2014 Health Care- and Human Services-related acts

Act No. 96 (S.27): An act relating to respectful language in the Vermont Statutes Annotated

Changes terminology used in the Vermont Statutes Annotated to refer more respectfully to persons with disabilities and other groups. For example, terms such as "mentally retarded" and "mental illness" were replaced by "intellectual disability" and "mental condition" or "psychiatric disability." The act specifies that changes in terminology shall not be construed to alter the substance or effect of existing law or judicial precedent.

Effective Date: July 1, 2014

Act No. 100 (H.559): An act relating to membership on the Building Bright Futures Council

- Allows designees to attend meetings of the Building Bright Futures Council in the place of the Secretary of Education and the Commissioners of Health, of Mental Health, and for Children and Families.
- Reduces from two to one the number of members from the House, reduces from no more than two to one the number of members from the Senate, and increases the number of at-large members of the Council from 12 to 14.

Effective Date: April 8, 2014

Act No. 104 (H.583): An act relating to the charge of the Vermont Child Poverty Council

- Authorizes Child Poverty Council to meet an unlimited number of times during the legislative session.
- Legislative members of the Council cannot receive compensation or reimbursement for expenses for participation in meetings held during the legislative session, but nonlegislative members who are not otherwise compensated and reimbursed for participation in Council meetings are entitled to compensation and reimbursement for expenses for meetings at all times.

Effective Date: April 14, 2014

Act No. 105 (H.576): An act relating to applications for the Lifeline program

Allows applications for the Lifeline program to be submitted directly to the Department for Children and Families for eligibility determination instead of to the Department of Taxes.

Effective Date: July 1, 2014

Act No. 123 (H.690): An act relating to the definition of serious functional impairment

Specifies that it is the intent of the General Assembly for the correctional designation "serious functional impairment" to apply only to individuals residing in a correctional facility and not to individuals reentering the community after incarceration.

Effective Date: May 9, 2014

Act No. 127 (H.874): An act relating to consent for admission to hospice care and for DNR/COLST orders

- Allows a family member of a patient or a person with a known close relationship to the patient to elect hospice care on the patient's behalf if the patient does not have an agent or guardian or if the agent or guardian is unavailable.
- Delays from July 1, 2014 until July 1, 2016 the deadline for the Department of Health to adopt rules for criteria for someone other than a patient, agent, or guardian to provide informed consent for a do-not-resuscitate (DNR) order or clinician order for life-sustaining treatment (COLST).
- Requires a guardian to obtain court approval before consenting to a COLST, as was already required for a DNR order.

Effective Date: May 10, 2014

Act 131 (H.373): An act relating to updating and reorganizing Title 33

- Updates and reorganizes Title 33 of the Vermont Statutes Annotated. It also moves provisions of law from other titles to Title 33 and from Title 33 to other titles and makes other technical, clarifying, and conforming changes.

Multiple effective dates, beginning on May 20, 2014

Act 134 (H.123): An act relating to Lyme disease and other tick-borne illnesses

- Requires policy statement to be issued to physicians, naturopathic physicians, and advanced practice registered nurses directing them to document the basis for a Lyme disease or other tick-borne illness diagnosis in patients' medical records; to provide information to patients that assist in their understanding of the available Lyme disease tests, the meaning of Lyme disease test results, and any limitations to those test results; and to obtain patients' written informed consent prior to administering long-term treatment for Lyme disease or other tick-borne illness.
- In the absence of misconduct, no disciplinary action against a physician, naturopathic physician, or advanced practice registered nurse solely for use of medical care recognized by the guidelines of the CDC, Infectious Diseases Society of America, or International Lyme and Associated Diseases Society for the treatment of a patient's Lyme disease or other tick-borne illness symptoms.
- Commissioner of Health to report in 2015 and 2016 on trends in the spread of Lyme disease and other tick-borne illnesses throughout Vermont and the Department's public education initiatives to date on the prevention and treatment of these diseases.

Effective Date: July 1, 2014

Act No. 135 (H.217) - An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands

- Prohibits smoking in hotel rooms, designated smoke-free areas of property or grounds owned by or leased to the State of Vermont, and any other area within 25 feet of State-owned buildings and offices.
- Prohibits smoking on the grounds of any hospital or secure residential recovery facility owned or operated by the State.
- Bans the use of electronic cigarettes on public school grounds.
- Prohibits smoking tobacco or electronic cigarettes on the indoor and outdoor premises of a licensed child care center or afterschool program at any time and, for licensed or registered family child care homes when children are present and in care, on the indoor premises and any outdoor area designated for child care.
- Prohibits smoking in a car occupied by a child eight years of age or younger. It also bans the sale of liquid or gel substances containing nicotine in Vermont unless the product is contained in child-resistant packaging.

Multiple effective dates, beginning on July 1, 2014

Act No. 140 (H.728) - An act relating to developmental services' system of care

- Amends Vermont's Developmental Disabilities Act to require certain components of the system of care plan to be adopted by rule instead of by DAIL. Those components include priorities for continuation of existing programs or development of new programs; criteria for receiving services or funding; types of services provided; and the process for evaluating and assessing the success of programs. The Commissioner is required to determine priorities within the system of care plan based upon criteria established in statute.
- Expands existing reporting requirement to direct DAIL to include in its annual report the extent to which principles of service are achieved within the system of care plan and whether people with developmental disabilities have any unmet service needs.

Effective Date: July 1, 2014

Act No. 144 (H.596) - An act relating to miscellaneous amendments to health care laws

This act makes several changes to Vermont's health care laws and requires the Administration to submit a number of reports. It allows small employers and their employees to purchase Vermont Health Benefit Exchange plans through the Exchange website, through navigators, by telephone, or directly from a health insurer. It details the process by which the Department of Financial Regulation (DFR) reviews rates and forms for non-major medical insurance plans and delays for one year the date on which health care providers, health insurers, and other payers must begin using standardized edits and payment rules. The act requires the Agency of Human Services to report by January 15, 2015 on the elements of Green Mountain Care for which the Agency plans to solicit bids for administration, as well as the dates by which it will solicit the bids and award contracts. It directs the Secretary of Administration to submit a conceptual waiver application expressing the State's intent to seek a federal Waiver for State Innovation and the State's interest in beginning the application process. The act requires urgent care clinics to accept patients of

all ages and prohibits them from discriminating against patients or prospective patients based on insurance status or type of health coverage. It requires pharmacy benefit managers to pay pharmacies within 14 days after receiving a claim and to disclose at least annually the amount they retained on prescription claims, and it places restrictions on the co-payment requirements pharmacy benefit managers may impose. The act also repeals legislators' and session-only legislative employees' eligibility to purchase the State Employees Health Benefit Plan at full cost and allows the Green Mountain Care Board to develop and implement global budgeting pilot projects at up to two hospitals.

Multiple effective dates, beginning on May 27, 2014

Act No. 153 (S.234) - An act relating to Medicaid coverage for home telemonitoring services

- Directs AHS to provide Medicaid coverage for home telemonitoring services performed by home health agencies or other qualified providers for Medicaid beneficiaries with certain serious or chronic medical conditions.

Effective Date: July 1, 2014

Act No. X (H.790) - An act relating to Reach Up, Reach Ahead, and the Enhanced Child Care Services Subsidy Program

- Increases the earned income disregard in the Reach Up program from the first $200.00 per month of earnings plus 25 percent of the remaining unsubsidized earnings to the first $250.00 per month of earnings plus 25 percent of the remaining unsubsidized earnings.
- Requires Reach Up case managers to meet with participating families following any statutory or regulatory changes affecting earned income disregard, asset limits, or other eligibility and benefit criteria to inform families of changes and advise them of opportunities to maximize earned income without a corresponding loss of benefits.
- Decreases the Reach Ahead food assistance benefit from $100.00 per month during the first six months of the program to $50.00 per month. It also extends the program from one to two years. During the second year of participation in the Reach Ahead program, families are eligible to receive a food assistance benefit of $5.00 per month and to participate in the enhanced child care subsidy program. The enhanced child care subsidy program is funded with savings resulting from caseload reductions in the Reach Up program and may be suspended or modified in the event there are insufficient savings available.

Multiple effective dates, beginning on July 1, 2014

Act No. X (S.281) - An act relating to vision riders and a choice of providers for vision and eye care services

- Requires health insurance plans to provide a choice of providers for vision and medical eye care services and to reimburse providers the same amount for the same services when provided by either an optometrist or an ophthalmologist.

- Requires health insurers to permit optometrists to participate in vision and medical eye care plans to the same extent as ophthalmologists and prohibits insurers from placing certain requirements on an optometrist or ophthalmologist as a condition for participation in a health insurance or vision plan.
- Ensures that optometrists and ophthalmologists are compensated for the services and materials they provide.

Effective Date: January 1, 2015

Act No. X (S.287) - An act relating to involuntary treatment and medication

- Amends existing provisions pertaining to the judicial processes for involuntary commitment and medication in the context of treating persons with serious mental illness. One significant change established by this act is the event that triggers the emergency examination. Under the act, the emergency examination must occur no later than 24 hours after initial certification rather than one working day after hospital admission. The effect of this change is that a proposed patient cannot be held indefinitely without the commencement of commitment proceedings. The change accelerates the filing of the application for involuntary treatment and appointment of counsel, both of which are contingent upon the emergency examination having occurred.
- Creates a new probable cause review that occurs within three days of the filing of an application for involuntary treatment. This new judicial process is a paper review based on the emergency examination and application for involuntary treatment and does not require a hearing. The application for involuntary treatment cannot be dismissed solely because the review does not occur within three days, if the Court finds good cause for the delay.
- Allows applications for involuntary treatment to be expedited in certain circumstances, meaning that the hearing occurs within 10 days of the order being granted. The Court must expedite applications for involuntary treatment for persons demonstrating a significant risk of causing the person or others serious bodily injury when clinical interventions have failed to address the risk of harm. The Court may expedite applications for involuntary treatment for persons who have received involuntary medication during the past two years, and based on the person's response to treatment, there is good cause to believe that additional time will not result in the person establishing a therapeutic relationship with providers or regaining competence
- In general a hearing on the application for involuntary treatment must occur prior to the filing of an application for involuntary medication. This act creates three circumstances in which the application for involuntary medication can be filed while the application for involuntary treatment is pending. First, if the person's application for involuntary treatment was expedited due to the fact that he or she poses a risk of serious bodily injury, the person's application for involuntary medication may be filed while his or her application for involuntary treatment is pending. Second, the person may waive the right to have a hearing on the application for involuntary treatment prior to the hearing on the application on involuntary medication. Third, if

a person has not had a hearing on the application for involuntary treatment within 26 days of its filing, an application for involuntary medication may be filed if the treating psychiatrist certifies that there is good cause to believe that additional time will not result in the person regaining competence or establishing a therapeutic relationship with providers and serious deterioration of the person's mental condition is occurring.

- When an application for involuntary medication is filed while the application for involuntary treatment is pending due to either the person presenting a risk of serious bodily injury or the hearing not occurring within 26 days, the two applications must be consolidated. However, when consolidation occurs this act requires a decision on the application for involuntary treatment to be rendered before a decision on the application for involuntary treatment.
- Other provisions of note added by this act include the submission of a report by the Commissioner of Mental Health to the Court, Secretary of Human Services, and patient's attorney every time a hearing on an application for involuntary treatment has not occurred within 60 days of its filing and the requirement that clear and convincing evidence that the treatment is appropriate be found prior to a Court order for a long-acting injection. In addition, this act removes the automatic stay on orders for involuntary medication until an appeal is taken.

Multiple effective dates, beginning on July 1, 2014

Act No. X (S.295) - An act relating to pretrial services, risk assessments, and criminal justice programs *(substance abuse provisions only)*

- **Medicaid sanctions:** DVHA to use its authority to sanction Medicaid-participating providers in and out of Vermont for operating in bad faith or not in compliance with State or federal requirements
    - sanctions may include exclusion or suspension from Medicaid, required prior authorizations, 100% review of provider's claims before payment, mandatory attendance at provider info sessions
- **Continued MAT in Corrections**: DOC to implement a one-year pilot project for the continued use of medication-assisted treatment in DOC facilities for detainees and sentenced inmates
    - uses methadone or buprenorphine and prescribed taper for incarcerated persons who were participating in community MAT immediately before incarceration
    - The MOU with Health Dept and "hub" providers must ensure that incarcerated persons who were not receiving MAT prior to incarceration do not receive priority over persons not in DOC custody who are on MAT waiting list
    - DOC must collaborate with Health Dept to provide opioid overdose prevention training for pilot project participants who are incarcerated and to distribute overdose rescue kits with naloxone at correctional facilities for people transitioning from incarceration back into the community
    - DOC and Health Dept to continue the Mediciation-Assisted Treatment for Inmates Work Group and report findings, including proposed schedule for

expansion, to the Corrections Oversight Committee during 2014 interim and to HCI, HHS, HJud, SH&W, and SJud by January 1, 2015

- **VPMS query**: AHS to adopt rules requiring:
  - all Medicaid participating providers in and out of Vermont who prescribe buprenorphine or a drug containing buprenorphine to a Vermont Medicaid beneficiary to query the VPMS the first time they prescribe it to the patient and at regular intervals thereafter
  - all providers licensed in Vermont who prescribe buprenorphine or a drug containing buprenorphine to a Vermont patient who is not on Medicaid to query the VPMS the first time they prescribe it to a patient and at regular intervals thereafter
- **Medication assisted therapy**: Health Dept to adopt rules for MAT for doctors treating fewer than 30 patients, including requirement that their patients are assessed to determine need for counseling and referred for counseling if appropriate
- **Narcan**: Board of Pharmacy to adopt protocols for licensed pharmacists to dispense or otherwise provide naloxone hydrocholoride (Narcan) to patients without a prescription. (Naloxone reverses opioid overdose)
- **DOC and health care reform**:
  - AHS and its departments to help DOC fully enact provisions of the ACA and Vermont's health care reform initiatives as they relate to people in the criminal justice population, including access to HIT, Blueprint, Medicaid enrollment, the Exchange, and other health plans to ensure seamless process for reentry into community or readmission to corrections
  - DOC to include substance abuse and mental health services in its RFP for inmate health services and report to Corrections Oversight Committee during 2014 interim regarding process for selecting inmate health services

Multiple effective dates, beginning on passage