

1 Introduced by Committee on Health Care

2 Date:

3 Subject: Health; health insurance; Medicaid; mental health; prior authorization

4 Statement of purpose of bill as introduced: This bill proposes to address
5 several health care-related topics, including mental health, hospital budget
6 review, expansion of VPharm coverage for certain beneficiaries, and the
7 review and modification of prior authorization requirements.

8 An act relating to miscellaneous health care provisions

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

10 * * * Mental Health * * *

11 Sec. 1. 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 (15) ~~Collect and review data from each psychiatric hospital licensed~~
18 ~~pursuant to chapter 43 of this title, which may include data regarding a~~
19 ~~psychiatric hospital's scope of services, volume, utilization, discharges, payer~~

1 ~~mix, quality, coordination with other aspects of the health care system, and~~
2 ~~financial condition. The Board's processes shall be appropriate to psychiatric~~
3 ~~hospitals' scale and their role in Vermont's health care system, and the Board~~
4 ~~shall consider ways in which psychiatric hospitals can be integrated into~~
5 ~~systemwide payment and delivery system reform. [Repealed.]~~

6 * * *

7 Sec. 2. 18 V.S.A. § 9451 is amended to read:

8 § 9451. DEFINITIONS

9 As used in this subchapter:

10 (1) "Hospital" means a ~~general~~ hospital licensed under chapter 43 of this
11 title, except a hospital that is conducted, maintained, or operated by the State
12 of Vermont.

13 * * *

14 Sec. 3. HOSPITAL BUDGET REVIEW; TRANSITIONAL PROVISIONS

15 (a) For any hospital whose budget newly comes under Green Mountain
16 Care Board review as a result of the amendments to 18 V.S.A. § 9451 made by
17 Sec. 2 of this act, the Board may increase the scope of the budget review
18 process set forth in 18 V.S.A. chapter 221, subchapter 7 for the hospital
19 gradually, provided the Board conducts a full review of the hospital's proposed
20 budget not later than the budget for hospital fiscal year 2024. In developing its
21 process for transitioning to a full review of the hospital's budget, the Board

1 shall collaborate with the hospital and with the Agency of Human Services to
2 prevent duplication of efforts and of reporting requirements. The Board and the
3 Agency shall jointly determine which documents submitted by the hospital to
4 the Agency are appropriate for the Agency to share with the Board.

5 (b) In determining whether and to what extent to exercise discretion in the
6 scope of its budget review for a hospital new to the Board’s hospital budget
7 review process, the Board shall consider:

8 (1) any existing fiscal oversight of the hospital by the Agency of Human
9 Services, including any memoranda of understanding between the hospital and
10 the Agency; and

11 (2) the fiscal pressures on the hospital as a result of the COVID-19
12 pandemic.

13 Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT

14 (a) Creation. There is created the Mental Health Integration Council for
15 the purpose of helping to ensure that all sectors of the health care system
16 actively participate in the State’s principles for mental health integration
17 established pursuant to 18 V.S.A. § 7251(4) and (8) and as envisioned in the
18 Department of Mental Health’s 2020 report “Vision 2030: A 10-Year Plan
19 for an Integrated and Holistic System of Care.”

20 (b) Membership.

21 (1) The Council shall be composed of the following members:

- 1 (A) the Commissioner of Mental Health or designee;
- 2 (B) the Commissioner of Health or designee;
- 3 (C) the Commissioner of Vermont Health Access or designee;
- 4 (D) the Commissioner for Children and Families or designee;
- 5 (E) the Commissioner of Corrections or designee;
- 6 (F) the Commissioner of Financial Regulation or designee;
- 7 (G) the Director of Health Care Reform or designee;
- 8 (H) the Executive Director of the Green Mountain Care Board or
9 designee;
- 10 (I) the Secretary of Education or designee;
- 11 (J) a representative, appointed by the Vermont Medical Society;
- 12 (K) a representative, appointed by the Vermont Association for
13 Hospitals and Health Systems;
- 14 (L) a representative, appointed by Vermont Care Partners;
- 15 (M) a representative, appointed by the Vermont Association of
16 Mental Health and Addiction Recovery;
- 17 (N) a representative, appointed by Bi-State Primary Care;
- 18 (O) a representative, appointed by the University of Vermont
19 Medical School;
- 20 (P) the Chief Executive Officer of OneCare Vermont or designee;

1 (Q) the Health Care Advocate established pursuant to 18 V.S.A.
2 § 9602;

3 (R) the Mental Health Care Ombudsman established pursuant to
4 18 V.S.A. § 7259;

5 (S) a representative, appointed by the insurance plan with the
6 largest number of covered lives in Vermont;

7 (T) two persons who have received mental health services in
8 Vermont, appointed by Vermont Psychiatric Survivors, including one person
9 who has delivered peer services;

10 (U) one family member of a person who has received mental health
11 services, appointed by the Vermont chapter of National Alliance on Mental
12 Illness; and

13 (V) one family member of a child who has received mental health
14 services, appointed by the Vermont Federation of Families for Children’s
15 Mental Health.

16 (2) The Council may create subcommittees comprising the Council’s
17 members for the purpose of carrying out the Council’s charge.

18 (c) Powers and duties. The Council shall address the integration of
19 mental health in the health care system including:

1 (1) identifying obstacles to the full integration of mental health into a
2 holistic health care system and identifying means of overcoming those
3 barriers;

4 (2) helping to ensure the implementation of existing law to establish
5 full integration within each member of the Council’s area of expertise;

6 (3) establishing commitments from non-state entities to adopt practices
7 and implementation tools that further integration;

8 (4) proposing legislation where current statute is either inadequate to
9 achieve full integration or where it creates barriers to achieving the principles
10 of integration; and

11 (5) fulfilling any other duties the Council deems necessary to achieve
12 its objectives.

13 (d) Assistance. The Council shall have the administrative, technical, and
14 legal assistance of Department of Mental Health.

15 (e) Report.

16 (1) On or before December 15, 2021, the Commissioners of Mental
17 Health and of Health shall report on the Council’s progress to the Joint
18 Health Reform Oversight Committee.

19 (2) On or before January 15, 2023, the Council shall submit a final
20 written report to the House Committee on Health Care and to the Senate
21 Committee on Health and Welfare with its findings and any

1 recommendations for legislative action, including a recommendation as to
2 whether the term of the Council should be extended.

3 (f) Meetings.

4 (1) The Commissioner of Mental Health shall call the first meeting of
5 the Council.

6 (2) The Commissioner of Mental Health shall serve as chair. The
7 Commissioner of Vermont Health Access shall serve as vice chair.

8 (3) The Council shall meet bimonthly between July 1, 2020 and
9 January 1, 2023.

10 (4) The Council shall cease to exist on July 30, 2023.

11 (g) Compensation and reimbursement. Members of the Council shall be
12 entitled to per diem compensation and reimbursement of expenses as
13 permitted under 32 V.S.A. § 1010 for not more than eight meetings. These
14 payments shall be made from monies appropriated to the Department of
15 Mental Health.

16 Sec. 5. BRATTLEBORO RETREAT; CONDITIONS OF STATE FUNDING

17 (a) Findings. In recognition of the significant need within Vermont's
18 health care system for inpatient psychiatric capacity, the General Assembly has
19 made significant investments in capital funds and in rate adjustments to assist
20 the Brattleboro Retreat in its financial sustainability. The General Assembly
21 has a significant interest in the quality of care provided at the Brattleboro

1 Retreat, which provides 100 percent of the State’s inpatient psychiatric care for
2 children and youths, and more than half of the adult inpatient care, of which
3 approximately 50 percent is paid for with State funding.

4 (b) Conditions. As a condition of further State funding, the General
5 Assembly requires that the following quality oversight measures be
6 implemented by the Brattleboro Retreat under the oversight of the Department
7 of Mental Health:

8 (1) Give authority and access to a mental health patient representative
9 pursuant to 18 V.S.A. § 7253(1)(J) to provide services on all inpatient units at
10 the Brattleboro Retreat that operate with the support of State funding,
11 regardless of whether a patient is in the custody or temporary custody of the
12 Commissioner.

13 (2) Provide to the Department of Mental Health all certificates of need
14 for emergency involuntary procedures, regardless of whether a patient is in the
15 custody or temporary custody of the Commissioner.

16 (3) Ensure that the mental health patient representative be a regular
17 presenter at the Battleboro Retreat’s employee orientation programming.

18 (c) Patient experience. To the extent feasible, the Department of Mental
19 Health shall meet monthly with the mental health patient representative, the
20 Mental Health Care Ombudsman, and representatives of the Brattleboro
21 Retreat to review patient experiences of care. On or before February 1, 2021,

1 the Department shall report to the House Committee on Health Care and to the
2 Senate Committee on Health and Welfare regarding patient experiences of care
3 at the Brattleboro Retreat.

4 * * * VPharm Coverage Expansion * * *

5 Sec. 6. 33 V.S.A. § 2073 is amended to read:

6 § 2073. VPHARM ASSISTANCE PROGRAM

7 (a) ~~Effective January 1, 2006, the~~ The VPharm program is established as a
8 State pharmaceutical assistance program to provide supplemental
9 pharmaceutical coverage to Medicare beneficiaries. The supplemental
10 coverage under subsection (c) of this section shall provide ~~only~~ the same
11 pharmaceutical coverage as the Medicaid program to enrolled individuals
12 whose income is not greater than ~~150~~ 225 percent of the federal poverty
13 guidelines ~~and only coverage for maintenance drugs for enrolled individuals~~
14 ~~whose income is greater than 150 percent and no greater than 225 percent of~~
15 ~~the federal poverty guidelines.~~

16 (b) Any individual with income ~~no~~ not greater than 225 percent of the
17 federal poverty guidelines participating in Medicare Part D, having secured the
18 low income subsidy if the individual is eligible and meeting the general
19 eligibility requirements established in section 2072 of this title, shall be
20 eligible for VPharm.

21 * * *

1 Sec. 7. SUPPLEMENTAL VPHARM COVERAGE; GLOBAL
2 COMMITMENT WAIVER RENEWAL; RULEMAKING

3 (a) The Agency of Human Services shall request approval from the Centers
4 for Medicare and Medicaid Services to include in Vermont’s Global
5 Commitment to Health Section 1115 Medicaid demonstration renewal an
6 expansion of the VPharm coverage for Vermont Medicare beneficiaries with
7 income between 150 and 225 percent of the federal poverty level (FPL) to be
8 the same as the pharmaceutical coverage under the Medicaid program.

9 (b) Within 30 days following approval of the VPharm coverage expansion
10 by the Centers for Medicare and Medicaid Services, the Agency of Human
11 Services shall commence the rulemaking process in accordance with 3 V.S.A.
12 chapter 25 to amend its rules accordingly.

13 * * * Prior Authorization * * *

14 Sec. 8. 18 V.S.A. § 9418b is amended to read:

15 § 9418b. PRIOR AUTHORIZATION

16 * * *

17 (h)(1) A health plan shall review the list of medical procedures and medical
18 tests for which it requires prior authorization at least annually and shall
19 eliminate the prior authorization requirements for those procedures and tests
20 for which such a requirement is no longer justified or for which requests are
21 routinely approved with such frequency as to demonstrate that the prior

1 authorization requirement does not promote health care quality or reduce
2 health care spending to a degree sufficient to justify the administrative costs to
3 the plan.

4 (2) A health plan shall attest to the Department of Financial Regulation
5 and the Green Mountain Care Board annually on or before September 15 that it
6 has completed the review and appropriate elimination of prior authorization
7 requirements as required by subdivision (1) of this subsection.

8 Sec. 9. PRIOR AUTHORIZATION; ELECTRONIC HEALTH RECORDS;
9 REPORT

10 On or before January 15, 2022, the Department of Financial Regulation, in
11 consultation with health insurers and health care provider associations, shall
12 report to the House Committee on Health Care, the Senate Committees on
13 Health and Welfare and on Finance, and the Green Mountain Care Board
14 opportunities to increase the use of real-time decision support tools embedded
15 in electronic health records to complete prior authorization requests for
16 imaging and pharmacy services, including options that minimize cost for both
17 health care providers and health insurers.

18 Sec. 10. PRIOR AUTHORIZATION; ALL-PAYER ACO MODEL; REPORT

19 The Green Mountain Care Board, in consultation with the Department of
20 Vermont Health Access, certified accountable care organizations, payers
21 participating in the All-Payer ACO Model, health care providers, and other

1 interested stakeholders, shall evaluate opportunities for and obstacles to
2 aligning and reducing prior authorization requirements under the All-Payer
3 ACO Model as an incentive to increase scale, as well as potential opportunities
4 to waive additional Medicare administrative requirements in the future. On or
5 before January 15, 2022, the Board shall submit the results of its evaluation to
6 the House Committee on Health Care and the Senate Committees on Health
7 and Welfare and on Finance.

8 Sec. 11. PRIOR AUTHORIZATION; GOLD CARDING; PILOT
9 PROGRAM; REPORTS

10 (a) On or before January 15, 2022, each health insurer with more than
11 1,000 covered lives in this State for major medical health insurance shall
12 implement a pilot program that automatically exempts from or streamlines
13 certain prior authorization requirements for a subset of participating health care
14 providers, some of whom shall be primary care providers.

15 (b) Each insurer shall make available electronically, including on a publicly
16 available website, details about its prior authorization exemption or
17 streamlining program, including:

18 (1) the medical procedures or tests that are exempt from or have
19 streamlined prior authorization requirements for providers who qualify for the
20 program;

21 (2) the criteria for a health care provider to qualify for the program;

1 (3) the number of health care providers who are eligible for the program,
2 including their specialties and the percentage who are primary care providers;
3 and

4 (4) whom to contact for questions about the program or about
5 determining a health care provider’s eligibility for the program.

6 (c) On or before January 15, 2023, each health insurer required to
7 implement a prior authorization pilot program under this section shall report to
8 the House Committee on Health Care, the Senate Committees on Health and
9 Welfare and on Finance, and the Green Mountain Care Board:

10 (1) the results of the pilot program, including an analysis of the costs
11 and savings;

12 (2) prospects for the health insurer continuing or expanding the
13 program;

14 (3) feedback the health insurer received about the program from the
15 health care provider community; and

16 (4) an assessment of the administrative costs to the health insurer of
17 administering and implementing prior authorization requirements.

18 Sec. 12. PRIOR AUTHORIZATION; PROVIDER EXEMPTIONS; REPORT

19 On or before September 30, 2021, the Department of Vermont Health
20 Access shall provide findings and recommendations to the House Committee
21 on Health Care, the Senate Committees on Health and Welfare and on Finance,

1 and the Green Mountain Care Board regarding clinical prior authorization
2 requirements in the Vermont Medicaid program, including:

3 (1) a description and evaluation of the outcomes of the prior
4 authorization waiver pilot program for Medicaid beneficiaries attributed to the
5 Vermont Medicaid Next Generation ACO Model;

6 (2)(A) for each service for which Vermont Medicaid requires prior
7 authorization:

8 (i) the denial rate for prior authorization requests; and

9 (ii) the potential for harm in the absence of a prior authorization
10 requirement;

11 (B) based on the information provided pursuant to subdivision (A) of
12 this subdivision (2), the services for which the Department would consider:

13 (i) waiving the prior authorization requirement; and

14 (ii) exempting from prior authorization requirements those health
15 care professionals whose prior authorization requests are routinely granted;

16 (3) the results of the Department’s current efforts to engage with health
17 care providers and Medicaid beneficiaries to determine the burdens and
18 consequences of the Medicaid prior authorization requirements and the
19 providers’ and beneficiaries’ recommendations for modifications to those
20 requirements;

