

1 Introduced by Committee on Health Care

2 Date:

3 Subject: Health care; universal access; reform; department organization

4 Statement of purpose: This bill would establish the goal of universal access to
5 essential health care services through a publicly financed, integrated, regional
6 health care delivery system in Vermont, provide mechanisms for cost
7 containment in the system, and provide a framework, schedule, and process ~~to~~
8 ~~be followed by the legislature~~ to achieve that goal.

9 AN ACT RELATING TO UNIVERSAL ACCESS TO HEALTH CARE IN
10 VERMONT

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

12 Sec. 1. SPECIFIC SYSTEM OBJECTIVES

13 To fulfill the goals and principles for transforming health care in Vermont,
14 the General Assembly adopts the following system objectives:

15 (1) Who is covered? All Vermont residents must be covered even if
16 they require health care while out of state. Coverage must be subject to
17 reasonable residency requirements.

18 (2) What is covered? All essential health care services must be covered.
19 A process must be developed to define essential health care services, taking
20 into consideration scientific evidence, available funds, and Vermonters' values.

1 (3) How is it financed? The universal access to health care system must
2 be financed primarily from broad-based taxes based on the ability to pay (for
3 example, pay roll or income taxes). An employer’s role in providing health
4 care coverage must be limited to contributing to system financing.

5 (4) How is care organized and delivered? Health care in Vermont must
6 be patient centered and delivered through an integrated, community-based
7 system, utilizing the hospital and primary care regions now in place, with
8 provider reimbursement consistent with patient-centered, community-based
9 delivery.

10 (5) How is it governed? The legislature must establish global budgets
11 for health care, appropriate necessary funds, and establish state health care
12 policy. Other decision making must be delegated to state agencies and
13 community-based entities.

14 **(6) How will costs be controlled?**

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

16 PART 6. HEALTH CARE ADMINISTRATION

17 CHAPTER X. NEW UNIVERSAL PLAN FOR TREATMENT,

18 SCREENING, AND EDUCATION

19 **Subchapter 1. General Provisions**

20 § X. LEGISLATIVE FINDINGS AND GOALS

21 The general assembly hereby finds that:

1 (1) Health care costs are continuing to rise at a pace that is causing
2 hardships to individuals and families, businesses, public institutions, and the
3 health care system itself.

4 (2) Health care costs are rising at an unsustainable rate. The growth in
5 total spending on health care is well above the increase in the Consumer Price
6 Index, and total spending growth on health care is well above other measures
7 of capacity to pay, such as gross state product or personal income.

8 (3) Between 1996 and 2002, health spending in Vermont rose 63 percent
9 while personal income rose 41 percent and the gross state product rose 35
10 percent.

11 (4) The ~~United States~~ Vermont spends more on health care than any
12 other country when measured as a proportion of gross domestic product.
13 [make vt specific]

14 (5) Businesses and employers in Vermont find that the cost of health
15 care has a strong and negative impact on the ability of Vermont to compete
16 nationally and internationally.

17 (6) The financing of health care is complex, fragmented, and
18 inequitable. Costs fall disproportionately on those with serious health
19 conditions and those with moderate and lower incomes.

20 (7) The cost of the health care system must become sustainable and the
21 rate of growth must be slowed over the next five to ten years.

1 (8) The most equitable and fair form of health care financing , the
2 health care system should be funded by is a broad-based tax. Revenues
3 from taxes will generally increase by the Consumer Price Index **and economic**
4 **growth** annually. ~~The cost of the system must be bent~~ **The persistent**
5 **increase in the cost of health care must be restrained** to correspond to a
6 more sustainable growth rate.

7 (9) At any particular time, approximately 10 percent of the Vermont
8 population is responsible for more than 70 percent of the health care spending,
9 with 90 percent of the population responsible for only 30 percent of spending.

10 (10) According to the Journal of the American Medical Association,
11 Vermont has the second highest quality of care for Medicare beneficiaries.

12 (11) Vermont is committed to reducing the rate of growth of health
13 care costs to its citizens by six to seven percent by 2015.

14 (12) There is a large and increasing number of people who have no
15 health insurance or who are underinsured. Over 60,000 Vermonters have no
16 health insurance, and being uninsured is associated with an increased rate of
17 illness and a shorter life expectancy. The rate of underinsurance is growing
18 due to the increased cost of premiums, resulting in more Vermonters
19 purchasing high-deductible plans and insurance plans with less coverage.

1 (13) Over one-half of bankruptcies **nationally** are associated with high
2 medical expenses. In about three-quarters of health-related bankruptcies, the
3 patient had insurance.

4 (14) Payment for health services is complex and administratively costly.
5 Cost shifting among payers is a serious problem. Current reimbursement
6 systems do not provide appropriate incentives for improving individual and
7 population health.

8 (add some large # with lots of 0's \$3.2 billion)

9 (15) ~~There are serious concerns about the quality and safety of~~
10 ~~health care.~~ Although ~~Vermont has an excellent health care system the~~
11 ~~quality of health care services in Vermont is generally very good, there are~~
12 ~~numerous opportunities is a need~~ to improve quality, efficiency, and safety.
13 There are an unacceptable number of adverse events attributable to medical
14 errors. Existing efforts to improve quality of care and patient safety should be
15 strengthened.

16 (16) In order to provide the necessary care to Vermonters, the health
17 care systems must move from a “cure-centered” system to a “care-based”
18 philosophy.

19 (17) As in every other state, Vermont’s delivery system is not
20 well-coordinated, especially in the area of information sharing. Efforts to

1 improve the integration of the disparate components of health care are
2 essential.

3 (18) The health care system must be responsive to **rapid** changes in
4 technology and medical advances. ~~Health care changes quickly and the~~
5 ~~system must be responsive to these changes.~~

6 ~~(19) The general assembly should continue to draw upon the~~
7 ~~significant and valuable work being accomplished by Coalition 21 in its~~
8 ~~effort to develop mechanisms for transforming Vermont's health care~~
9 ~~system.~~

10 § 5012. GOALS AND PRINCIPLES FOR HEALTH CARE

11 (a) The general assembly finds that a systemic and well-coordinated
12 transformation of **the way that health care is delivered and financed system**
13 **that encompasses the entire system, covering all Vermonters,** is required.
14 The way health care **“system” is delivered and financed** at present does not
15 operate as a complete and integrated system, and this accounts for a number of
16 challenges in creating change that requires payers, providers, citizens,
17 regulatory institutions, and administrative units to work together. The system
18 must be organized and operated as a cohesive and unified system in order for
19 successful change to be implemented.

20 (b) The changes to the way health care **system is delivered and financed**
21 must be systemic and initiated across the board in a coordinated fashion.

1 Piecemeal or stand-alone measures that affect only some groups will not be
2 sufficient or equitable. Incremental steps, especially early in the process, **will**
3 **may** be necessary, but they must be taken within a complete vision of how
4 they contribute to long-term outcomes and how they tie into and advance a
5 coordinated plan of transformation of the whole system.

6 (c) The general assembly adopts the following Coalition 21 principles as a
7 framework for improving Vermont’s health care system:

8 (1) Principle I: It is the policy of the state of Vermont to ensure
9 universal access to and coverage for essential health care services for all
10 Vermonters. Universal access means the absence of barriers to essential health
11 care services. Access needs to be equitable. Vermonters must have coverage
12 for essential services that are delivered in the same high quality manner
13 regardless of economic or geographic situations. It is a critical social policy
14 goal that all Vermonters have health coverage and that all Vermonters actively
15 participate in the health system.

16 (2) Principle II: Health care coverage needs to be comprehensive and
17 continuous. Coverage for essential health services needs to follow the
18 individual from birth to death and be responsive and seamless through
19 employment and life changes. Vermonters must have access to high quality
20 care throughout their lives.

1 (3) Principle III: Vermont’s health delivery system must model
2 continuous improvement of health care quality and safety. Continuous
3 improvement in health care quality and safety must be integrated into the
4 operation of the health care system, drawing on and promoting evidence-based
5 and best practices, striving for optimal outcomes for the resources expended.
6 It is essential that wellness and public health initiatives that promote healthy
7 lifestyles and preventive care be the foundation of the health system. The
8 health care system must promote care that is safe, timely, effective,
9 patient-centered, efficient and equitable.

10 (4) Principle IV: The financing of health care in Vermont must be
11 sufficient, equitable, fair, and sustainable. Universal access to a continuous
12 and comprehensive package of essential high quality health care is a public
13 good. The financing mechanism for attaining a workable, affordable and
14 sustainable health care system needs to be adequately and fairly financed and
15 operated in a manner that ensures both high quality of care and efficient use of
16 resources.

17 (5) Principle V: Built-in accountability for quality, cost, access and
18 participation must be the hallmarks of Vermont’s health care system. The
19 health system must be accountable to the people it serves in respect to the
20 quality of care and the management of costs.

1 (6) Principle VI: Vermonters must be engaged, to the best of their
2 ability, to pursue healthy lifestyles, to focus on preventive care and wellness
3 efforts, and to make informed use of all health care services throughout their
4 lives.

5 § 5013. DEFINITIONS

6 As used in this chapter:

7 (1) “Department” means the department of health care administration
8 established by section 5021 of this title to administer the health care plan
9 established under this chapter.

10 (2) “Health benefits board” means the Vermont health care benefits
11 board established under section 5032 of this title to establish priorities of
12 covered benefits of the Vermont health care plan.

13 (3) “Health care plan” means the new universal plan for treatment,
14 screening, and education established under this chapter.

15 (4) “Health care professional” means an individual licensed, **registered**
16 **or certified** in the state of Vermont to provide health services.

17 (5) “Health service” means any medically necessary treatment or
18 procedure to maintain, diagnose, or treat an individual’s physical or mental
19 condition, including services provided pursuant to a physician’s order and
20 services to assist in activities of daily living.

1 (6) “Hospital” shall have the same meaning as in section 1902 of this
2 title and may include hospitals located out of state.

3 (7) “Hospital service” means any health service received in a hospital
4 and any associated costs for professional services.

5 (8) “Preventive care” means screening, counseling, treatment, or
6 medication determined by scientific evidence to be effective at avoiding
7 disease.

8 (9) “Primary care” means health services provided by professionals
9 specifically trained for and skilled in first-contact and continuing care for
10 persons with previously undiagnosed signs, symptoms, or health concerns, not
11 limited by problem origin (biological, behavioral, or social), organ system, or
12 diagnosis. Primary care services include health promotion, disease prevention,
13 health maintenance, counseling, patient education, case management, and the
14 diagnosis and treatment of acute and chronic illnesses in a variety of health
15 care settings, which are provided by a variety of health care professionals.

16 (10) “Regulatory Review Board” means the **health** care regulatory
17 review board established by section 5041 of this title to hear appeals and
18 perform other judicial functions relating to the administration and
19 implementation of the health care plan under this chapter.

20 (11) “Vermont resident” means an individual domiciled in Vermont as
21 evidenced by an intent to maintain a principal dwelling place in Vermont

1 indefinitely and to return to Vermont if temporarily absent, coupled with an act
2 or acts consistent with that intent. The commissioner of the department of
3 health care administration shall establish specific criteria for showing
4 residency.

5 **Subchapter 2. Department of Health Care Administration**

6 § 5021. DEPARTMENT OF HEALTH CARE ADMINISTRATION

7 (a) A department of health care administration is created and shall have the
8 powers and duties established by this chapter. The department shall consist of:

9 (1) A division of health care ~~financing-regulation~~;

10 (2) A division of health care planning and analysis; and

11 (3) A division of health care purchasing.

12 (b) The following units are attached to the agency for the purpose of
13 assistance and administrative support:

14 (1) a health care quality unit responsible for providing policy advice and
15 oversight to the divisions and to ensure that the department's functions are
16 carried out in such a way as to promote quality and safety;

17 (2) a community health board advisory task force made up of one
18 representative from each community health board established under section
19 5025 of this title, which shall advise the divisions of the department to ensure
20 that regional issues and needs are integrated into the department's functions;
21 and

1 (3) a health care benefits board establish hed pursuant to section 5032 of
2 this title, which shall be responsible for developing the health benefit plans and
3 the community health board regions created pursuant to this chapter.

4 (c) The department shall be under the direction and supervision of a
5 commissioner who shall be appointed by the governor with the advice and
6 consent of the senate and shall serve at the pleasure of the governor.

7 (d) The commissioner shall be responsible to the governor and shall plan,
8 coordinate, and direct the functions vested in the department. The
9 commissioner shall prepare and submit to the governor an annual budget and
10 shall prepare and submit to the governor and the general assembly in
11 November of each year a report concerning the operations of the department
12 for the preceding fiscal year and the future goals and objectives of the
13 department.

14 (e) The commissioner may delegate the powers and assign the duties
15 transferred from other departments, offices, and divisions to the department of
16 health care administration in such a manner as the commissioner deems
17 appropriate.

18 (f) The commissioner may adopt rules and apply for any waivers of federal
19 law or regulation subject to the approval of the health care regulatory review
20 board established in section 5041 of this title necessary to carry out the
21 provisions of this chapter.

1 § 5022. DIVISION OF HEALTH CARE REGULATION

2 (a) The division of health care regulation is created within the department
3 of health care administration and shall be headed by a director.

4 (b) The division shall have the following responsibilities:

5 (1) hospital budget reviews under subchapter 7 of this title;

6 (2) health insurance regulation under chapter 107 of Title 8;

7 (3) certificate of need reviews under subchapter 5 of this title;

8 (4) development of a unified health care budget under section 9406 of
9 this title;

10 (5) Other duties.

11 § 5023. DIVISION OF HEALTH CARE PLANNING AND ANALYSIS

12 (a) The division of health care planning and analysis is created within the
13 department of health care administration and shall be headed by a director.

14 (b) The division of health care planning and analysis shall:

15 (1) Develop and maintain the health resource allocation plan under 9405
16 of this title;

17 (2) Oversee the development of hospital community reports and needs
18 assessments under sections 9405a and 9405b of this title;

19 (3) conduct the expenditure analysis required by section 9406 of this
20 title;

1 (4) maintain the health care databases required by section 9410 of this
2 title;

3 (5) Oversee other duties.

4 § 5024. DIVISION OF HEALTH CARE PURCHASING

5 (a) The division of health care purchasing is created within the department
6 of health care administration and shall be headed by a director.

7 (b) The division of health care purchasing shall administer any spending
8 that qualifies for federal match payments under 42 U.S.C. subchapters 19 and
9 21, and any spending for any other state-financed medical assistance program,
10 including pharmaceutical programs and the health benefit plan established
11 under this chapter. The administration may include any billing or collection
12 functions necessary to implement this chapter.

13 § 5025. INTEGRATED SYSTEMS OF HEALTH CARE

14 (a) The department shall develop a long-term strategy for integrating the
15 health care delivery system, containing health care costs, lowering the rate of
16 health care spending, and improving the quality of care. The long-term strategy
17 plan shall be reported to the general assembly by January 1, 2007.

18 (b) By March 15, 2006, the department shall submit to the general
19 assembly a plan for establishing community health boards within each region
20 of the state as determined by the benefits board under subsection (b) of this

1 section. The plan shall include standards and criteria for board membership
2 and functions.

3 (1) Functions of each community health board shall include integrating
4 and coordinating the delivery of care within its region; conducting an annual
5 community needs assessment, including an inventory of existing health
6 services and health care professionals and a prioritization of the health care
7 needs of its region, all of which shall be reflected in the department’s health
8 resource allocation plan; community health care planning; receiving ongoing
9 public input on the quality and organization of health services within its
10 region; making recommendations on the budgetary needs of its region; **issuing**
11 **a community health report card annually evaluating whether the health**
12 **system is meeting the goals of the community’s health care plan; and,**
13 designating an individual to serve on the community health board advisory
14 task force.

15 (2) Membership of each community health board shall reflect the
16 cultural and economic diversity of its region, with ~~patients~~ **individuals** who
17 are not also health care professionals making up at least 51 percent of the
18 directors. Other members shall include at least one representative from the
19 local community hospital; specialty, primary, and alternative health care
20 professionals; and any other key stakeholders in that region.

1 (3) By January 1, 2009, a universal access health care plan to provide
2 Vermont residents coverage for all other health services in addition to primary
3 and preventive and hospital services, to be implemented no later than July 1,
4 2009.

5 § 5032. HEALTH CARE BENEFITS BOARD

6 (a) The health care benefits board is established to establish and maintain a
7 prioritized list of health services from which the universally accessible health
8 care plan is constituted as required under section 5033 of this title, to establish
9 and revise if necessary health care delivery regions to be overseen by the
10 community health boards, and, if appropriate, to provide clinical health policy
11 advice to the department in an advisory capacity.

12 (b) The health care benefits board shall consist of seven members who shall
13 be residents of the state of Vermont. Within 90 days of passage of this section,
14 the governor, with advice and consent of the senate, shall appoint the members,
15 including two traditional health care professionals, one representative of
16 hospitals, one complimentary and alternative health care professional, one
17 provider of community health services, and two ~~consumers of health services~~
18 **individuals** who are not **related to**, licensed, trained, or employed as a health
19 care professional or in a health care facility. The members of the board shall
20 have **staggered** terms of six years.

21 (c) The health care benefits board shall elect a chair and vice chair from its

1 membership who shall serve for one year or until their successors are elected.

2 (d) A majority of the members of the board shall constitute a quorum. The
3 board shall act only by vote of a majority of its members present and voting at
4 a meeting called upon adequate notice to all its members and at which a
5 quorum is in attendance. The meetings shall be scheduled as necessary to
6 fulfill the board’s duties.

7 (e) Committee members who are not full-time state employees shall be
8 entitled to per diem and expenses as provided in 32 V.S.A. § 1010.

9 § 5033. NEW UNIVERSAL PLAN FOR TREATMENT, SCREENING,

10 AND EDUCATION

11 (a) The board shall develop a list of prioritized health services as described
12 in subsection (b) of this section. The list of prioritized health services shall be
13 determined and amended by the board after consideration of:

14 (1) A public process designed to respond to Vermonters’ health care
15 values and priorities;

16 (2) Credible scientific research and comment by health care
17 professionals concerning clinical efficacy and risk, including reviewing the
18 United States Preventive Service Task Force recommended list;

19 (3) Health care ethics;

20 (4) The cost-effectiveness of health services and technology;

21 (5) Revenues anticipated to be available to finance the health plan; and

1 (6) The state health plan and the health resource allocation plan
2 established under section 9405 of this title.

3 (b) The benefits board shall propose to the general assembly the universal
4 health care plan offering coverage to Vermont residents consistent with the
5 following terms and schedule:

6 (1) On or before February 15, 2006, a prioritized list of preventive care,
7 primary care, and hospital services; and

8 (2) On or before February 15, 2008, a prioritized list of health services
9 for a comprehensive common benefits plan.

10 (c) The general assembly shall have authority to accept or reject the
11 proposed health care plans through a joint house and senate resolution. The
12 general assembly shall not have the authority to modify specific covered health
13 services and must act on each proposed list in its entirety.

14 § 5034. BUDGET DEVELOPMENT PROCESS

15 (a) After approval of the prioritized list of health services, the division of
16 health care **financing regulation** shall establish a price for each health service
17 on the prioritized list based on the average current payment made for these
18 health services.

19 (b) The division of health care **financing regulation** shall negotiate with
20 hospitals, health care professionals, and groups of health care professionals to
21 establish a payment rate for the prioritized list of health services sufficient to

1 provide reasonable access to health services covered by the health care plan, to
2 provide sufficient payment to health care professionals to cover actual cost and
3 a reasonable margin, and to encourage the stability of health care professionals.

4 With respect to hospitals in particular:

5 (1) The division of health care **financing regulation** shall negotiate with
6 hospitals for a global hospital payment for health services provided under the
7 health care plan. The division shall consider the global hospital budget under
8 section 9461 of this title and other information necessary to the determination
9 of the appropriate payment, including all other revenue received from other
10 sources. The global hospital payment shall be reflected in the department's
11 annual budget submitted to the general assembly as a specific line item.

12 (2) Annually, the division of health care **financing regulation** shall
13 develop a global hospital budget for each hospital located in Vermont. The
14 division shall consider the health resource allocation plan under section 9405
15 of this title and the unified health care budget under section 9406 of this title,
16 as applicable to hospitals, the hospital budget review under section 9456 of this
17 title, the global hospital payments under subdivision (1) of this subsection, and
18 all other revenue received by hospitals when developing the global hospital
19 budget. The global hospital budget shall be submitted to the health care
20 regulatory review board for approval.

1 (3) The global hospital budget developed under subdivision (2) of this
2 subsection shall serve as a spending cap within which hospital costs are
3 controlled, resources directed, and quality and access assured. The global
4 hospital budget shall limit the total annual growth of hospital costs to the
5 Consumer Price Index plus three percent. The division shall ensure that
6 hospital budget reviews and certificates of need are consistent with the global
7 hospital budget.

8 (4) The division shall adopt rules specifying the circumstances under
9 which a hospital may seek amendment of its budget after approval by the
10 health care regulatory review board. An amendment to a hospital's budget
11 shall be reviewed by the department and then brought to the health care
12 regulatory review board for consideration.

13 (c) The department shall propose its budget to the general assembly on or
14 before January 15 of each year, including recommended expenditures during
15 the next succeeding calendar year for each sector of the health care system
16 providing a health service under the health care plan and anticipated revenues
17 available to support such expenditures.

18 (d) The department shall adopt by rule standards and procedures necessary
19 to implement this section.

1 (e) A hospital or health care professional aggrieved by an adverse decision
2 of the division may appeal to the health care regulatory review board under
3 subchapter 4 of this chapter.

4 §5035. ADMINISTRATION

5 (a) The division for health care purchasing shall administer the plan, or
6 under an open bidding process, solicit and receive bids from insurance carriers
7 or third party administrators for plan administration.

8 (b) By February 15, 2006, the department shall report to the general
9 assembly with a plan for designing reimbursement rates in order to encourage
10 cost-containment and the provision of high quality health services in an
11 integrated setting.

12 (c) After the general assembly's approval of the budget for the health care
13 plan, the division of health care purchasing shall establish by rule standards
14 and procedures to provide coverage of health services and expenditures that are
15 in financial balance with the approved budget. Such standards and procedures
16 shall include:

17 (1) Uniform reimbursement mechanisms that encourage high quality
18 and cost-effective care. Reimbursement mechanisms shall compensate
19 adequately for the operating costs of providing health services efficiently and
20 may include fee supplements to encourage certain health services provided by
21 specialized health care professionals or in different geographic regions of the

1 state. Reimbursement rates shall not vary by consumer, based for example on
2 the consumer's eligibility for Medicaid;

3 (2) A reference pricing reimbursement mechanism whereby a consumer
4 may choose to pay additional reimbursement for health services determined by
5 the board to be less effective or more expensive than other comparable health
6 services; and

7 (3) The health benefit plan's terms and conditions.

8 (d) Individuals covered by the health care plan shall not be billed any
9 additional amount for health services covered by the plan except as provided
10 for as cost-sharing in section 5036 of this title.

11 (e) The assistance provided under this chapter shall be the secondary payer
12 with respect to a health service that may be covered in whole or in part by Title
13 XVIII of the Social Security Act (Medicare) or by any other federally funded
14 health benefit plan.

15 (f) The health care plan provided for under this chapter shall comply with
16 42 U.S.C. subchapter 19 (Medicaid) unless the department, after approval of
17 the regulatory board and the general assembly, seeks and receives a federal
18 waiver.

19 (g) After approval of the health care plan by the general assembly, the
20 department of health care administration shall publish a description of the
21 services covered by the plan required by this chapter.

1 (h) Any prescription drug coverage offered by the health care plan required
2 by this chapter shall be consistent with the standards and procedures applicable
3 to the pharmacy best practices and cost control program established by sections
4 1996 and 1998 of Title 33.

5 (i) The division or plan administrator shall make available the necessary
6 information, forms, and billing procedures to health care professionals to
7 ensure payment for health services covered under the health care plan. The
8 division or plan administrator shall inform health care professionals of
9 acceptable proof of residency which will qualify an individual for coverage.
10 The division shall ensure that health care professionals are compensated for
11 administrative tasks associated with enrolling individuals in the plan.

12 (j) The division or plan administrator shall ~~use the simplest~~ **a simplified**
13 **form used** to determine eligibility for Medicaid, the Vermont health access
14 plan, or any state pharmacy program for enrollment in the health care plan to
15 ensure that any individual eligible for Medicaid, the Vermont health access
16 plan, or the state pharmacy programs has the opportunity to enroll and to
17 ensure the administration of Medicaid is as invisible as possible to health care
18 professionals and Vermonters. The division shall provide coverage for health
19 services up to three months prior to the date of application for Medicaid, the
20 Vermont health access plan, or the state pharmacy programs. The division

1 shall seek any necessary amendments to any state plans or federal waivers
2 necessary to implement this subsection.

3 (k) A beneficiary aggrieved by an adverse decision of the division or plan
4 administrator may appeal to the health care regulatory review board
5 established in subchapter 4 of this chapter.

6 § 5036. COST SHARING

7 The division of health care purchasing shall establish by rule
8 income-sensitized minimal deductibles, co-payments, or other cost-sharing
9 amounts applicable to the health care plan required by this chapter. The plan
10 may also include financial or other incentives that have been demonstrated to
11 encourage healthy lifestyles.

12 § 5037. EVALUATION

13 Beginning March 1, 2006, and annually thereafter, the commissioner shall
14 submit a written report to the general assembly assessing the department's
15 progress in achieving the system goals of the new universal plan for treatment,
16 screening, and education. The report shall making findings relative to the
17 plan's impact on the overall health of Vermonters and the quality of health
18 services delivered in the state and shall address any administrative or other
19 financial savings realized as a result of the plan. In addition, the report shall
20 include the commissioner's recommendations for further legislation and
21 funding.

1 **Subchapter 4. Health Care Regulatory Review Board**

2 **§ 5041. HEALTH CARE REGULATORY REVIEW BOARD**

3 (a) A health care regulatory review board is created to consist of a
4 chairperson and two members.

5 (b) The chairperson shall be nominated, appointed, and confirmed in the
6 manner of a superior judge, except that the chairperson and each member shall
7 not be required to be admitted to the practice of law in this state.

8 (c) Members of the board other than the chairperson shall be appointed in
9 accordance with this subsection. Whenever a vacancy occurs, public
10 announcement of the vacancy shall be made. The governor shall submit at
11 least five names of potential nominees to the judicial nominating board for
12 review. The judicial nominating board shall review the candidates in respect to
13 judicial criteria and standards only and shall recommend to the governor those
14 candidates the board considers qualified. The governor shall make the
15 appointment from the list of qualified candidates. The appointment shall be
16 subject to the advice and consent of the senate.

17 (d) The term of each member of the health care administration board shall
18 be six years. Any appointment to fill a vacancy shall be for the unexpired
19 portion of the term vacated. A member wishing to succeed himself or herself
20 in office may seek reappointment under the terms of this section.

1 (e) Notwithstanding section 2004 of Title 3 or any other provision of law,
2 members of the board may be removed only for cause. If a board member who
3 hears all or a substantial part of a case retires from office before such case is
4 completed, he or she shall remain a member of the board for the purpose of
5 concluding and deciding such case and signing the findings, orders, decrees,
6 and judgments therein. A retiring chairperson shall also remain a member for
7 the purpose of certifying questions of law if an appeal is taken. For such
8 service, he or she shall receive a reasonable compensation to be fixed by the
9 remaining members of the board and necessary expenses while on official
10 business.

11 (f) A case shall be deemed completed when the health care administration
12 board enters a final order therein even though such order is appealed to the
13 supreme court and the case remanded by that court to the board. Upon
14 remand, the board then in office may in its discretion consider relevant
15 evidence, including any part of the transcript of testimony in the proceedings
16 prior to appeal.

17 (g) The chairperson shall have general charge of the offices and employees
18 of the health care administration board.

19 § 5042. QUALIFICATIONS OF MEMBERS AND CLERK

20 A person in the employ of or holding any official relation to any company
21 subject to the supervision of the health care regulatory review board, or

1 engaged in the management of such company, or owning stock, bonds, or other
2 securities thereof, or who is, in any manner, connected with the operation of
3 such company in this state shall not be a member or clerk of the board; nor
4 shall any person holding the office of member or clerk of the board or
5 personally or in connection with a partner or agent render professional service
6 for or against or make or perform any business contract with any company
7 subject to such supervision relating to the business of such company; nor shall
8 such person, directly or indirectly, receive from any such company any
9 commission, gift, or reward.

10 § 5043. CLERK; OATH

11 The health care regulatory review board shall appoint a clerk, who shall
12 serve at its pleasure. The board members and clerk shall be sworn to the
13 faithful discharge of the duties of their offices and, before entering upon the
14 same, shall file a certificate of their oaths for record in the office of the
15 secretary of state.

16 § 5044. QUORUM; MEETINGS

17 Two health care regulatory review board members shall constitute a quorum
18 for the transaction of any business. Meetings of the board may be held at any
19 time or place within the state upon call of the chair or the other two members,
20 after a reasonable notice to the other members, and shall be held at such times

1 and places as in the judgment of the board will best serve the convenience of
2 all parties in interest.

3 § 5045. POWERS OF SINGLE BOARD MEMBER OR OTHER
4 OFFICER OR EMPLOYEE

5 (a) One health care regulatory review board member or any officer or
6 employee of the board duly appointed by the chairperson of the board may
7 inquire into and examine any matter within the jurisdiction of the board.

8 (b) A hearing officer may administer oaths in all cases, so far as the
9 exercise of that power is properly incidental to the performance of his or her
10 duty or that of the board. A hearing officer may hold any hearing in any matter
11 within the jurisdiction of the board to hear.

12 (c) A hearing officer shall report his or her findings of fact in writing to the
13 board in the form of a proposal for decision. A copy shall be served upon the
14 parties pursuant to section 811 of Title 3. However, judgment on such findings
15 shall be rendered only by a majority of the board.

16 (d) At least 12 days prior to a hearing before the board or a hearing officer,
17 the board shall give written notice of the time and place of the hearing to all
18 parties to the case and shall indicate the name and title of the person designated
19 to conduct the hearing.

1 (e) Upon written request to the board at least five days prior to the hearing
2 by all parties to the case, the chairperson shall appoint at least a majority of the
3 board to conduct the hearing.

4 (f) Notwithstanding subsection (c) of this section, the chairperson may
5 appoint a hearing officer to hear and finally determine any consumer complaint
6 where the amount in controversy does not exceed \$2,000.00. Upon petition of
7 a party, filed within 30 days of issuance of the hearing officer's decision and
8 order, or on its own motion, the health care administration board may
9 determine that the hearing officer's decision and order should be treated as a
10 proposal for decision and order as provided in subsection (c) of this section.

11 The board may grant such request for good cause, including but not limited to
12 apparent error of fact or procedural or substantive law and may conduct
13 additional evidentiary hearings or hear oral argument from the parties. If such
14 request is not timely made, or is not granted by the board, the decision and
15 order of the hearing officer shall become the final decision and order of the
16 board.

17 § 5046. COURT OF RECORD; SEAL

18 The health care regulatory review board shall have the powers of a court of
19 record in the determination and adjudication of all matters over which it is
20 given jurisdiction. It may render judgments, make orders and decrees, and
21 enforce the same by any suitable process issuable by courts in this state. The

1 board shall have an official seal on which shall be the words "State of
2 Vermont. Health Care Regulatory Review Board. Official Seal."

3 § 5047. FEES, PROCESS, AND ADDITIONAL POWERS

4 The health care regulatory review board shall use the same fees, process,
5 and procedures and have the same procedural powers as the public service
6 board provided for in sections 10, 11, 17, 18, and 19 of Title 30.

7 § 5048. REVIEW BY THE SUPREME COURT

8 The review and powers of the supreme court shall be the same for this
9 subchapter as established for the public service board under sections 12, 14,
10 and 15 of Title 30.

11 § 5049. JURISDICTION

12 The health care regulatory review board shall have jurisdiction to:

13 (1) hear contested cases for aggrieved parties of an adverse decision
14 under chapter 19 of Title 33 and under this chapter;

15 (2) approve reimbursement rates and methodologies established under
16 this chapter, including global hospital budgets under subdivision 5034(b)(3) of
17 this title; and

18 (3) approve certificate of need proposals under subchapter 5 of this title,
19 the unified health care budget under section 9406 of this title, and hospital
20 budget reviews under subchapter 7 of this title.

1 stakeholders and soliciting input from citizens about health care. The
2 committee at a minimum shall:

3 (1) have regional public hearings;

4 (2) have regional and statewide meetings with stakeholders, such as
5 employers, hospitals, physicians, insurers;

6 (3) solicit information through a survey that shall be available on
7 line as well as on paper;

8 (4) arrange for facilitated focus groups; and

9 (5) maintain a web site.

10 (b) In order to obtain a broad range of information and input, the
11 committee shall collaborate with the agency of human services regional
12 partnerships, the Vermont ethics network, and area health education
13 centers (AHEC) in developing and implementing the public process.

14 (c) The house health care committee, with support from the joint fiscal
15 office, shall oversee the following studies:

16 (1) determine the statewide economic impact of a universal access
17 health care plan on the state, including employers, municipal, and school
18 budgets, existing businesses, and Vermont residents;

19 (2) determine what part of health care spending is **fixed and not**
20 dependent on volume, including the effect of public financing, and the effect of
21 any reduction in utilization rates; and

1 (3) determine any savings in administrative costs from moving to a
2 universal coverage, publicly financed health care system.

3 (d) With the approval of the speaker of the house, the committee may retain
4 the services of one or more consultants or experts to assist in its work.

5 (e) The committee may meet as needed and shall have such powers as are
6 needed to carry out the purposes of this section. Committee members shall be
7 entitled to per diem and expenses as provided in 2 V.S.A. § 406.

8 Sec. 5. LEGISLATIVE OVERSIGHT

9 The health access oversight committee established by Sec. 13 of No. 14 of
10 the Acts of 1995 shall be responsible for legislative oversight of the
11 implementation and ongoing operation of the health care plan required by this
12 chapter. The department shall report on the implementation of the plan and
13 ongoing operation and financial status of the health care plan at such times and
14 with such information as the committee determines is necessary to fulfill its
15 legislative oversight responsibilities. The committee's annual report on the
16 Vermont health access plan shall include findings and recommendations
17 concerning the health care plan required by this subchapter.

18 *[Housekeeping provisions: need to change current statutes re: CON &*
19 *hospital budget reviews to reflect new structure]*

20 Sec. 6. 3 V.S.A. § 3091(a) is amended to read:

1 § 3091. HEARINGS

2 (a) An applicant for or a recipient of assistance, benefits, or social services
3 from the ~~department of social and rehabilitation services, the department of~~
4 ~~prevention, assistance, transition, and health access, the office of economic~~
5 ~~opportunity, the department of aging and disabilities, the office of child~~
6 ~~support, department for children and families and the department of aging and~~
7 independent living or an applicant for a license from one of those departments
8 or offices, or a licensee, may file a request for a fair hearing with the human
9 services board, except that appeals regarding health care assistance shall be
10 heard by the health care hearing board established under subchapter 3a of
11 chapter 19 of Title 33. An opportunity for a fair hearing will be granted to any
12 individual requesting a hearing because his or her claim for assistance,
13 benefits, or services is denied, or is not acted upon with reasonable
14 promptness; or because the individual is aggrieved by any other agency action
15 affecting his or her receipt of assistance, benefits, or services, or license or
16 license application; or because the individual is aggrieved by agency policy as
17 it affects his or her situation.

1 *****Immediate specific access enhancements*****

2 **** Federally Qualified Health Centers ****

3 Sec. 7. **FEDERALLY QUALIFIED HEALTH CENTERS (F.Q.H.C.)**

4 **CAPITALIZATION GRANTS; CASE MANAGEMENT**

5 F.Q.H.C. Capitalization Grants. There is appropriated from the general
6 fund in fiscal year 2006 to the department of health the amount of \$250,000.00
7 for the purpose of providing initial capitalization for federally qualified health
8 centers and health centers who have received federal designation, but no
9 funding and for providing funds to the latter health centers to establish an
10 income-sensitized sliding scale fee schedule for patients. In distributing the
11 grants, the department shall consider ensuring the geographic distribution of
12 health centers around the state and the location of correctional facilities, as
13 well as the criteria under federal law. Priority shall be given to health centers
14 in Lamoille, Orange, Rutland and Washington counties.

15 ***** Health Care Information Technology *****

16 Sec. 8. 18 V.S.A. § 9434(a)(6) is added to read:

17 (6) The purchase or lease of new health care information technology.

18 Sec. 9. 18 V.S.A. § 9434(c)(5) is added to read:

19 (5) The purchase or lease of new health care information technology.

1 Sec. 10. 18 V.S.A. § 9435(a) is amended to read:

2 (a) Excluded from this subchapter are offices of physicians, dentists, or
3 other practitioners of the healing arts, meaning the physical places which are
4 occupied by such providers on a regular basis in which such providers perform
5 the range of diagnostic and treatment services usually performed by such
6 providers on an outpatient basis unless they are subject to review under
7 subdivisions 9434(a)(4) or (6) of this title.

8 Sec. 11. 18 V.S.A. § 9437(6) is added to read:

9 (6) if the application is for the purchase or lease of new health care
10 information technology, it conforms with the health care information
11 technology plan established under section 9440b of this title.

12 Sec. 12. 18 V.S.A. § 9440b is added to read:

13 § 9440b. INFORMATION TECHNOLOGY; REVIEW PROCEDURES;
14 BOARD; PLAN

15 (a) The commissioner shall establish by rule standards and procedures for
16 reviewing applications for the purchase or lease of health care information
17 technology beginning July 1, 2006. Such applications shall not be granted
18 unless they are consistent with the health care information technology plan
19 established by the health care information technology board under this section.

20 (b) By October 1, 2005, a health care information technology board shall
21 be established. Members shall include the commissioner of the department of

1 health care administration and a representative from each of the following
2 organizations: one or more private health insurers, the Vermont program for
3 quality in health care, health care facilities identified by the Vermont
4 association of hospitals and health systems, the Vermont medical society, and
5 the health care ombudsman. The term of each member shall be three years.
6 Any appointment to fill a vacancy shall be for the unexpired portion of the
7 term vacated. A member wishing to succeed himself or herself in office may
8 seek reappointment by the commissioner. The health care information
9 technology board shall design a health care information technology plan as
10 described in subsection (c) of this section and shall have administrative and
11 staff support from the department of health care administration.

12 (c) By January 1, 2006, the health care information technology board shall
13 design a health care information technology plan with the goal of developing
14 and implementing a statewide, interactive health care database, as well as
15 related technologies designed to promote patient education, physician best
16 practices, electronic connectivity to health care data, and, overall, a more
17 efficient and less costly means of delivering quality health care in Vermont
18 while simultaneously capturing cost overruns. The plan shall include
19 provisions relating to:

20 (1) patient records;

21 (2) methods of referral for patients;

- 1 (3) data standards related to common claims and billing and other
2 financial reporting standards and procedures;
3 (4) privacy and security practices;
4 (5) consumer access to health information;
5 (6) access to medical best practices, including diagnostic tools by health
6 care professionals;
7 (7) chronic care registries;
8 (8) uniform health care information collecting and reporting standards
9 and practices, including common definitions;
10 (9) a delivery system accessible at all facilities, including clinics;
11 (10) a recommended process that would allow hospitals and health care
12 facilities that invest in health information technology that is compatible with
13 the health information technology plan to have those costs recognized in their
14 budgets when reviewed by the commissioner; and
15 (11) an analysis of the cost of the recommendations made.

16 (d) The statewide, integrated information technology system shall be fully
17 implemented by January 1, 2010.

18 Sec. 13. MEDICAL MALPRACTICE ARBITRATION

19 (a) Sec. 50 (effective date) of No. 160 of the Acts of the 1991 Adj. Sess.
20 (1992), is amended to read as follows:

21 Sec. 50. EFFECTIVE DATE

1 Secs. 46, 47, 48, and 49, amending chapter 215 of Title 12 to provide for
2 mandatory arbitration in medical malpractice cases and admission of practice
3 guidelines, shall take effect ~~on the effective date of a universal access health~~
4 ~~care system enacted by the general assembly~~ upon implementation of the
5 universal access health care plan under subdivision 5031(a) of Title 18.

6 (b) Three years after mandatory medical malpractice arbitration goes into
7 effect, the commissioner of the department of health care administration shall
8 review medical malpractice and tort law, and file a report with the general
9 assembly. The report shall include the board's recommendations for changes
10 to the mandatory arbitration process, if appropriate. If universal
11 cost-containment measures affect or place limits on clinical decision-making,
12 the board shall recommend limitations on the liability of providers who follow
13 practice guidelines, if appropriate. The commissioner shall seek advice and
14 assistance in developing recommendations under this subsection from an
15 advisory group established under subdivision 9411(3) of Title 18 consisting of
16 representatives of the judicial branch, the health care provider community, the
17 legal community, health insurers, medical malpractice insurers, and health care
18 consumers. To the fullest extent possible, the recommendations shall be based
19 upon the board's collection of data specific to Vermont.

1 **Sec. 14. WORKERS' COMPENSATION STUDY**

2 **The department of health care administration shall investigate ways of**
3 **coordinating or integrating the universal health care plan under this act**
4 **with the current workers compensation system and shall make**
5 **recommendations to the general assembly by January 1, 2006.**

6 **Sec. 15. TRANSFER OF POSITIONS**

7 Effective October 1, 2005 and consistent with the provisions of this act, the
8 Secretary of Administration shall transfer to the department of health care
9 administration and place under the supervision of the department's
10 commissioner:

11 (1) All employees, professional and support staff, consultants, and
12 positions of the office of Vermont health access under section 3088 of Title 3
13 and the remaining balances of all appropriation amounts for personal services
14 and operating expenses;

15 (2) All employees, professional and support staff, consultants, and
16 positions of the division of rate setting under chapter 9 of Title 33 and the
17 remaining balances of all appropriation amounts for personal services and
18 operating expenses; and

19 (3) All employees, professional and support staff, consultants, and
20 positions of the division of health care administration pursuant to chapter 221

1 of Title 18 and the remaining balances of all appropriation amounts for
2 personal services and operating expenses.

3 Sec. 16. STATUTORY REVISION

4 The Statutory Revision Commission shall revise the Vermont Statutes
5 Annotated as necessary to reflect the purposes of this act.

6 Sec. 17. APPROPRIATION

7 There is appropriated from the general fund for fiscal year 2006 the amount
8 of \$100,000.00 to the legislature to be maintained in a separate account to be
9 utilized by the committee for ~~this purpose~~ **the studies in Sec. 4.**

10 Sec. 18. REVENUE [not yet drafted]

11 Sec. 19. EFFECTIVE DATES

12 This act is effective upon passage, except that Sec. 6 (human service board)
13 shall not become effective until January 1, 2006. The health care regulatory
14 review board shall not begin the oversight functions described in this act until
15 January 1, 2006. Until that time, the functions delegated to the health care
16 regulatory review board shall remain with the agency or department which
17 currently provides those functions.