H.206

An act relating to miscellaneous changes affecting the duties of the Department of Vermont Health Access

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

Sec. 1. 33 V.S.A. § 1992 is amended to read:

§ 1992. MEDICAID COVERAGE FOR ADULT DENTAL SERVICES

(a) Vermont Medicaid shall provide coverage for medically necessary dental services provided by a dentist, dental therapist, or dental hygienist working within the scope of the provider's license as follows:

(1) Preventive services, including prophylaxis and fluoride treatment, with no co-payment. These services shall not be counted toward the annual maximum benefit amount set forth in subdivision (2) of this subsection.

(2)(A) Diagnostic, restorative, and endodontic procedures, to a maximum of $1,000.00 per calendar year, provided that the Department of Vermont Health Access may approve expenditures in excess of that amount when exceptional medical circumstances so require. Exceptional medical circumstances include emergency dental services, as defined by the Department by rule.

(B) The following individuals shall not be subject to the annual maximum benefit amount set forth in this subdivision (2):

(i) individuals served through the Community Rehabilitation and Treatment and Developmental Disability Services programs pursuant to Vermont's Global Commitment to Health Section 1115 demonstration; and

(ii) Medicaid beneficiaries who are pregnant or in the postpartum eligibility period, as defined by the Department by rule.

(3) Other dental services as determined by the Department by rule.

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Sec. 2. 33 V.S.A. chapter 19, subchapter 1 is amended to read:

Subchapter 1. Medicaid

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§ 1908. MEDICAID; PAYER OF LAST RESORT; RELEASE OF INFORMATION

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(d) On and after July 1, 2016, an insurer shall:

(1) ~~accept~~ Accept the Agency's right of recovery and the assignment of rights and shall not charge the Agency or any of its authorized agents fees for the processing of claims or eligibility requests. Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information that will enable the Agency to determine the existence of third-party coverage for Medicaid recipients, the period during which Medicaid recipients may have been covered by the insurer, and the nature of the

coverage provided, including information such as the name, address, and identifying number of the plan.

(2) If the insurer requires prior authorization for an item or service, accept the Agency's authorization that the item or service is covered under the Medicaid state plan or waiver as if such authorization were the insurer's prior authorization.

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§ 1909. DIRECT PAYMENTS TO AGENCY; DISCHARGE OF INSURER'S OBLIGATION

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(c)(1) An insurer that receives notice that the Agency has made payments to the provider shall pay benefits or send notice of denial directly to the Agency. Receipt of an Agency claim form by an insurer constitutes notice that payment of the claim was made by the Agency to the provider and that form supersedes any contract requirements of the insurer relating to the form of submission.

(2) An insurer shall respond to any request made by the Agency regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of such health care item or service.

(3) An insurer shall not:

(A) deny a claim submitted by the Agency solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if the claim is submitted by the Agency within the three-year period beginning on the date on which the item or service was furnished and any action by the Agency to enforce its rights with respect to a claim is commenced within six years ~~of~~ following the Agency's submission of the claim~~.~~; or

(B) deny a claim submitted by the Agency on the basis of failing to obtain a prior authorization for the item or service for which the claim is being submitted, if the Agency has transmitted authorization that the item or service is covered by the Medicaid state plan or waiver under subdivision 1908(d)(2) of this title.

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Sec. 3. 18 V.S.A. § 4284 is amended to read:

§ 4284. PROTECTION AND DISCLOSURE OF INFORMATION

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(b)(1) The Department shall provide only the following persons with access to query the VPMS:

(A) a health care provider, dispenser, or delegate who is registered with the VPMS and certifies that the requested information is for the purpose

of providing medical or pharmaceutical treatment to a bona fide current patient;

(B) personnel or contractors, as necessary for establishing and maintaining the VPMS;

(C) the Medical Director of the Department of Vermont Health Access and the Director's designee, for the purposes of Medicaid quality assurance, utilization, and federal monitoring requirements with respect to Medicaid recipients for whom a Medicaid claim for a Schedule II, III, or IV controlled substance has been submitted;

(D) a medical examiner or delegate from the Office of the Chief Medical Examiner, for the purpose of conducting an investigation or inquiry into the cause, manner, and circumstances of an individual's death; and

(E) a health care provider or medical examiner licensed to practice in another state, to the extent necessary to provide appropriate medical care to a Vermont resident or to investigate the death of a Vermont resident.

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Sec. 4. FEDERALLY QUALIFIED HEALTH CENTERS; ALTERNATIVE PAYMENT METHODOLOGY; REPORT

The Department of Vermont Health Access shall collaborate with representatives of Vermont's federally qualified health centers (FQHCs) to develop a mutually agreeable alternative payment methodology for Medicaid

payments to the FQHCs. On or before December 15, 2023, the Department shall provide a progress report on the development of the methodology to the House Committee on Health Care and the Senate Committee on Health and Welfare.

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2023.