S.132

Introduced by Senator Lyons

Referred to Committee on

Date:

Subject: Health; health care reform; Agency of Human Services; Green Mountain Care Board; Department of Health; accountable care organizations; health care providers; health insurers

Statement of purpose of bill as introduced: This bill proposes to consolidate responsibility for health care innovation under the Director of Health Care Reform in the Agency of Human Services and to add new criteria to the certification requirements for accountable care organizations. It would require accountable care organizations to collect, analyze, and report quality data to the Green Mountain Care Board to enable the Board to determine value-based payment amounts and the appropriate distribution of shared savings among the accountable care organization's participating health care providers. It would also require accountable care organizations to provide the Office of the Auditor of Accounts with access to their records to enable the Auditor to audit their financial statements, receipt and use of federal and State monies, and performance. The bill would require the Green Mountain Care Board to review and approve proposed health care contracts and fee schedules between health plans and health care providers and would place certain conditions on

1 the health care contracting process. It would seek to increase transparency in
2 the purchase and lease of items of durable medical equipment and would take
3 an incremental approach to requiring health insurance coverage for hearing
4 aids. The bill would also require submission of reports to the General
5 Assembly on health insurers' administrative expenses, inclusion of specialty
6 care in the All-Payer ACO Model, accountable care organizations' care
7 coordination efforts, and the likely impacts of requiring health insurance plans
8 to offer at least two primary care visits per year without cost-sharing.

9 An act relating to health care reform implementation

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

11 * * * Responsibility for Health Care Reform Efforts * * *

12 Sec. 1. 3 V.S.A. § 3027 is amended to read:

13 § 3027. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY
14 AND AFFORDABILITY

15 (a) The Director of Health Care Reform in the Agency of Human Services
16 shall be responsible for the coordination of health care system reform efforts
17 among Executive Branch agencies, departments, and offices, and for
18 coordinating with the Green Mountain Care Board established in 18 V.S.A.
19 chapter 220.

1 (b) The Director of Health Care Reform shall coordinate and lead all State
2 initiatives relating to health care reform, including innovations in health care
3 system payment and delivery.
4 Sec. 2. ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL;
5 AGENCY OF HUMAN SERVICES; OVERSIGHT AND
6 IMPLEMENTATION
7 Upon renewal of the terms of the All-Payer Accountable Care Organization
8 Model agreement with the Centers for Medicare and Medicaid Services, the
9 Agency of Human Services shall assume responsibility for oversight of State
10 efforts to achieve the agreement targets in the Model, as described in 18 V.S.A.
11 § 9551, and any similar or successor model, and shall lead the State's efforts to
12 achieve the agreement targets, the State's renegotiation efforts, and the
13 stakeholder involvement processes.
14 * * * Accountable Care Organizations * * *
15 Sec. 3. 18 V.S.A. § 9382 is amended to read:
16 § 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS
17 (a) In order to be eligible to receive payments from Medicaid or
18 commercial insurance through any payment reform program or initiative,
19 including an all-payer model, each accountable care organization shall obtain
20 and maintain certification from the Green Mountain Care Board. The Board
21 shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and

processes for certifying accountable care organizations. To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

(1) The ACO's governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input. The salaries for the ACO's executive officers do not exceed an amount equal to the median salary for a primary care physician participating in the ACO.

(2) The ACO has established appropriate mechanisms and care models to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO. The ACO coordinates with the Blueprint's patient-centered medical homes and community health teams and acts as the link connecting patients with appropriate health care and social services, including those offered by designated agencies, specialized service agencies, parent-child centers, and schools. The ACO ensures equal access to appropriate mental health care that meets standards of quality, access, and

1 affordability equivalent to other components of health care as part of an
2 integrated, holistic system of care.
3 * * *
4 (4) The ACO has established appropriate mechanisms and criteria for
5 accepting health care providers to participate in the ACO that prevent
6 unreasonable discrimination and are related to the needs of the ACO and the
7 patient population served. The ACO may contract with a participating
8 provider for a multi-year term.
9 * * *
10 (7) The ACO has performance standards and measures to evaluate the
11 quality and utilization of care delivered by its participating health care
12 providers. The ACO has the ability to develop and implement targeted quality
13 improvement measures as appropriate.
14 * * *
15 (b)(1) The Green Mountain Care Board shall adopt rules pursuant to
16 3 V.S.A. chapter 25 to establish standards and processes for reviewing,
17 modifying, and approving the budgets of ACOs with 10,000 or more attributed
18 lives in Vermont. To the extent permitted under federal law, the Board shall
19 ensure the rules anticipate and accommodate a range of ACO models and sizes,
20 balancing oversight with support for innovation. In its review, the Board shall
21 review and consider:

* * *

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

(i) the annual salaries and benefits for all of the ACO's employees; or

(ii) the same salary and other compensation information for the ACO's officers, directors, key employees, and other highly compensated employees for the previous calendar year that the ACO provided to the U.S. Internal Revenue Service on Form 990 and related attachments for the most recent tax year, or that the ACO would have been required to provide on Form 990 if the ACO was exempt from federal income tax under 26 U.S.C. § 501;

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

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

(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing

1 unreasonable burdens on primary care providers or on ACO member
2 organizations; and
3 (Q) the extent to which the ACO has met the quality measures
4 specified in its payer contracts and, if one or more of the quality measures has
5 not been met, the ACO's and payer's plan to remedy the deficiencies.
6 * * *
7 Sec. 4. 18 V.S.A. § 9384 is added to read:
8 § 9384. ACCOUNTABLE CARE ORGANIZATIONS; VALUE-BASED
9 PAYMENTS; DISTRIBUTION OF SHARED SAVINGS
10 (a) The Green Mountain Care Board, using the results of an accountable
11 care organization's quality analyses pursuant to section 9574 of this title, shall
12 establish a methodology for determining the amounts of the value-based
13 payments that the accountable care organization shall make to its participating
14 providers for delivering services to its attributed patients. The Board shall
15 apply its methodology and shall notify health insurers and Vermont Medicaid
16 of the value-based payment amounts based on its determinations in order to
17 inform the insurers' development of their rates for the Board's review in
18 accordance with 8 V.S.A. § 4062 and to inform Medicaid's development of its
19 all-inclusive population-based payment arrangements for the Board's review in
20 accordance with section 9573 of this title.

1 (b) The Board, using the results of an accountable care organization's
2 quality analyses pursuant to section 9574 of this title, shall determine
3 appropriate allocations of shared savings, if any, for distribution among the
4 accountable care organization's participating providers.
5 Sec. 5. 18 V.S.A. § 9574 is added to read:
6 § 9574. DATA COLLECTION AND ANALYSIS
7 (a) An accountable care organization shall collect and analyze clinical data
8 regarding patients' age, health condition or conditions, health care services
9 received, and clinical outcomes in order to determine the quality of the care
10 provided to its attributed patients, implement targeted quality improvement
11 measures, and ensure proper care coordination and delivery across the
12 continuum of care.
13 (b) An accountable care organization shall provide the results of its quality
14 analyses pursuant to subsection (a) of this section to the Green Mountain
15 Board to enable the Board to determine the amounts of the ACO's value-based
16 payments to participating providers in accordance with subsection 9384(a) of
17 this title and to calculate appropriate allocations of shared savings for
18 distribution among participating providers in accordance with subsection
19 9384(b) of this title.

1 Sec. 6. 18 V.S.A. § 9575 is added to read:

2 § 9575. ACCESS TO RECORDS

3 An accountable care organization certified pursuant to section 9382 of this
4 title shall make available to the Office of the Auditor of Accounts all records
5 of the accountable care organization, and any affiliated entity, that the Auditor,
6 in his or her discretion and upon his or her request, determines are needed to
7 enable the Office of the Auditor of Accounts to audit the accountable care
8 organization's financial statements, receipt and use of federal and State
9 monies, and performance as set forth in 32 V.S.A. § 163.

10 * * * Green Mountain Care Board Duties * * *

11 Sec. 7. 18 V.S.A. § 9375 is amended to read:

12 § 9375. DUTIES

13 (a) The Board shall execute its duties consistent with the principles
14 expressed in section 9371 of this title.

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

16 * * *

17 (16) Establish the methodology for determining the amounts of an
18 accountable care organization's value-based payments and the appropriate
19 allocations of shared savings among the organization's participating providers.

20 (17) Review and approve proposed fee schedules and health care
21 contracts between health plans and health care providers.

1 * * *

2 * * * Health Care Contract and Fee Schedule Review * * *

3 Sec. 8. 18 V.S.A. § 9384 is added to read:

4 § 9384. REVIEW OF HEALTH CARE CONTRACTS AND FEE

5 SCHEDULES

6 (a) As used in this section, "contracting entity," "health care contract,"

7 "health care provider," and "health plan" have the same meanings as in

8 chapter 221, subchapter 2 of this title.

9 (b) A health care contract between a health plan or other contracting entity

10 and a health care provider shall not be effective until it has been reviewed and

11 approved by the Green Mountain Care Board for fairness and consistency with

12 the provisions of chapter 221, subchapter 2 of this title, the Board's rules, and

13 other applicable laws.

14 (c) A fee schedule setting forth the amounts that a health plan or other

15 contracting entity shall reimburse a health care provider for delivering health

16 care services shall not be effective until it has been reviewed and approved by

17 the Green Mountain Care Board for fairness and compliance with the Board's

18 rules and other applicable laws.

19 (d) The Board shall adopt rules in accordance with 3 V.S.A. chapter 25

20 establishing the fee schedule and health care contract review processes,

1 <u>including the standards under which the Board will review proposed fee</u>
2 <u>schedules and health care contracts.</u>
3 Sec. 9. 18 V.S.A. § 9418c is amended to read:
4 § 9418c. FAIR CONTRACT STANDARDS
5 (a) Required information.
6 (1) Each contracting entity shall provide and each health care contract
7 shall obligate the contracting entity to provide participating health care
8 providers information sufficient for the participating provider to determine the
9 compensation or payment terms for health care services, including all of the
10 following:
11 (A) The manner of payment, such as fee-for-service, capitation, case
12 rate, or risk.
13 (B) ~~On~~ <u>Upon</u> request, the fee-for-service dollar amount allowable for
14 each CPT code for those CPT codes that a provider in the same specialty
15 typically uses or that the requesting provider actually bills. Fee schedule
16 information may be provided by CD-ROM or electronically, at the election of
17 the contracting entity, but a provider may elect to receive a hard copy of the
18 fee schedule information instead of the CD-ROM or electronic version.
19 (C) A clearly understandable, readily available mechanism, such as a
20 specific website address, that includes the following information:

(i) the name of the commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer uses;

(ii) the standard or standards from subsection 9418a(c) of this title that the entity uses for claim edits;

(iii) payment percentages for modifiers; and

(iv) any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product, which are made at the request of the health plan, contracting entity, covered entity, or payer, and which have been approved by the Commissioner pursuant to subsection 9418a(b) or (c) of this title.

(2) Contracting entities shall provide the information described in subdivisions (1)(A) and (B) of this subsection to health care providers who are actively engaged in the process of determining whether to become a participating provider in the contracting entity's network.

(3) ~~Contracting entities may require health care providers to execute written confidentiality agreements with respect to fee schedule and claim edit information received from contracting entities.~~ [Repealed.]

* * *

(b) Summary disclosure form.

* * *

(5) Upon request, contracting entities shall provide the summary disclosure form to a participating provider or a provider who is actively engaged in the process of determining whether to become a participating provider within 60 days of the request.

(c)(1) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in subdivisions (a)(1)(A) and (B) of this section. A contracting entity shall provide at least 120 days for a provider's consideration of a proposed contract and for negotiation of contract terms, including reimbursement amounts.

(2) Health care contracts shall be for a minimum of two years.

(3) Prior to a health care contract taking effect, it shall be reviewed and approved by the Green Mountain Care Board in accordance with section 9384 of this title for fairness and consistency with the provisions of this subchapter, the Board's rules, and other applicable laws.

* * *

(e) ~~The requirements of subdivision (b)(5) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract.~~ [Repealed.]

1 Sec. 10. GREEN MOUNTAIN CARE BOARD; HEALTH CARE
2 CONTRACTS; FEE SCHEDULES; REPORT
3 (a) The Green Mountain Care Board shall collect and review a
4 representative sample of health care contracts and fee schedules from health
5 insurers, including contracts and fee schedules with hospital-affiliated and non-
6 hospital-affiliated health care providers, in order to inform the Board's
7 development of its methodology for reviewing health care contracts and fee
8 schedules in accordance with 18 V.S.A. § 9384.
9 (b) On or before January 15, 2022, the Board shall provide information to
10 the House Committee on Health Care and the Senate Committees on Health
11 and Welfare and on Finance regarding the Board's proposed methodology for
12 reviewing health care contracts and fee schedules, including the standards and
13 criteria that the Board intends to use for its reviews.
14 (c) Confidential business information and trade secrets received from an
15 insurer pursuant to subsection (a) of this section shall be exempt from public
16 inspection and copying under 1 V.S.A. § 317(c)(9) and shall be kept
17 confidential, except that the Board may disclose or release information
18 publicly in summary or aggregate form if doing so would not disclose
19 confidential business information or trade secrets.

1 * * * Durable Medical Equipment * * *
2 Sec. 11. 18 V.S.A. chapter 221, subchapter 10 is added to read:
3 Subchapter 10. Durable Medical Equipment
4 § 9481. DURABLE MEDICAL EQUIPMENT; COST TRANSPARENCY
5 (a) As used in this section, "durable medical equipment" means equipment,
6 such as a walker, wheelchair, or home oxygen equipment, that:
7 (1) can withstand repeated use;
8 (2) primarily and customarily serves a medical purpose;
9 (3) generally is not useful to an individual without an illness or injury;
10 and
11 (4) is appropriate for use in the home.
12 (b) A health insurer shall provide clear information to patients regarding
13 their out-of-pocket exposure for the purchase of items of durable medical
14 equipment.
15 (c)(1) A provider of durable medical equipment shall inform a patient
16 whether it would be more cost-effective for that patient to purchase a specific
17 item of durable medical insurance for cash rather than using insurance.
18 (2) A health insurer shall not prohibit or penalize a provider of durable
19 medical equipment for disclosing to an insured the cash price for an item of
20 durable medical equipment or for providing information to an insured

1 regarding the insured's cost-sharing amount for an item of durable medical
2 equipment.
3 * * * Health Insurance Coverage for Hearing Aids * * *
4 Sec. 12. 8 V.S.A. § 4088l is added to read:
5 § 4088l. HEARING AIDS
6 (a) As used in this section:
7 (1) "Health insurance plan" means a group health insurance policy or
8 health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402,
9 and includes Medicaid and any other plan offered or administered by the State
10 or a subdivision or instrumentality of the State, but does not include:
11 (A) a qualified health benefit plan or reflective health benefit plan
12 offered in accordance with 33 V.S.A. chapter 18, subchapter 1; or
13 (B) a policy or plan providing coverage for a specified disease or
14 other limited benefit coverage.
15 (2) "Hearing aid" means any small, wearable electronic instrument or
16 device designed and intended for the ear for the purpose of aiding or
17 compensating for impaired human hearing and any parts, attachments, or
18 accessories, including earmolds and associated remote microphones that pair
19 with hearing aids to improve word comprehension in difficult listening
20 situations in live or telecommunication settings. The term does not include
21 batteries, cords, large-audience assisted listening devices, such as those

1 designed for auditoriums, or stand-alone assisted listening devices that can
2 function without a hearing aid.
3 (3) "Hearing aid professional services" means the practice of fitting,
4 selecting, dispensing, selling, or servicing hearing aids, or a combination,
5 including:
6 (A) evaluation for a hearing aid;
7 (B) fitting of a hearing aid;
8 (C) programming of a hearing aid;
9 (D) hearing aid repairs;
10 (E) follow-up adjustments, servicing, and maintenance of a hearing
11 aid;
12 (F) ear mold impressions; and
13 (G) auditory rehabilitation and training.
14 (4) "Hearing care professional" means an audiologist or hearing aid
15 dispenser licensed under 26 V.S.A. chapter 67, a physician licensed under
16 26 V.S.A. chapter 23 or 33, a physician assistant licensed under 26 V.S.A.
17 chapter 31, or an advanced practice registered nurse licensed under 26 V.S.A.
18 chapter 28.
19 (b) A health insurance plan shall cover the cost of a hearing aid for each ear
20 and the associated hearing aid professional services when the hearing aid or
21 aids are prescribed, fitted, and dispensed by a hearing care professional.

1 (c)(1) The coverage provided by a health plan for hearing aids and
2 associated services shall be limited only by medical necessity.
3 (2) A covered individual may select a hearing aid that exceeds the limits
4 set forth in subdivision (1) of this subsection and pay the additional cost.
5 (d) The coverage required by this section shall not be subject to a
6 deductible, co-payment, or coinsurance provision that is less favorable to a
7 covered individual than the deductible, co-payment, or coinsurance provisions
8 that apply generally to other nonprimary care items and services under the
9 health insurance plan.
10 (e)(1) A covered individual who has exhausted all applicable internal
11 review procedures provided by the health insurance plan shall have the right to
12 an independent external review as set forth in section 4089f of this title.
13 (2) The provisions of subdivision (1) of this subsection shall not apply
14 to a Medicaid beneficiary, whose grievance shall be redressed as set forth in
15 3 V.S.A. § 3091.
16 Sec. 13. APPLICATION TO MODIFY BENCHMARK PLAN; REPORT
17 (a) On or before May 7, 2021, the Agency of Human Services, in
18 consultation with the Department of Financial Regulation and the Green
19 Mountain Care Board, shall apply to the Centers for Medicare and Medicaid
20 Services to modify the essential health benefits in Vermont's benchmark plan

1 to include coverage of hearing aids and related services at a minimum standard
2 of medical necessity beginning in plan year 2023.
3 (b) The Agency shall contract for actuarial services to the extent necessary
4 to prepare the actuarial certification and report required as part of the
5 application process.
6 (c) On or before April 1, 2021, the Agency shall provide a draft of the
7 completed application materials, including the actuarial certification and
8 report, to the Medicaid and Exchange Advisory Committee and the Office of
9 the Health Care Advocate and make them available on its website. The
10 Agency shall accept public comments on the application materials, shall
11 respond to all public comments, and shall incorporate the public comments
12 into its final application materials when practicable.
13 (d) The Agency shall provide periodic updates on the disposition of its
14 application to the House Committee on Health Care, the Senate Committees on
15 Health and Welfare and on Finance, the Medicaid and Exchange Advisory
16 Committee, and the Office of the Health Care Advocate.
17 Sec. 14. AGENCY OF HUMAN SERVICES; FEDERAL APPROVAL
18 The Agency of Human Services shall seek approval from the federal
19 Centers for Medicare and Medicaid Services to provide coverage of hearing
20 aids for individuals enrolled in Medicaid as set forth in Sec. 12 of this act.

1 * * * State Health Improvement Plan * * *

2 Sec. 15. 18 V.S.A. § 9405(a) is amended to read:

3 (a) The ~~Secretary of Human Services or designee~~ <u>Commissioner of Health</u>,
4 in consultation with the Chair of the Green Mountain Care Board and health
5 care professionals and after receipt of public comment, shall adopt a State
6 Health Improvement Plan that sets forth the health goals and values for the
7 State. The ~~Secretary~~ <u>Commissioner</u> may amend the Plan as the ~~Secretary~~
8 <u>Commissioner</u> deems necessary and appropriate. The Plan shall include health
9 promotion, health protection, nutrition, and disease prevention priorities for the
10 State; identify available human resources as well as human resources needed
11 for achieving the State's health goals and the planning required to meet those
12 needs; identify gaps in ensuring equal access to appropriate mental health care
13 that meets standards of quality, access, and affordability equivalent to other
14 components of health care as part of an integrated, holistic system of care; and
15 identify geographic parts of the State needing investments of additional
16 resources in order to improve the health of the population. Copies of the Plan
17 shall be submitted to members of the Senate Committee on Health and Welfare
18 and the House Committee on Health Care.

1 * * * Reports * * *

2 Sec. 16. GREEN MOUNTAIN CARE BOARD; HEALTH INSURANCE;
3 ADMINISTRATIVE EXPENSES; REPORT

4 On or before January 15, 2022, the Green Mountain Care Board shall
5 provide to the House Committee on Health Care and the Senate Committees on
6 Health and Welfare and on Finance an analysis of the increases in health
7 insurers' administrative expenses over the most recent five-year period for
8 which information is available and a comparison of those increases with
9 increases in the Consumer Price Index.

10 Sec. 17. AGENCY OF HUMAN SERVICES; ALL-PAYER ACO MODEL;
11 SPECIALTY CARE; REPORT

12 On or before January 15, 2022, the Director of Health Care Reform in the
13 Agency of Human Services shall provide information to the House Committee
14 on Health Care and the Senate Committee on Health and Welfare regarding the
15 manner in which specialty care shall be incorporated appropriately into the All-
16 Payer ACO model and when that incorporation shall occur.

17 Sec. 18. ACCOUNTABLE CARE ORGANIZATIONS; CARE
18 COORDINATION; REPORT

19 On or before January 15, 2022, each accountable care organization certified
20 pursuant to 18 V.S.A. § 9382 shall provide to the House Committee on Health
21 Care and the Senate Committee on Health and Welfare a description of the

1 accountable care organization's initiatives to connect primary care practices
2 with social service providers, including the specific individuals or position
3 titles responsible for carrying out these care coordination efforts.
4 Sec. 19. PRIMARY CARE VISITS; COST-SHARING; REPORTS
5 (a) On or before January 15, 2022, the Department of Vermont Health
6 Access, in consultation with the Department of Financial Regulation, health
7 insurers, and other interested stakeholders, shall provide to the House
8 Committee on Health Care and the Senate Committees on Health and Welfare
9 and on Finance an analysis of the likely impacts on qualified health plans,
10 patients, providers, health insurance premiums, and population health of
11 requiring individual and small group health insurance plans to provide each
12 insured with at least two primary care visits per year with no cost-sharing
13 requirements.
14 (b) On or before January 15, 2022, the Green Mountain Care Board, in
15 consultation with the Departments of Financial Regulation and of Human
16 Resources, health insurers, and other interested stakeholders, shall provide to
17 the House Committee on Health Care and the Senate Committees on Health
18 and Welfare and on Finance an analysis of the likely impacts on patients,
19 providers, health insurance premiums, and population health of requiring large
20 group health insurance plans, including the plans offered to State employees

1 and to school employees, to provide each insured with at least two primary
2 care visits per year with no cost-sharing requirements.
3 * * * Effective Dates * * *
4 Sec. 20. EFFECTIVE DATES
5 (a) Sec. 3 (18 V.S.A. § 9382) shall take effect on passage and shall apply
6 beginning with the ACO certification and budget review for ACO fiscal year
7 2023.
8 (b) Secs. 7 and 8 (18 V.S.A. §§ 9375 and 9384; Green Mountain Care
9 Board; health care contract review) shall take effect on April 1, 2023, with the
10 Board reviewing all proposed health care contracts between contracting entities
11 and providers under negotiation on and after that date.
12 (c) Sec. 9 (18 V.S.A. § 9418c; fair contract standards) shall take effect on
13 passage and shall apply to all contract negotiations beginning on and after that
14 date, except that 18 V.S.A. § 9418c(c)(2) and (3) shall take effect on April 1,
15 2022.
16 (d) Sec. 11 (18 V.S.A. § 9481; durable medical equipment) shall take effect
17 on July 1, 2021.
18 (e) Sec. 12 (8 V.S.A. § 4088l) shall take effect on January 1, 2022 and shall
19 apply:
20 (1) to the State Employees Health Plan on and after January 1, 2022;

1 (2) to large group health insurance plans issued on and after January 1,
2 2022 on such date as a health insurer offers, issues, or renews the plan, but in
3 no event later than January 1, 2023; and
4 (3) to Medicaid upon approval by the Centers for Medicare and
5 Medicaid Services of Vermont's request to provide coverage of hearing aids or
6 on January 1, 2022, whichever occurs last.
7 (f) The remaining sections shall take effect on passage.