TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 721 entitled "An act relating to expanding access to Medicaid and Dr. Dynasaur" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. SHORT TITLE

This act shall be known and may be cited as the "Medicaid Expansion Act of 2024."

Sec. 2. FINDINGS

The General Assembly finds that:

(1) Medicaid is a comprehensive public health insurance program, funded jointly by state and federal governments. Vermont's Medicaid program currently covers adults with incomes up to **138** percent of the federal poverty level (FPL), children up to 19 years of age from families with incomes up to **317** percent FPL, and pregnant individuals with incomes up to **213** percent FPL.

(2) States may customize their Medicaid programs with permission from the federal government through waivers and demonstrations. Vermont is the only state in the nation that operates its entire Medicaid program under a

1 comprehensive statewide demonstration, called the Global Commitment to
2 Health, that offers the same services to residents in all regions of the State.
3 (3) Vermont's unique Medicaid program provides comprehensive
4 coverage for a full array of health care services, including primary and
5 specialty care; reproductive and gender-affirming care; hospital and surgical
6 care; prescription drugs; long-term care; mental health, dental, and vision care;
7 disability services; substance use disorder treatment; and some social services
8 and supportive housing services.
9 (4) There are no monthly premiums for most individuals covered under
10 Vermont's Medicaid program, and co-payments are minimal or nonexistent for
11 most Medicaid coverage. For example, the highest co-payment for
12 prescription drugs for a Medicaid beneficiary is just $3.00.
13 (5) Close to one-third of all Vermonters, including a majority of all
14 children in the State, have coverage provided through Vermont Medicaid,
15 making it the largest health insurance program in Vermont.
16 (6) In 2021, the six percent uninsured rate for Vermonters who had an
17 annual income between 251 and 350 percent FPL was double the three percent
18 overall uninsured rate. And for those 45 to 64 years of age, the estimated
19 number of uninsured Vermonters increased more than 50 percent over the
20 previous three years, from 4,900 uninsured in 2018 to 7,400 in 2021.

1 (7) Cost is the primary barrier to health insurance coverage for
2 uninsured Vermonters. More than half (51 percent) of uninsured individuals
3 identify cost as the only reason they do not have insurance.
4 (8) During the COVID-19 public health emergency, the uninsured rate
5 for Vermonters with incomes just above Medicaid levels (between 139 and
6 200 percent FPL) fell from six percent in 2018 to two percent in 2021. This
7 drop was due in large part to the federal Medicaid continuous coverage
8 requirement, which allowed individuals to remain on Medicaid throughout the
9 pandemic even if their incomes rose above the Medicaid eligibility threshold.
10 A majority of Vermonters (56 percent) with incomes between 139 and
11 200 percent FPL were on Medicaid in 2021.
12 (9) The end of the public health emergency and the beginning of the
13 federally required Medicaid "unwinding" means that many of these
14 Vermonters are losing their comprehensive, low- or no-cost Medicaid health
15 coverage.
16 (10) Almost nine in 10 (88 percent) insured Vermonters visited a doctor
17 in 2021, compared with just 48 percent of uninsured Vermonters. Insured
18 Vermonters are also significantly more likely to seek mental health care than
19 uninsured Vermonters (34 percent vs. 21 percent).
20 (11) Marginalized populations are more likely than others to forgo
21 health care due to cost. Vermonters who are members of gender identity

1 minority groups are the most likely not to receive care from a doctor because
2 they cannot afford to (12 percent). In addition, eight percent of each of the
3 following populations also indicated that they are unlikely to receive care
4 because of the cost: Vermonters under 65 years of age who have a disability,
5 Vermonters who are Black or African American, and Vermonters who are
6 LGBTQ.

7 (12) Many Vermonters under 65 years of age who have insurance are
8 considered "underinsured," which means that their current or potential future
9 medical expenses are more than what their incomes can bear. The percentage
10 of underinsured Vermonters is increasing, from 30 percent in 2014 to
11 37 percent in 2018 and to 40 percent in 2021.

12 (13) Vermonters 18 to 24 years of age are the most likely to be
13 underinsured among those under 65 years of age, with 37 percent or
14 38,700 young adults falling into this category.

15 (14) The highest rates of underinsurance are among individuals with the
16 lowest incomes, who are just over the eligibility threshold for Medicaid.
17 Among Vermonters under 65 years of age, 43 percent of those earning 139–
18 150 percent FPL and 49 percent of those earning 151–200 percent FPL are
19 underinsured.

20 (15) Underinsured Vermonters 18 to 64 years of age spend on average
21 approximately 2.5 times more on out-of-pocket costs than fully insured

1 individuals, with an average of $4,655.00 for underinsured adults compared
2 with less than $1,900.00 for fully insured individuals.
3 (16) Individuals with lower incomes or with a disability who turn
4 65 years of age and must transition from Medicaid to Medicare often face what
5 is known as the "Medicare cliff" or the "senior and disabled penalty" when
6 suddenly faced with paying high Medicare costs. Individuals with incomes
7 between $14,580.00 and $21,876.00 per year, and couples with incomes
8 between $19,728.00 and $29,580.00 per year, can go from paying no monthly
9 premiums for Medicaid or a Vermont Health Connect plan to owing hundreds
10 of dollars per month in Medicare premiums, deductibles, and cost-sharing
11 requirements.
12 (17) The Patient Protection and Affordable Care Act, Pub. L. No. 111-
13 148, allows young adults to remain on their parents' private health insurance
14 plans until they reach 26 years of age. The same option does not exist under
15 Dr. Dynasaur, Vermont's public children's health insurance program
16 established in accordance with Title XIX (Medicaid) and Title XXI (SCHIP) of
17 the Social Security Act, however, so young adults who come from families
18 without private health insurance are often uninsured or underinsured.
19 (18) In order to promote the health of young adults and to increase
20 access to health care services, the American Academy of Pediatrics
21 recommends that coverage under Medicaid and SCHIP, which in Vermont

1 means Dr. Dynasaur, be made available to all individuals from 0 to 26 years of
2 age.
3 **Sec. 3. DEPARTMENT OF VERMONT HEALTH ACCESS;**
4 **TECHNICAL ANALYSIS; REPORTS**
5 **(a) The Agency of Human Services, in collaboration with interested**
6 **stakeholders, shall undertake a technical analysis relating to expanding**
7 **access to Medicaid and Dr. Dynasaur, to rates paid to health care**
8 **providers for delivering services to individuals on Medicaid and Dr.**
9 **Dynasaur, and to the structure of Vermont's health insurance markets.**
10 **(b) The technical analysis relating to expanding access to Medicaid and**
11 **Dr. Dynasaur shall examine the feasibility of; consider the need for one or**
12 **more federal waivers or one or more amendments to Vermont's Global**
13 **Commitment to Health Section 1115 demonstration, or both, for; develop**
14 **a proposed implementation timeline and estimated costs of**
15 **implementation for; and estimate the programmatic costs of, each of the**
16 **following:**
17 **(1) expanding eligibility for Medicaid for adults who are 26 years of**
18 **age or older but under 65 years of age and not pregnant to individuals**

1 **with incomes at or below 317 percent of the federal poverty level (FPL) by**
2 **2030;**
3 **(2) expanding eligibility for Dr. Dynasaur to all Vermont residents**
4 **up to 26 years of age with incomes at or below 317 percent FPL by 2030;**
5 **(3) amending Vermont's Medicaid state plan to expand eligibility**
6 **for Dr. Dynasaur to all Vermont residents up to 21 years of age with**
7 **incomes at or below 317 percent FPL as soon as reasonably practicable;**
8 **(4) expanding eligibility for Dr. Dynasaur to all pregnant**
9 **individuals with incomes at or below 317 percent by 2030;**
10 **(5) expanding eligibility for the Immigrant Health Insurance Plan**
11 **established pursuant to 33 V.S.A. chapter 19, subchapter 9 to all**
12 **individuals up to 65 years of age with incomes up to 317 percent FPL who**
13 **have an immigration status for which Medicaid or Dr. Dynasaur is not**
14 **available; and**
15 **(6) implementing a proposed schedule of sliding-scale cost-sharing**
16 **requirements for beneficiaries of the expanded Medicaid, Dr. Dynasaur,**
17 **and Immigrant Health Insurance Plan programs.**
18 **(c)(1) The technical analysis relating to Medicaid provider**
19 **reimbursement rates shall include:**

1 **(A) an analysis of the expected enrollment by proposed expansion**
2 **population for each of the programs described in subsection (b) of this**
3 **section;**
4 **(B) an examination of the insurance coverage individuals in each**
5 **proposed expansion population currently has, if any, and the average**
6 **reimbursement rates under that coverage by provider type as a**
7 **percentage of the Medicare rates for the same services;**
8 **(C) an analysis of how current Vermont Medicaid rates compare**
9 **to rates paid to Vermont providers, by provider type, under Medicare and**
10 **average commercial health insurance fee schedules;**
11 **(D) an assessment of how other states' public option and**
12 **Medicaid buy-in programs set provider rates, which providers are**
13 **included, the basis for those rates by provider type, and any available data**
14 **regarding the impacts of those rates on provider participation and patient**
15 **access to care;**
16 **(E) an estimate of the costs to the State, by provider type, if**
17 **providers were reimbursed at 125 percent, 145 percent, and 160 percent of**
18 **Medicare rates, with both primary care and specialty care services**
19 **reimbursed under the Resource-Based Relative Value Scale (RBRVS) fee**
20 **schedule;**

1 **(F) if a fee schedule is benchmarked to Medicare rates, how best**
2 **to structure a methodology that avoids federal Medicare rate cuts while**
3 **ensuring appropriate inflationary indexing;**
4 **(G) an estimate of the costs to the State and an analysis of the**
5 **advantages and disadvantages of benchmarking rates for RBRVS-**
6 **equivalent professional services based on the average commercial health**
7 **insurance rates paid to Vermont providers rather than the Medicare fee-**
8 **for-service physician fee schedule;**
9 **(H) if rate differentials will continue between primary care and**
10 **specialty care services under the RBRVS fee schedule, an estimate of the**
11 **costs of including comprehensive prenatal, labor and delivery,**
12 **postpartum, and psychiatric services under the primary care rate;**
13 **(I) a proposed methodology for comparing Medicaid home health**
14 **and pediatric palliative care rates against Medicare home health**
15 **prospective payment system or Medicare hospice rates;**
16 **(J) a proposed alternative payment methodology for federally**
17 **qualified health centers (FQHCs) that sets a percentage greater than 100**
18 **percent of the Medicare FQHC encounter rate as the minimum encounter**
19 **rate paid to health centers for included Medicaid services, recognizing**
20 **that the Department of Vermont Health Access must pay FQHCs a**

1 **Medicaid prospective payment system rate calculated in accordance with**
2 **Section 1902(bb)(2) of the Social Security Act; and**
3 **(K) a proposed process for annually reviewing Vermont**
4 **Medicaid's reimbursement rates for dental services and evaluating**
5 **progress toward achieving other recommendations detailed in the report**
6 **of the Dental Access and Reimbursement Working Group established**
7 **pursuant to 2019 Acts and Resolves No. 72, Sec. E.306.3.**
8 **(2) As used in this subsection, "provider type" means each category**
9 **of health care provider for which Medicaid maintains a reimbursement**
10 **methodology, including hospital inpatient services; hospital outpatient**
11 **services; professional services reimbursed based on the RBRVS fee**
12 **schedule; services provided by federally qualified health centers and rural**
13 **health centers; suppliers of durable medical equipment, prosthetics,**
14 **orthotics, and supplies; clinical laboratory services; home health services;**
15 **hospice services; pediatric palliative care services; ambulance services;**
16 **anesthesia services; dental services; assistive community care services;**
17 **and applied behavior analysis services.**
18 **(d) The technical analysis relating to Vermont's health insurance**
19 **markets shall include:**
20 **(1) determining the potential advantages and disadvantages to**
21 **individuals, small businesses, and large businesses of modifying Vermont's**

1 **current health insurance market structure, including the impacts on**
2 **health insurance premiums and on Vermonters' access to health care**
3 **services;**
4 **(2) exploring other affordability mechanisms to address the 2026**
5 **expiration of federal enhanced cost-sharing subsidies for plans issued**
6 **through the Vermont Health Benefit Exchange; and**
7 **(3) examining the feasibility of creating a public option or other**
8 **mechanism through which otherwise ineligible individuals or employees of**
9 **small businesses, or both, could buy into Vermont Medicaid coverage.**
10 **(e) The sum of $350,000.00 is appropriated from the General Fund to**
11 **the Agency of Human Services in fiscal year 2025 for the technical**
12 **analysis required by this section.**
13 **(f) On or before January 15, 2025, the Agency of Human Services shall**
14 **submit the technical analysis required by this section to the House**
15 **Committees on Health Care and on Appropriations and to the Senate**
16 **Committees on Health and Welfare, on Finance, and on Appropriations.**
17 **The analysis shall include the feasibility of each item described in**
18 **subsections (b)–(d) of this section; the federal strategy for achieving each**
19 **item, including identification of any necessary federal waivers, the process**
20 **for obtaining such waivers, and the likelihood of approval for each such**
21 **waiver; the costs, both programmatic costs and technological and**

operational costs; a timeline for implementation of each recommended action; and a description of any legislative needs.

Sec. 4. 33 V.S.A. § 1901e is amended to read:

§ 1901e. GLOBAL COMMITMENT FUND

* * *

(c)(1) Annually, on or before October 1, the Agency shall provide a detailed report to the Joint Fiscal Committee that describes the managed care organization's investments under the terms and conditions of the Global Commitment to Health Medicaid Section 1115 waiver, including the amount of the investment and the agency or departments authorized to make the investment.

(2) In addition to the annual report required by subdivision (1) of this subsection, the Agency shall provide the information set forth in subdivisions (A)–(E) of this subdivision annually as part of its budget presentation. The Agency may choose to provide the required information for ~~only a~~ **the** subset of the Global Commitment investments **being independently evaluated** in any one year~~, provided that the Agency shall provide the information for not less than 20 percent of all of the investments in any one year and shall rotate the investments on which it reports such that it provides the information set forth in subdivisions (A)–(F) of this subdivision for each investment at least once every five years~~. The information to be provided shall include:

1 (A) a detailed description of the investment;

2 (B) which Vermonters are served by the investment;

3 (C) the cost of the investment;

4 (D) the efficacy of the investment; **and**

5 (E) ~~the amount of return on the investment, if applicable; and~~

6 ~~(F)~~ where in State government the investment is managed, including

7 the division or office responsible for the management.

8 Sec. 5. 33 V.S.A. § 2031 is amended to read: ***(will be updated)***

9 § 2031. CREATION OF CLINICAL UTILIZATION REVIEW BOARD

10 (a) ~~No later than June 15, 2010, the Department of Vermont Health Access~~

11 ~~shall create a~~ The Clinical Utilization Review Board is established in the

12 Department of Vermont Health Access to examine existing medical services,

13 emerging technologies, and relevant evidence-based clinical practice

14 guidelines and make recommendations to the Department regarding coverage,

15 unit limitations, place of service, and appropriate medical necessity of services

16 in the State's Medicaid programs.

17 (b)(1) The Board shall comprise 10 members with diverse medical

18 experience, to be appointed by the Governor upon recommendation of the

19 Commissioner of Vermont Health Access.

20 (2) The Board shall solicit additional input as needed from individuals

21 with expertise in areas of relevance to the Board's deliberations. The Medical

Director of the Department of Vermont Health Access shall serve as the State's liaison to the Board.

(3) Board member terms shall be staggered, but in no event longer than three years from the date of appointment.

(4) The Board shall meet at least quarterly~~, provided that the Board shall meet no less frequently than once per month for the first six months following its formation~~.

(c) The Board shall have the following duties and responsibilities:

(1) Identify and recommend to the Commissioner of Vermont Health Access opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:

(A) examining high-cost and high-use services identified through the programs' current medical claims data;

(B) reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;

(C) reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;

(D) conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as

appropriate, to identify specific opportunities for exploration and to solicit recommendations;

(E) identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;

(F) determining whether it would be clinically and fiscally appropriate for the Department of Vermont Health Access to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers;

(G) consulting with the Department's Drug Utilization Review Board as appropriate to coordinate Medicaid prescription drug coverage in connection with covered services in order to optimize patient outcomes; and

~~(G)~~(H) considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

(2) Recommend to the Commissioner of Vermont Health Access the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, postservice claim review, and frequency limits. Recommendations shall be consistent with the Department's existing

1 utilization processes, including those related to transparency, timeliness, and
2 reporting. Prior to submitting final recommendations to the Commissioner of
3 Vermont Health Access, the Board shall ensure time for public comment is
4 available during the Board's meeting and identify other methods for soliciting
5 public input.
6 (d) The Commissioner may adopt a mechanism recommended pursuant to
7 subdivision (c)(2) of this section with or without amendment, provided that if
8 the Commissioner proposes to amend the mechanism recommended by the
9 Board, ~~he or she~~ the Commissioner shall request the Board to consider the
10 amendment before the mechanism is implemented or is filed as a proposed
11 administrative rule pursuant to 3 V.S.A. § 838.
12 **Sec. 6. 33 V.S.A. § 2032 is amended to read:**
13 § 2032. ROLE OF DEPARTMENT OF VERMONT HEALTH ACCESS
14 * * *
15 (e) The Department shall conduct comprehensive evaluations of the
16 Board's success in improving clinical and utilization results using claims data
17 and a survey of health care professional satisfaction. The Department shall
18 report annually by January 15 to the House Committee on Health Care and the
19 Senate Committee on Health and Welfare regarding the results of the most
20 recent evaluation or evaluations and a summary of the Board's activities and
21 recommendations since the last report**, including the services reviewed and**

1 **the coverage decisions made**. The provisions of 2 V.S.A. § 20(d) (expiration
2 of required reports) shall not apply to the report to be made under this
3 subsection.

4 * * *

5 Sec. 7. MEDICARE SAVINGS PROGRAMS; INCOME ELIGIBILITY

6 The Agency of Human Services shall make the following changes to the
7 Medicare Savings Programs:

8 (1) increase the Qualified Medicare Beneficiary (QMB) Program
9 income threshold to 150 percent of the federal poverty level (FPL);

10 (2) eliminate the Specified Low-Income Medicare Beneficiary (SLMB)
11 Program; and

12 (3) increase the Qualifying Individual (QI) Program income threshold to
13 185 percent FPL.

14 Sec. 8. MEDICAID STATE PLAN AMENDMENTS

15 (a) The Agency of Human Services shall request approval from the Centers
16 for Medicare and Medicaid Services to amend Vermont's Medicaid state plan
17 to make adjustments to the Medicare Savings Programs as set forth in Sec. 7 of
18 this act.

19 (b) If amendments to Vermont's Medicaid state plan **or to Vermont's**
20 **Global Commitment to Health Section 1115 demonstration, or both,** are
21 necessary to implement any of the other provision of this act, the Agency of

1 Human Services shall seek approval from the Centers for Medicare and
2 Medicaid Services as expeditiously as possible ~~to enable implementation of all~~
3 ~~provisions of this act at the times specified in the act~~.
4 Sec. 9. EFFECTIVE DATES
5 This act shall take effect on passage, except that Sec. 7 (Medicare Savings
6 Programs; income eligibility) shall take effect upon approval by the Centers for
7 Medicare and Medicaid Services of the amendment to Vermont's Medicaid
8 state plan as directed in Sec. 8(a).
9
10
11
12 (Committee vote: ___________)
13 _______________________
14 Representative ___________
15 FOR THE COMMITTEE