and on Finance an estimate of the costs of providing
7 primary care to all Vermont residents, with and without cost-sharing by the
8 patient, beginning on January 1, 2017.

9 (b) The report shall include an estimate of the cost of primary care to those
10 Vermonters who access it if a universal primary care plan is not implemented,
11 and the sources of funding for that care, including employer-sponsored
12 and individual private insurance, Medicaid, Medicare, and other
13 government-sponsored programs, and patient cost-sharing such as deductibles,
14 coinsurance, and co-payments.

15 (c) Departments and agencies of State government and the Green Mountain
16 Care Board shall provide such data to the Joint Fiscal Office as needed to
17 permit the Joint Fiscal Office to perform the estimates and analysis required by
18 this section. If necessary, the Joint Fiscal Office may enter into confidentiality
19 agreements with departments, agencies, and the Board to ensure that
20 confidential information provided to the Office is not further disclosed.

21 Sec. 38. APPROPRIATION

1 Up to \$200,000.00 is appropriated from the General Fund to the Joint Fiscal
2 Office in fiscal year 2016 to be used for assistance in the calculation of the cost
3 estimates required in Sec. 37 of this act; provided, however, that the
4 appropriation shall be reduced by the amount of any external funds received by
5 the Office to carry out the estimates and analysis required by Sec. 37.

6 Sec. 39. REPEALS

7 (a) 18 V.S.A. §§ 9411 (other powers and duties of the Commissioner of
8 Financial Regulation) and 9415 (allocation of expenses) are repealed.

9 (b) 12 V.S.A. chapter 215, subchapter 2 shall be repealed on July 1, 2020.

10 * * * Effective Dates * * *

11 Sec. 40. EFFECTIVE DATES

12 (a) Secs. 1 (all-payer model), 2 (St. Johnsbury accountable care
13 community), 3 (Green Mountain Care Board duties), 4 (VITL), 7 and 8 (direct
14 enrollment in Exchange plans), 9–11 (large group market), 13 (public
15 employees' health benefits), 30 and 31 (presuit mediation), 32 (Medicaid
16 provider rate setting), 33 (designated agency budgets), 34–38 (universal
17 primary care), and this section shall take effect on passage.

18 (b) Secs. 14 (Medicaid reimbursement rates), 15 (provider payment parity
19 implementation), 16–27 (transfer DFR duties to Green Mountain Care Board),
20 28 and 29 (suspension and review of uniform forms), and 39 (repeals) shall
21 take effect on July 1, 2015.

1 (c) Secs. 5 and 6 (telemedicine) shall take effect on October 1, 2015.

2 (d) Sec. 14 (provider payment parity) shall take effect on January 1, 2017.

3 (e) Sec. 12 (consumer price comparison) shall take effect on July 1, 2016.

4 and that after passage the title of the bill be amended to read: “An act relating
5 to health care”.

6

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11

12 (Committee vote: _____)

13

14

Senator _____

15

FOR THE COMMITTEE