115 STATE STREET
MONTPELIER, VT 05633
TEL: (802) 828-2228
FAX: (802) 828-2424

STATE OF VERMONT
GENERAL ASSEMBLY
HOUSE COMMITTEE ON
APPROPRIATIONS

MEMORANDUM

To: Rep. William Lippert, Chair, House Committee on Health Care

From: Rep. Mitzi Johnson, Chair, House Committee on Appropriations

Date: February 2, 2016

Subject: Provisions in the Governor's Proposed FY 2017 Budget

The House Appropriations Committee has started work on the Governor's proposed FY 2017 Budget and would like to inform you about proposals that fall under the jurisdiction of the Health Care committee.

The House Appropriations Committee welcomes and appreciates your input and would like to give you the opportunity to comment on any of the proposals; however, it is not necessary to respond to all of the proposals unless you have concerns or recommendations. If you would like to respond it would be helpful if you could do so by the end of the day on February 24th.

Sec. B.1106 FISCAL YEAR 2017 ONE-TIME FIFTY-THIRD WEEK OF MEDICAID COST FUNDING

(a) In fiscal year 2017, $10,300,000 of general funds, $12,248,000 of federal funds, and $22,548,000 of global commitment funds are appropriated to the Agency of Administration for appropriation transfer to the Agency of Human Services Global Commitment upon determination of the Commissioner of Finance and Management the amount necessary to fund the 53rd week of Medicaid expenditures. Any remaining general funds shall be placed in the 27/53 Reserve established by Sec. B.1107 of this Act.

(b) Upon transfer to the Agency of Human Services Global Commitment, the Agency shall allocate up to $22,548,000 of global commitment funds to appropriations where 53rd week expenditures were incurred.

(c) The Commissioner of Finance and Management shall report to the Joint Fiscal Committee in July 2017 on the status of funds appropriated in this section.

EXPLANATION: One-time appropriation to the Finance and Management to be transferred to the Agency of Human Services to cover costs associated with the 53rd week of Medicaid expenditures.

Sec. B.1107 32 V.S.A. § 308e is added to read:

§ 308e. 27/53 Reserve

(a) There is hereby created within the General Fund Reserve a known as the 27/53 Reserve. The purpose of this reserve is to meet the liabilities of the reoccurring 27th Payroll and the 53rd week of Medicaid Payments. These liabilities will be funded by paying a pro rate portion, each year, before the liability comes due. Beginning in State Fiscal Year 2018 and continuing every year thereafter, a portion of the general fund will be allocated for this purpose.

(1) Annually at the November Joint Fiscal Committee meeting, the Commissioner of Finance and Management will report on the anticipated liability for the next 27th payroll and 53rd week and provide a schedule of annual payments needed to meet the obligation of the next 27th Payroll and 53rd Medicaid payment. At the November meeting the Joint Fiscal Committee will adopt the annual recommended transfer to the 27/53 Reserve.

(b) At the end of the fiscal year, after the full statutory transfer is made to the General Fund Budget Stabilization Reserve, the Commissioner or Finance and Management will transfer funds to the 27/53 reserve up to amount recommended by the Joint Fiscal Committee at the November meeting. This transfer will occur prior to the transfers to the General Fund Balance Reserve outlined in 32. V.S.A. § 308c.

(c) Use of 27/53 Reserve:

(1) In a fiscal year where a 27th payroll or 53rd payroll is incurred, the General Assembly will appropriate the funds in the 27th/53rd Reserve to meet the expenditures within the year that these payments are due.

EXPLANATION: Establishes a reserve within the General Fund specifically for future liabilities associated with the 53rd week of Medicaid payments and the 27th Pay period.

Sec. E.100 EXECUTIVE BRANCH POSITION AUTHORIZATIONS

(a) The establishment of the following new permanent classified positions is authorized in fiscal year 2017 as follows:

(1) In the Department of Vermont Health Access – one (1) Financial Director and two (2) Financial Manager.

EXPLANATION: Additional positions required to assist with the implementation of expanded payroll tax.

(2) In the Green Mountain Care Board – one (1) Healthcare Statistical Information Administrator, one (1) Health Facility Senior Auditor & Rate Specialist, and two (2) Reimbursement Analyst.

EXPLANATION: Additional positions required to assist with the implementation of the All Payer Model.

***

(3) In the Department of Vermont Health Access – one (1) attorney.

EXPLANATION: Additional position required to assist with the implementation of expanded payroll tax. Only 0.5 FTE are funded in the DVHA budget.

(c) The positions established in this section shall be transferred and converted from existing vacant positions in the Executive Branch, and shall not increase the total number of authorized State positions, as defined in Sec. A.107 of this act.

Sec. E.100.2 SHIFT DCF PILOT POSITIONS TO DVHA

(a) Notwithstanding 2015 Act. 179 sec. E.100(d)(3), positions at the Department for Children and Families Health Access Eligibility Unit established through the position pilot established by 2014 Act 179 E.100.1(d) shall transfer to the Department of Vermont Health Access.

EXPLANATION: This language is required to enable the movement to DVHA of those HAEU DCF positions created under the position pilot.

Sec. E.100.4 Funding for the Office of the Health Care Advocate

(a) Of the funds appropriated in Sec. B.100, $ 1,297,406 shall be used for the contract with the Office of the Health Care Advocate.

EXPLANATION: Pursuant to 2015 Act 54 Sec 53 (c)

Sec. E.304 3 V.S.A. § 3091(h) is amended to read:

(h)(1) Notwithstanding subsections (d) and (f) of this section, the Secretary shall review all Board decisions and orders concerning TANF, TANF-EA, office of child support cases, ~~and~~ Medicaid and the Vermont Health Benefit Exchange. The secretary shall:

(A) adopt a Board decision or order, except that the Secretary may reverse or modify a Board decision or order if:

(i) the Board's findings of fact lack any support in the record; or

(ii) the decision or order implicates the validity or applicability of any Agency policy or rule.

(B) issue a written decision setting forth the legal, factual or policy basis for reversing or modifying a Board decision or order.

(2) Notwithstanding subsections (d) and (f) of this section, a Board decision and order concerning TANF, TANF-EA, Office of Child Support, ~~or~~ Medicaid and the Vermont Health Benefit Exchange shall become the final and binding decision of the Agency upon its approval by the Secretary. The Secretary shall either approve, modify or reverse the Board's decision and order within 15 days of the date of the Board decision and order. If the Secretary fails to issue a written decision within 15 days as required by this subdivision, the Board's decision and order shall be deemed to have been approved by the Secretary.

(3) Notwithstanding subsection (f) of this section, only the claimant may appeal a decision of the Secretary to the Supreme Court. Such appeals shall be pursuant to Rule 13 of the Vermont Rules of Appellate Procedure. The Supreme Court may stay the Secretary's decision upon the claimant's showing of a fair ground for litigation on the merits. The Supreme Court shall not stay the Secretary's order insofar as it relates to a denial of retroactive benefits.

EXPLANATION: The Secretary of AHS has final decision-making authority over a HSB decision or order concerning Medicaid. The Secretary may reverse or modify such a decision or order if the HSB's findings of fact lack support in the record or if the decision or order implicates the validity or applicability of an agency policy or rule. The Secretary does *not* have similar authority over VHC cases (e.g., cases concerning the amount of APTC or CSR someone is entitled to receive). The Secretary should have authority to reverse or modify HSB decisions and orders in VHC cases to ensure that the applicable state and federal rules are properly interpreted and applied.

Sec. E.306 18 V.S.A. § 9351 is amended to read:

§ 9351. HEALTH INFORMATION TECHNOLOGY PLAN

* * *

(b) The Health Information Technology Plan shall:

* * *

(5) recommend funding mechanisms for the ongoing development and maintenance costs of a statewide health information system, including funding options ~~and an implementation strategy for a loan and grant program~~;

* * *

(7) integrate the information technology components of the Blueprint for Health established in chapter 13 of this title, the Agency of Human Services' Enterprise Master Patient Index, and all other Medicaid management information systems being developed by the Department of Vermont Health Access, information technology components of the quality assurance system, ~~the program to capitalize with loans and grants electronic medical record systems in primary care practices,~~ and any other information technology initiatives coordinated by the Secretary of Administration pursuant to 3 V.S.A. § 2222a; and

* * *

(c) The Secretary of Administration or designee shall update the plan annually to reflect emerging technologies, the State's changing needs, and such other areas as the Secretary or designee deems appropriate. The Secretary or designee shall solicit recommendations from Vermont Information Technology Leaders, Inc. (VITL) and other entities in order to update the Health Information Technology Plan pursuant to this section, including applicable standards, protocols, and pilot programs, and may enter into a contract or grant agreement with VITL or other entities to update some or all of the Plan. Upon approval by the Secretary, the updated Plan shall be distributed to the Commissioner of Information and Innovation; ~~the Commissioner of Financial Regulation;~~ the Commissioner of Vermont Health Access; the Secretary of Human Services; the Commissioner of Health; the Commissioner of Mental Health; the Commissioner of Disabilities, Aging, and Independent Living; the Senate Committee on Health and Welfare; the House Committee on Health Care; affected parties; and interested stakeholders.

* * *

~~(f) Qualified applicants may seek grants to invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information from federal agencies, including the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the U.S. Department of Agriculture, and the Federal Communications Commission. The Secretary of Administration or designee shall require applicants for grants authorized pursuant to Section 13301 of Title XXX of Division A of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to submit the application for State review pursuant to the process established in federal Executive Order 12372, Intergovernmental Review of Federal Programs. Grant applications shall be consistent with the goals outlined in the strategic plan developed by the Office of the National Coordinator for Health Information Technology and the statewide Health Information Technology Plan.~~

EXPLANATION: The deleted language was included in statute to operationalize a federal program. That federal program has been defunded.

Sec. E.306.1 18 V.S.A. § 9352(h) is amended to read:

~~(h) Loan and grant programs. VITL shall solicit recommendations from the Secretary of Administration or designee, health insurers, the Vermont Association of Hospitals & Health Systems, Inc., the Vermont Medical Society, Bi-State Primary Care Association, the Council of Developmental and Mental Health Services, the Behavioral Health Network, the Vermont Health Care Association, the Vermont Assembly of Home Health Agencies, other health professional associations, and appropriate departments and agencies of State government, in establishing a financing program, including loans and grants, to provide electronic health records systems to providers, with priority given to Blueprint communities and primary care practices serving low~~

~~income Vermonters. Health information technology systems acquired under a grant or loan authorized by this section shall comply with data standards for interoperability adopted by VITL and the State Health Information Technology Plan. An implementation plan for this loan and grant program shall be incorporated into the State Health Information Technology Plan.~~ [Repealed.]

EXPLANATION: The deleted language was included in statute to operationalize a federal program. That federal program has been defunded.

Sec. E.306.2 18 V.S.A. § 706(c) and (d) are amended to read:

(c)(1) The Blueprint payment reform methodologies shall include per-person per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating the community health teams. Per-person per-month payments to practices shall be based on the official National Committee for Quality Assurance's Physician Practice Connections--Patient Centered Medical Home (NCQA PPC-PCMH) score to the extent practicable and shall be in addition to their normal fee-for-service or other payments.

(2) Consistent with the recommendation of the Blueprint expansion design and evaluation committee, the director of the Blueprint may recommend to the Commissioner of the Department of Vermont Health Access ~~implement~~ changes to the payment amounts or to the payment reform methodologies described in subdivision (1) of this subsection, including by providing for enhanced payment to health care professional practices which operate as a medical home, including primary care naturopathic physicians' practices; payment toward the shared costs for community health teams; or other payment methodologies required by the Centers for Medicare and Medicaid Services (CMS) for participation by Medicaid or Medicare.

(3) Health insurers shall modify payment methodologies and amounts to health care professionals and providers as required for the establishment of the model described in sections 703 through 705 of this title and this section, including any requirements specified by the Centers for Medicare and Medicaid Services (CMS) in approving federal participation in the model to ensure consistency of payment methods in the model.

(4) In the event that the secretary of human services is denied permission from the Centers for Medicare and Medicaid Services (CMS) to include financial participation by Medicare, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.

(d) An insurer may appeal a decision ~~of the director~~ to require a particular payment methodology or payment amount to the commissioner of Vermont health access, who shall provide a hearing in accordance with 3 V.S.A. chapter 25. An insurer aggrieved by the decision of the commissioner may appeal to the superior court for the Washington district within 30 days after the commissioner issues his or her decision.

EXPLANATION: The statutory language above has been amended to reflect the fact that the Commissioner of DVHA is responsible for the DVHA budget; any changes to Blueprint payment methodologies should be recommended to and approved by the Commissioner of DVHA.

Sec. E.306.3 2014 Acts and Resolves No.179, Sec. E.306.1 as amended by, 2015 Acts and Resolves No. 58, Sec. E.306, is further amended to read:

Sec. E. 306 EMERGENCY RULES

(a) The Agency of Human Services shall adopt rules pursuant to 3 V.S.A. chapter 25 prior to June 30, ~~2016~~ 2017 to conform Vermont's rules regarding operation of the Vermont Health Benefit Exchange to federal guidance and regulations implementing the provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care

and Education Reconciliation Act of 2010, Pub. L. No. 111-152. The rules shall be adopted to achieve timely compliance with federal laws and guidance and shall be deemed to meet the standard for the adoption of emergency rules required pursuant to 3 V.S.A. § 844(a).

EXPLANATION: This amendment was made to No. 179, Sec. E. 306.1 during the 2015 legislative session (authority was extended to June 30, 2016). Federal rules regulating the operation of the Vermont Health Benefit Exchange will continue to be promulgated after June 30, 2016. Providing an extension to emergency rulemaking authority through the end of SFY 2017 will help to ensure that the State can comply with timelines set in forthcoming federal regulations.

Sec. E.306.6 33 V.S.A. § 1901e(c) is amended to read:

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

EXPLANATION: To specify due date for the report submitted by AHS to the JFC.

Sec. E.306.7 33 V.S.A. § 1908 is amended to read:

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

(a) Any clause in an insurance contract, plan or agreement which limits or excludes payments to a recipient is void.

(b) Medicaid shall be the payer of last resort to any insurer which contracts to pay health care costs for a recipient.

(c) Every applicant for or recipient of Medicaid under this subchapter is deemed to have authorized all third parties to release to the agency all information needed by the agency to secure or enforce its rights under this subchapter. The agency shall inform an applicant or recipient of the provisions of this subsection at the time of application for Medicaid benefits.

(d) ~~At the agency's request, an insurer shall provide the agency with the information necessary to determine whether an applicant or recipient of Medicaid under this subchapter is or was covered by the insurer and the nature of the coverage, including the member, subscriber, or policyholder information necessary to determine third party liability and other information required under 18 V.S.A. § 9410(h). The agency may require the insurer to provide the information electronically.~~ On or after November 1, 2015, any insurer shall 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 as required by 18 V.S.A. § 9410(h). 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 and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided, including the name, address, and identifying number of the plan.

(e)(1) The insurer shall transmit to the Agency, in a manner prescribed by the Centers for Medicare and Medicaid Services or as agreed between insurer and the Agency, an electronic file of all identified subscribers or policyholders, or their dependents, for whom there is data corresponding to the information contained in this section.

(2) An insurer shall comply with a request under the provisions of this subsection no later than sixty (60) days after the date of request by the Agency and shall only be required to provide the Agency with the information required by this section.

(3) The Agency shall request the data from an insurer once every month.

(f)(1) Each insurer shall maintain a file system containing the name, address, group policy number, coverage type, social security number, and date of birth of each subscriber or policyholder, and each dependent of the subscriber or policyholder covered by the insurer, including policy effective and termination dates, claim submission address, and employer's mailing address.

(2) 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 and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided, including the name, address, and identifying number of the plan.

(g) The Agency shall promulgate rules governing the exchange of information under this section. Such rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records including, but not limited to, provisions under the federal Health Insurance Portability and Accountability Act (HIPAA).

~~(e)~~ (h) From funds recovered pursuant to this subchapter, the federal government shall be paid a portion equal to the proportionate share originally provided by the federal government to pay for medical assistance to a recipient or minor.

EXPLANATION: DVHA needs private insurer data files in a Medicaid format that CMS now uses to allow DVHA to determine whether members have private insurance that should pay for medical claims before DVHA pays claims. Further, federal law requires that the state shall provide assurances to the Secretary that it has in effect laws requiring health insurers to provide data regarding who is enrolled in private coverage and dates of coverage and benefits.

Sec. E.306.8 33 V.S.A. § 1904 is added to read:

§ 1904. Confidentiality of Medicaid applications and records; Disclosure to Authorized Representative

(a) All applications and records concerning any applicant or recipient of Medicaid established by chapter 19 of this Title shall be confidential and shall be open to inspection only to persons authorized by the Department, this state, or the United States for purposes directly related to plan administration. In addition, the Department shall maintain a process to allow a Medicaid applicant or recipient or his or her authorized representative to have access to confidential information when necessary for an eligibility determination and the appeals process.

(b) Applications and records considered confidential are those which disclose:

(1) The name and address of the applicant or recipient;

(2) The medical services provided;

(3) The applicant or recipient's social and economic circumstances;

(4) The agency's evaluation of personal information;

(5) The medical data which includes but is not limited to diagnosis and past history of disease and disability; and

(6) Any information received for the purpose of verifying income eligibility and determining the amount of medical assistance payments.

(c) Violation of this statute shall result in an administrative penalty of not more than $1,000.00 for a first violation and not more than $2,000.00 for any subsequent violation.

(d) For purposes of this section:

(1) "Authorized representative" shall mean any person designated by a Medicaid applicant or recipient to review confidential information about the Medicaid applicant or recipient pertaining to the eligibility determination and the appeals process.

(2) "Purposes directly related to plan administration" means establishing eligibility, determining the amount of medical assistance, providing services to recipients, conducting or assisting with an investigation or prosecution, or civil or criminal proceedings in relation to the administration of the State Medicaid Program.

EXPLANATION: Federal law at 42 U.S.C. § 1396a (a)(7) and 42 C.F.R. § 431.301 requires a state statute imposing legal sanctions for the use and disclosure of Medicaid case information, other than for "program purposes." Vermont currently has no such statute.

Sec. E.306.9 33 V.S.A. § 1910(l) is amended to read:

(l) In cases in which the court has determined the amount of recovery allocated for past medical expenses, the Agency's lien shall be limited to that amount. There shall be a presumption that the amount of any recovery allocated for past medical expenses is equal to the amount of the Agency's lien or, if the entire recovery is less than the amount of the Agency's lien, the entire recovery. Any more limited allocation for past medical expenses must be shown by clear and convincing evidence and the burden of proof is on the party challenging the presumption.

EXPLANATION: DVHA proposes to create a rebuttable presumption that some or all of a Medicaid beneficiary's recovery is allocated to medical expenses and therefore available to DVHA during recovery from a third-party to help ease the administrative burden on DVHA associated with third-party liability recoveries.

Sec. E.306.10 33 V.S.A. § 2001(c) is amended to read:

(c) The Commissioner of Vermont Health Access shall report annually on or before ~~August 31~~ October 30 to the Health Reform Oversight Committee concerning the Pharmacy Best Practices and Cost Control Program. Topics covered in the report shall include issues related to drug cost and utilization; the effect of national trends on the pharmacy program; comparisons to other states; and decisions made by the Department's Drug Utilization Review Board in relation to both drug utilization review efforts and the placement of drugs on the Department's preferred drug list.

EXPLANATION: This report is based on State Fiscal Years, a due date of August 31st does not provide sufficient time to collect and process the necessary data, compile the report, and properly review the report before submission. Changing the due date to October 30th allows enough time for data analysis and compilation of the report.

Sec. E.307 INVESTING IN PRIMARY CARE SERVICES

(a) The sum of $8,400,000.00 in Global Commitment funds is appropriated to the Department of Vermont Health Access in fiscal year 2016 to increase reimbursement rates to primary care providers beginning on July 1, 2016 for services provided to Medicaid beneficiaries.

EXPLANATION: This funding will restore the enhanced primary care payments as defined by the Affordable Care Act. These rates were in place from January 1, 2013 to December 31,2014 and were fully funded by Federal dollars. 2015 Act 54, Sec. 57 appropriated $1,000,667 to increase reimbursement rates to Primary Care providers. This funding coupled with the funding from 2015 Act 54 will restore primary care reimbursement rates to pre-December 31, 2014 levels.

Sec. E.307.1 INVESTING IN DENTAL CARE SERVICES

(a)The sum of $2,200,000.00 in Global Commitment funds is appropriated to the Department of Vermont Health Access in fiscal year 2016 to increase reimbursement rates to practicing dentists beginning on July 1, 2016 for preventive services provided to Medicaid beneficiaries.

EXPLANATION: This section provides an 18% increase in reimbursements for preventive dental services including routine care such as restorations, fluoride treatment and cleanings.

Sec. E.312 Health – public health
(a) AIDS/HIV funding:

(1) In fiscal year 2017 and as provided in this section, the Department of Health shall provide grants in the amount of $475,000 in AIDS Medication Rebates special funds to the Vermont AIDS service and peer-support organizations for client-based support services. The Department of Health AIDS Program shall meet at least quarterly with the Community Advisory Group (CAG) with current information and data relating to service initiatives. The funds shall be allocated according to an RFP process.

(2) Ryan White Title II funds for AIDS services and the Vermont Medication Assistance Program (VMAP) shall be distributed in accordance with federal guidelines. The federal guidelines shall not apply to programs or services funded solely by State general funds.

(3)(A) The Secretary of Human Services shall immediately notify the Joint Fiscal Committee if at any time there are insufficient funds in VMAP to assist all eligible individuals. The Secretary shall work in collaboration with persons living with HIV/AIDS to develop a plan to continue access to VMAP medications until such time as the General Assembly can take action.

(B) As provided in this section, the Secretary of Human Services shall work in collaboration with the VMAP Advisory Committee, which shall be composed of no less than 50 percent of members who are living with HIV/AIDS. If a modification to the program's eligibility requirements or benefit coverage is considered, the Committee shall make recommendations regarding the program's formulary of approved medication, related laboratory testing, nutritional supplements, and eligibility for the program.

(4) In fiscal year 2017, the Department of Health shall provide grants in the amount of $100,000 in general funds to Vermont AIDS service organizations and other Vermont HIV/AIDS prevention providers for community-based HIV prevention programs and services. These funds shall be used for HIV/AIDS prevention purposes, including improving the availability of confidential and anonymous HIV testing; prevention work with at-risk groups such as women, intravenous drug users, and people of color; and anti-stigma campaigns. No more than 15 percent of the funds may be used for the administration of such services by the recipients of these funds. The method by which these prevention funds are distributed shall be determined by mutual agreement of the Department of Health and the Vermont AIDS service organizations and other Vermont HIV/AIDS prevention providers.

EXPLANATION: Annual language outlining grants for HIV and AIDS services. Please note that the language above differs from prior years in that the funds "shall be allocated according to an RFP process." In prior years the funds were specifically designated to individual Vermont AIDS service and peer-support organizations. In addition, language in FY 2016 included a sec.(4)(b) which specified that "funding for tobacco cessation and prevention activities in fiscal year 2016 shall include funding for tobacco cessation programs that serve pregnant women."

Thank you for your review and consideration.