

1 Sec. XX. STATEWIDE PRIOR AUTHORIZATION PILOT PROGRAM

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

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

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

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

19 (c) The pilot program shall be in effect from July 1, 2013 through June 30,
20 2015. During the term of the pilot program, the Board shall collect data on
21 system savings, provider satisfaction, requests for the selected drugs and

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

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

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

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

2 § 9414b. ANNUAL REPORTING BY THE DEPARTMENT OF VERMONT

3 HEALTH ACCESS

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

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

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

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

12 (4) the total number of denials of service by the Department at the
13 preauthorization level;

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

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

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

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

- 1 (9) the effects of the Department’s policy of allowing automatic
2 approval of certain prior authorizations on the number of requests for imaging,
3 medical procedures, prescription drugs, and home care.
- 4 (b) The Department may indicate the extent of overlap or duplication in
5 reporting the information described in subsection (a) of this section.
- 6 (c) To the extent practical, the Department shall model its report on the
7 standardized form created by the Department of Financial Regulation for use
8 by health insurers under subsection 9414a(c) of this title.