

1 TO THE HONORABLE SENATE:

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

8 \* \* \* All-Payer Model \* \* \*

9 Sec. 1. ALL-PAYER MODEL; MEDICARE AGREEMENT

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

14 (1) is consistent with the principles of health care reform expressed in  
15 18 V.S.A. § 9371, to the extent permitted under Section 1115A of the Social  
16 Security Act and approved by the federal government;

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

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

3           (4) allows Medicare patients to choose **their among** providers;

4           (5) includes outcome measures for population health; and

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

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

9                                   CHAPTER 227. ALL-PAYER MODEL

10           § 9551. ALL-PAYER MODEL

11           In order to implement a value-based payment model allowing participating  
12           health care providers to be paid by Medicaid, Medicare, and commercial  
13           insurance using a common methodology that may include population-based  
14           payments and increased financial predictability for providers, the Green  
15           Mountain Care Board and Agency of Administration shall ensure that the  
16           model:

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

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

1           (3) maximizes alignment between Medicare, Medicaid, and commercial  
2           payers to the extent permitted under federal law and waivers from federal law,  
3           including:

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

5                   (B) attribution and payment mechanisms;

6                   (C) patient protections;

7                   (D) care management mechanisms; and

8                   (E) provider reimbursement processes;

9           (4) strengthens and invests in primary care;

10           (5) incorporates social determinants of health;

11           (6) adheres to federal and State laws on parity of mental health and  
12           substance abuse treatment and integrates mental health and substance abuse  
13           treatment systems into the overall health care system;

14           (7) includes a process for integration of community-based providers,  
15           including home health agencies, mental health agencies, developmental  
16           disability service providers, emergency medical service providers, and area  
17           agencies on aging, and their funding streams **to the extent permitted under**  
18           **federal law**, into a transformed, fully integrated health care system that may  
19           include transportation and housing;

20           (8) continues to prioritize the use, where appropriate, of existing local  
21           and regional collaboratives of community health providers that develop

1 integrated health care initiatives to address regional needs and evaluate best  
2 practices for replication and return on investment;

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

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

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

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

18 (13) supports coordination of patients' care and care transitions through  
19 the use of technology, with patient consent, such as sharing electronic  
20 summary records across providers and using telemedicine, home  
21 telemonitoring, and other enabling technologies; and



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

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

9           § 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

10          (a) In order to be eligible to receive payments from Medicaid or  
11          commercial insurance through any payment reform program or initiative,  
12          including an all-payer model, each accountable care organization **with 10,000**  
13          **or more attributed lives in Vermont (delete?)** shall obtain and maintain  
14          certification from the Green Mountain Care Board. The Board shall adopt  
15          rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for  
16          certifying accountable care organizations, **which may include consideration**  
17          **of acceptance of accreditation by the National Committee for Quality**  
18          **Assurance or another national accreditation organization for any of the**  
19          **criteria set forth in this section. To the extent permitted under federal**  
20          **law, the Board shall ensure these rules anticipate and accommodate a**  
21          **range of ACO models and sizes, balancing oversight with support for**

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

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

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

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

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

18 (5) the ACO has established mechanisms **and care models** to promote  
19 evidence-based health care, patient engagement, coordination of care, use of  
20 electronic health records, and other enabling technologies to promote

1 integrated, efficient, **seamless**, and effective health care services **across the**  
2 **continuum of care, where feasible;**

3 (6) the ACO's **participating providers has have** the capacity for  
4 meaningful participation in health information exchanges;

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

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

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

15 (10) the ACO **has offers assistance to health care consumers,**

16 **including:**

17 **(A) an accessible mechanism for explaining how ACOs work;**

18 **provides contact information for the Office of the Health Care Advocate;**

19 **maintains maintaining** a consumer telephone line for complaints and

20 grievances from attributed patients;

1            **(B) responds and makes responding and making** best efforts to  
2            resolve complaints and grievances from attributed patients, including providing  
3            assistance in identifying appropriate rights under a patient’s health plan;

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

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

8            **(E) shares sharing** deidentified complaint and grievance information  
9            with the Office of the Health Care Advocate at least twice annually;

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

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

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

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

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

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

8           (b)(1) The Green Mountain Care Board shall adopt rules pursuant to  
9           3 V.S.A. chapter 25 to establish standards and processes for reviewing,  
10           modifying, and approving **ACO the budgets of ACOs with 10,000 or more**  
11           **attributed lives in Vermont. To the extent permitted under federal law,**  
12           **the Board shall ensure the rules anticipate and accommodate a range of**  
13           **ACO models and sizes, balancing oversight with support for innovation.**

14           In its review, the Board shall review and consider:

15           (A) information regarding utilization of the health care services  
16           delivered by health care providers participating in the ACO **and care models**  
17           **for appropriate utilization, including the provision of innovative services;**

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

20           (C) the expenditure analysis for the previous year and the proposed  
21           expenditure analysis for the year under review **by payer;**

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

3           (E) any reports from professional review organizations;

4           (F) the ACO’s efforts to prevent duplication of high-quality services  
5 being provided efficiently and effectively by existing community-based  
6 providers in the same geographic area, **as well as its integration of efforts**  
7 **with the Blueprint for Health and its regional care collaboratives;**

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

15           (H) **the extent to which the ACO provides incentives for systemic**  
16 **integration of community-based providers in its care model or**  
17 **investments to expand capacity in existing community-based providers, in**  
18 **order to promote seamless coordination of care across the care**  
19 **continuum;**

20           (I) the extent to which the ACO provides incentives for systemic  
21 health care investments in social determinants of health, such as developing

1 support capacities that prevent hospital admissions and readmissions, reduce  
2 length of hospital stays, improve population health outcomes, reward healthy  
3 lifestyle choices, and improve the solvency of and address the financial risk to  
4 community-based providers that are participating providers of an accountable  
5 care organization;

6 **(J) the extent to which the ACO provides incentives for**  
7 **preventing adverse childhood experiences (ACEs), such as developing**  
8 **quality outcome measures for use by primary care providers working with**  
9 **children and families, developing partnerships between nurses and**  
10 **families, providing opportunities for home visits, and including**  
11 **parent-child centers as participating providers in the ACO;**

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

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

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

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

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

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

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

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

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

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

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

1       (e) To the extent required to avoid federal antitrust violations, the Board  
2       shall supervise the participation of health care professionals, health care  
3       facilities, and other persons operating or participating in an accountable care  
4       organization. The Board shall ensure that its certification and oversight  
5       processes constitute sufficient State supervision over these entities to comply  
6       with federal antitrust provisions and shall refer to the Attorney General for  
7       appropriate action the activities of any individual or entity that the Board  
8       determines, after notice and an opportunity to be heard, may be in violation of  
9       State or federal antitrust laws without a countervailing benefit of improving  
10       patient care, improving access to health care, increasing efficiency, or reducing  
11       costs by modifying payment methods.

12                                   \* \* \* Rulemaking \* \* \*

13       Sec. 6. GREEN MOUNTAIN CARE BOARD; RULEMAKING

14       On or before January 1, 2018, the Green Mountain Care Board shall adopt  
15       rules governing the oversight of accountable care organizations pursuant to  
16       18 V.S.A. § 9382. On or before January 15, 2017, the Board shall provide an  
17       update on its rulemaking process and its vision for implementing the rules to  
18       the House Committee on Health Care and the Senate Committees on Health  
19       and Welfare and on Finance.

1       Sec. 7. DENIAL OF SERVICE; RULEMAKING

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

9                           \* \* \* Implementation Provisions \* \* \*

10       Sec. 8. TRANSITION; IMPLEMENTATION

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

20           (b) On or before January 1, 2018, the Board shall begin certifying  
21       accountable care organizations that meet the criteria established in 18 V.S.A.

1 § 9382(a) and shall only approve accountable care organization budgets after  
2 review and consideration of the criteria set forth in 18 V.S.A. § 9382(b). If the  
3 Green Mountain Care Board and the Agency of Administration pursue  
4 development and implementation of an all-payer model, then on and after  
5 January 1, 2018 they shall implement the all-payer model in accordance with  
6 18 V.S.A. § 9551.

7 \* \* \* Resource Allocation \* \* \*

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

9 Sec. 9. 18 V.S.A. § 9374(e) is amended to read:

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

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

1           (3) To the extent funds are available, the Board shall support research  
2           that examines may examine, on its own or through collaboration or  
3           contracts with third parties, the effectiveness of existing requirements for  
4           health care professionals, such as quality measures and prior authorization, and  
5           evaluate alternatives that improve quality, reduce costs, and reduce  
6           administrative burden.

7           **Sec. 10. PRIMARY CARE PROFESSIONAL ADVISORY GROUP**

8           (a) The Green Mountain Care Board shall establish a primary care  
9           professional advisory group to provide input and recommendations to the  
10           Board. The Board shall seek input from the primary care professional advisory  
11           group to address issues related to the administrative burden facing primary care  
12           professionals, including:

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

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

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



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

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

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

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

1       (c) As used in this section:

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

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

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

12 **Sec. 12. MEDICAID PATHWAY; REPORT (from S.196)**

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

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

5        The Secretary's report shall address:

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

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

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

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

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

16        **Sec. 13. MEDICAID ADVISORY RATE CASE FOR ACO SERVICES**

17               **On or before December 31, 2016, the Green Mountain Care Board shall**  
18               **review any all-inclusive population-based payment arrangement between**  
19               **the Department of Vermont Health Access and an accountable care**  
20               **organization for calendar year 2017. The Board's review shall include the**  
21               **number of attributed lives, eligibility groups, covered services, elements of**

1 **the per-member, per-month payment, and any other nonclaims payments.**

2 **The review shall be nonbinding on the Agency of Human Services, and**

3 **nothing in this section shall be construed to abrogate the designation of**

4 **the Agency of Human Services as the single State agency as required by**

5 **42 C.F.R. § 431.10.**

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

7 The Green Mountain Care Board, **the Department of Vermont Health**

8 **Access, and interested stakeholders** shall consider the appropriate role,

9 if any, of using multi-year budgets for ACOs, **Medicaid, and other**

10 **State-funded health care programs** to reduce administrative burden, improve

11 care quality, and ensure sustainable access to care. On or before January 15,

12 2017, the Green Mountain Care Board **and the Department of Vermont**

13 **Health Access** shall report **their** findings and recommendations to the House

14 Committees on Health Care and on Human Services and the Senate

15 Committees on Health and Welfare and on Finance.

16 **Sec. 15. MULTI-YEAR BUDGETS; MEDICAID; REPORT**

17 **The Joint Fiscal Office and the Department of Finance and**

18 **Management, in collaboration with the Agency of Human Services**

19 **Central Office and the Department of Vermont Health Access, shall**

20 **consider the appropriate role, if any, of using multi-year budgets for**

21 **Medicaid and other State-funded health care programs to reduce**

1 **administrative burden, improve care quality, and ensure sustainable**  
2 **access to care. On or before January 15, 2017, the Joint Fiscal Office and**  
3 **the Department of Finance and Management shall report their findings**  
4 **and any recommendations for statutory change to the House Committees**  
5 **on Appropriations, on Health Care, and on Human Services and the**  
6 **Senate Committees on Appropriations, on Health and Welfare, and on**  
7 **Finance.**

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

9 **On or before January 15, 2017, the Green Mountain Care Board shall**  
10 **present information to the House Committee on Health Care and the**  
11 **Senate Committees on Health and Welfare and on Finance on the status of**  
12 **its efforts to achieve alignment between Medicare, Medicaid, and**  
13 **commercial payers in the all-payer model as required by 18 V.S.A.**  
14 **§ 9551(a)(3).**

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

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

17 (a) **Regardless of any future developments in payment and delivery**  
18 **system reform, Vermont is likely to continue to have uninsured or**  
19 **underinsured residents. Expanding access to primary care services is a**  
20 **proven method for improving population health.** It is the intent of the  
21 **General Assembly to move forward with implementation of universal primary**

1 care for all Vermonters or expansion of Dr. Dynasaur to all Vermont residents  
2 up to 26 years of age, or both.

3 (b) In order to determine a path forward toward implementing universal  
4 primary care in Vermont, **on or before DATE**, the Secretary of  
5 Administration, **in collaboration with the Joint Fiscal Office**, shall **provide**  
6 **to the Joint Fiscal Office:**

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

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

14 (3) **incorporate the savings estimates into a multi-year cost model**  
15 **with utilization and trend assumptions the impacts on the individual,**  
16 **small group, and large group health insurance markets of providing**  
17 **primary care through a universal, publicly funded program; and**

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

1        (c)(1) In order to determine a path forward toward expanding Dr. Dynasaur  
2        to all Vermont residents up to 26 years of age, the ~~Agency Secretary~~ of  
3        Administration, in collaboration with the Joint Fiscal Office, shall analyze  
4        the financial implications of expanding Dr. Dynasaur, and the State's  
5        children's Medicaid and Children's Health Insurance Program to all  
6        Vermont residents up to 26 years of age.

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

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

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

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

19                (E) The cost estimates shall project increasing provider  
20                reimbursement rates at regular intervals from 100 percent of Medicare  
21                rates up to commercial rates. Medicare and commercial rates shall be

1 determined based on claims data from the Vermont's all-payer claims  
2 database.

3 (3)(A) On or before DATE, the Secretary shall submit a report to  
4 the Joint Fiscal Office comprising its analysis of the costs of expanding  
5 Dr. Dynasaur to all Vermont residents up to 26 years of age and potential  
6 plans for financing the expansion. The financing plans shall be consistent  
7 with the principles of equity expressed in 18 V.S.A. § 9371(11), which  
8 states that financing of health care in Vermont must be sufficient, fair,  
9 predictable, transparent, sustainable, and shared equitably. In developing  
10 the financing plans, the Secretary shall consider the following:

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

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

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

21 (iv) expansion or reform of existing taxes;

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

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

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

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

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

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

7 (2) To the extent necessary to conduct the analyses required by  
8 subsections (b) and (c) of this section, a health insurer licensed to do  
9 business in Vermont shall provide any information requested by the  
10 Secretary or the Secretary's contractors within 30 days of the request.

11 The Secretary may enter into a confidentiality agreement with an insurer  
12 if the data requested includes personal health information or other  
13 confidential material.

14 \* \* \* Exchange Sustainability Analysis \* \* \*

15 Sec. 18. VERMONT HEALTH BENEFIT EXCHANGE

16 TECHNOLOGY; SUSTAINABILITY ANALYSIS; REPORT (from  
17 **H.865**)

18 (a)(1) The Joint Fiscal Office, in collaboration with one or more  
19 independent third parties pursuant to contracts negotiated for that purpose,  
20 shall conduct an analysis and provide a report to the General Assembly on or  
21 before December 1, 2016 on the current functionality and long-term

1 sustainability of the technology for Vermont’s Health Benefit Exchange,  
2 including a review of the deficiencies in Vermont Health Connect functionality  
3 and the integration, connectivity, and business logic of each as they pertain to  
4 both the back-end systems and the user interface of Vermont Health Connect.

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

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

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

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

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

7                    **\*\*\* Health Care Research Commission \*\*\***

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

9                    **CHAPTER 27. HEALTH CARE RESEARCH COMMISSION**

10                  **§ 961. CREATION OF COMMISSION**

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

14                  **(b) Members of the Commission shall include two members of the**  
15                  **House of Representatives appointed by the Speaker of the House, two**  
16                  **members of the Senate appointed by the Senate Committee on**  
17                  **Committees, and one member appointed by the Governor.**

18                  **(c) The Commission may meet as needed. For attendance at meetings**  
19                  **during adjournment of the General Assembly, members of the**  
20                  **Commission shall be entitled to per diem compensation and**  
21                  **reimbursement of expenses pursuant to section 406 of this title. The**

1 member appointed by the Governor shall be entitled to per diem  
2 compensation and reimbursement of expenses pursuant to 32 V.S.A.  
3 § 1010 if he or she is not a full-time State employee.

4 § 962. EMPLOYEES; BUDGET

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

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

11 (2)(A) All requests for assistance, information, and advice from the  
12 Commission and all information the Commission receives in connection  
13 with research or related studies is exempt from public inspection and  
14 copying under the Public Records Act and shall be kept confidential  
15 unless the party requesting assistance or providing information specifies  
16 otherwise. Documents, transcripts, and minutes of Commission meetings,  
17 including written testimony submitted to the Commission, are not  
18 confidential under this subdivision.

19 (B) The staff of the Commission may sign data use agreements  
20 and confidentiality agreements on the Commission's behalf in order to  
21 collect the data, including health care claims and tax information, needed

1 **to carry out the duties of the Commission. Data collected by Commission**  
2 **staff may be used only for the purposes of studies and evaluation.**

3 **Appropriate data standards shall be maintained to ensure confidentiality.**

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

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

12 **§ 963. FUNCTIONS**

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

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

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

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

1 **(4) keeping minutes of its meetings and maintaining them in a file.**

2 **\*\*\* Positions \*\*\***

3 **Sec. 20. POSITIONS**

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

9 **\*\*\* Appropriations \*\*\***

10 **Sec. 21. APPROPRIATIONS**

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

15 **(b) Appropriation for Health Care Research Commission?**

16 **Sec. 22. FISCAL YEAR 2016; REVERSIONS; APPROPRIATIONS**

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



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

2

3

4        (Committee vote: \_\_\_\_\_)

5

\_\_\_\_\_

6

Senator \_\_\_\_\_

7

FOR THE COMMITTEE