Sec. XX. ~~**STATEWIDE**~~ PRIOR AUTHORIZATION PILOT PROGRAM

(a) The Green Mountain Care Board shall develop and administer a ~~**statewide**~~ pilot program for the purpose of measuring the system savings within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The Board shall also measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care.

(b) In developing and implementing the pilot program, the Board shall collaborate with health care professionals and health insurers**,** throughout the State **or regionally,** to establish two groups:

(1) a control group of health care professionals who shall continue to adhere to prior authorization requirements established and maintained by the health insurers; and

(2) a group of health care professionals~~**, not to exceed 100,**~~ who shall be exempt from the prior authorization requirements selected by the Board for inclusion in the pilot program.

(c) The pilot program shall be in effect from **July 1, 2013** through June 30, 2015. During the term of the pilot program, the Board shall collect data on system savings, provider satisfaction, requests for the selected drugs and

services, and expenditures on the selected drugs and services from the two groups.

(d)(1) On or before **January 15, 2014**, the Board shall submit a preliminary report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance its evaluation of the ~~**statewide**~~ prior authorization pilot program to date. The report shall include findings on the effect of eliminating prior authorization requirements on system savings, provider satisfaction, requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. The report shall also include recommendations regarding whether the program should be continued after June 30, 2015**,** whether the program should be expanded to include more health care providers, **or whether the program should otherwise be modified.**

(2) On or before **September 15, 2015**, the Board shall submit a final report on the results of the ~~**statewide**~~ prior authorization pilot program to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance. The report shall address the Board's findings and recommendations with respect to prior authorization requirements for prescription drugs and health care services.

[Pilot Program: Alternative Approach]

Sec. XX. PRIOR AUTHORIZATION PILOT PROGRAM PROPOSAL

(a) The Green Mountain Care Board shall develop a proposal for implementing a pilot program for the purpose of measuring the system savings within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The program shall be designed to measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. In developing the pilot program proposal, the Board shall collaborate with health care professionals and health insurers throughout the State or regionally.

(b) On or before January 15, 2014, the Board shall submit its pilot program proposal to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. XX. 18 V.S.A. § 9414b is added to read:

§ 9414b. ANNUAL REPORTING BY THE DEPARTMENT OF VERMONT HEALTH ACCESS

(a) The Department of Vermont Health Access shall annually report the following information, in plain language, to the House Committee on Health Care and the Senate Committee on Health and Welfare, as well as posting the information on its website:

(1) the total number of Vermont lives covered by Medicaid;

(2) the total number of claims submitted to the Department for services provided to Medicaid beneficiaries;

(3) the total number of claims denied by the Department;

(4) the total number of denials of service by the Department at the preauthorization level, **the total number of denials that were appealed, and of those, the total number overturned**;

(5) the total number of adverse determinations made by the Department;

(6) the total number of claims denied by the Department because the service was experimental, investigational, or an off-label use of a drug; was not medically necessary; or involved access to a provider that is inconsistent with the limitations imposed by Medicaid;

(7) the total number of claims denied by the Department as duplicate claims, as coding errors, or for services or providers not covered;

(8) the Department's legal expenses related to claims or service denials during the preceding year; and

(9) the effects of the Department's policy of allowing automatic approval of certain prior authorizations on the number of requests for imaging, medical procedures, prescription drugs, and home care.

(b) The Department may indicate the extent of overlap or duplication in reporting the information described in subsection (a) of this section.

(c) To the extent practical, the Department shall model its report on the standardized form created by the Department of Financial Regulation for use by health insurers under subsection 9414a(c) of this title.

(d) The Department of Financial Regulation shall post on its website, in the same location as the forms posted under subdivision 9414a(d)(1) of this title, a link to the information reported by the Department of Vermont Health Access under subsection (a) of this section.