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STATE OF VERMONT
GENERAL ASSEMBLY
HOUSE COMMITTEE ON HEALTH CARE

MEMORANDUM

To: Representative Mitzi Johnson, Chair, House Committee on Appropriations

From: Representative Bill Lippert, Chair, House Committee on Health Care

Date: February 26, 2016 -

Subject: Committee on House Health Care FY17 budget recommendations

The House Committee on Health Care appreciates the opportunity to provide recommendations on the FY17 budget proposals. We have (A) reviewed and responded to the sections included in the Committee on Appropriations' February 2, 2016 budget memo and (B) outlined the House Committee on Health Care's budget priorities, as requested. As the House Committee on Appropriations reviews the House Committee on Health Care's recommendations or brings forward additional proposals relating to health care, the House Committee on Health Care would like the opportunity to engage in dialogue and provide further input into the House Committee on Appropriations' decisions.

A. Comments and recommendations on Governor's proposed budget language

The Committee supports some of the proposals, recommends modifications to others, and would like to propose some additional language for inclusion in the budget bill. We have addressed only those sections of the budget language on which we wish to provide feedback; to the extent that we do not comment on a section, our silence should be taken as our acceptance of the proposed language.

Sec. E.100 - Executive Branch Position Authorizations

If the Governor's proposed provider tax increases are not enacted this session, the 3.5 positions requested for the Department of Vermont Health Access (DVHA) in subdivisions (a)(1) and (3) should not be necessary and should be deleted. The Committee supports the Green Mountain Care Board's (GMCB) request for positions to assist with the implementation of the All Payer Model and we have provided additional thoughts about the GMCB and its staffing needs in a later section of this memo. The Committee would caution the Committee on Appropriations, however, to be mindful of the timing of the position requests and the additional positions

approved as part of the FY16 budget but not yet filled, in light of the uncertain implementation timeline for the All Payer Model.

Sec. E.100.4 - Funding for the Office of the Health Care Advocate
Funding for the Office of the Health Care Advocate is a high priority for the Committee, which is addressed in additional legislative language in a later section of this memo.

Sec. E.306.7 - Medicaid as payer of last resort
The Committee took testimony from several interested parties on the proposed amendments to the language on Medicaid as the payer of last resort. We recommend changes to the language included in the Governor's budget proposal, which represents consensus revisions agreed to by DVHA, BlueCross BlueShield of Vermont, and MVP Health Care. The revised language reads as follows:

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 and after July 1, 2016, an 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. 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 the name, address, and identifying number of the plan.

(e)(1) Upon request, to the extent permitted under the federal Health Insurance Portability and Accountability Act and other federal privacy laws and notwithstanding any State privacy law to the contrary, an insurer shall transmit to the Agency, in a manner prescribed by the Centers for Medicare and Medicaid Services or as agreed between the insurer and the Agency, an electronic file of all of the insurer's identified subscribers or policyholders and their dependents.

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

(3) The Agency shall request the data from an insurer once each month. The Agency shall not request subscriber or policyholder enrollment data that precedes the date of the request by more than three years.

(4) The Agency shall use the data collected pursuant this section solely for the purposes of determining whether a Medicaid recipient also has or has had coverage with the insurer providing the data.

(5) The Agency shall ensure that all data collected and maintained pursuant to this section is collected and stored securely and that such data is stored no longer than necessary to determine whether Medicaid benefits may be coordinated with the insurer, or as otherwise required by law. Insurers shall not be liable for any security incidents caused by the Agency in the collection or maintenance of the data.

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

(2) The Agency shall adopt rules governing the exchange of information pursuant to this section. The rules shall be consistent with laws relating to the confidentiality or privacy of personal information and medical records, including the Health Insurance Portability and Accountability Act.

(g) 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.

Sec. E.306.7 - Confidentiality of Medicaid applications and records

The Committee did not take testimony on this section, but our Legislative Counsel recommends a few changes for clarity and to ensure that the confidentiality provisions apply to all departments in the Agency of Human Services that interact with Medicaid beneficiaries, not only DVHA. The recommended language would add a second section related to this topic, and the language would read as follows:

Sec. E.306.7. 33 V.S.A. § 111(a) is amended to read:

(a)(1) The names of or information pertaining to applicants for or recipients of assistance or benefits, including information obtained under section 112 of this title, shall not be disclosed to anyone, except for the purposes directly connected with the administration of the Department or when required by law.

(2) Names of or information pertaining to applicants for or recipients of Medicaid shall be subject to the confidentiality provisions set forth in section 1902 of this title.

Sec. E.306.71. 33 V.S.A. § 1902a is added to read:

§ 1902a. CONFIDENTIALITY OF MEDICAID APPLICATIONS AND RECORDS

(a) All applications submitted and records created under the authority of this chapter concerning any applicant for or recipient of Medicaid are confidential and shall be made available only to persons authorized by the Agency, the State, or the United States for purposes directly related to plan administration. In addition, the Agency 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 that disclose:

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

(2) medical services provided;

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

(4) the Agency's evaluation of personal information;

(5) medical data, including diagnosis and past history of disease or disability; and

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

(c) A person found to have violated this section may be assessed 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) As used in this section:

(1) "Authorized representative" means 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, and civil or criminal proceedings related to the administration of the State Medicaid program.

Sec. E.306.9 - Medicaid liens

The Committee asked the House Committee on Judiciary to consider the language proposed in this section. The Committee has concerns about the potential for the Agency to recover funds in excess of a Medicaid beneficiary's recovery for medical expenses and reserves judgment on the language until the Judiciary Committee has an opportunity to review it when the General Assembly returns during the week of March 7, 2016.

Sec. E.306.10 - Pharmacy Best Practices and Cost Control Program

The Committee supports the change in the reporting date from August 31 to October 30 as recommended in the Governor's budget proposals. The Committee also recommends changing the recipient of the report from the Health Care Oversight Committee and the Health Reform Oversight Committee to the standing committees of jurisdiction, a change consistent with language in H.765, An act relating to technical corrections, which passed the House on February 12, 2016. As further amended, the language would read:

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

§ 2001. LEGISLATIVE OVERSIGHT

(a) In connection with the Pharmacy Best Practices and Cost Control Program, the Commissioner of Vermont Health Access shall report for review by the ~~Health Care Oversight Committee, prior to initial implementation, and~~ House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare prior to any subsequent modifications:

(1) the compilation that constitutes the preferred drug list or list of drugs subject to prior authorization or any other utilization review procedures;

(2) any utilization review procedures, including any prior authorization procedures; and

(3) the procedures by which drugs will be identified as preferred on the preferred drug list, and the procedures by which drugs will be selected for prior authorization or any other utilization review procedure.

(b) The ~~Health Care Oversight Committee~~ Committees shall closely monitor implementation of the preferred drug list and utilization review procedures to ensure that the consumer protection standards enacted pursuant to section 1999 of this title are not diminished as a result of implementing the preferred drug list and the utilization review procedures, including any unnecessary delay in access to appropriate medications. The ~~Committee~~ Committees shall

ensure that all affected interests, including consumers, health care providers, pharmacists, and others with pharmaceutical expertise have an opportunity to comment on the preferred drug list and procedures reviewed under this subsection.

(c) The Commissioner of Vermont Health Access shall report annually on or before ~~August 31~~ October 30 to the ~~Health Reform Oversight Committee~~ House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare 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.

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Sec. E.307 - Investing in primary care services

The Committee understands that an increase in primary care reimbursement rates is a priority that is contingent on revenue from the Governor's proposed increases in the provider tax. While the Committee is supportive of increasing primary care rates, we have identified higher priorities for this budget year and have placed this at number five on our list of priorities.

Sec. E.307.1 - Investing in dental care services

The Committee understands that an increase in dental care reimbursement rates is contingent on revenue from the Governor's proposed increases in the provider tax. The Committee is not prepared to make the increase a priority at this time.

Sec. E. 312 - Public health funding

The Committee will defer to the Committee on Human Services to make recommendations on this section.

Additional comments on Governor's proposed budget language

Prior authorization for outpatient psychotherapy

The Department of Vermont Health Access (DVHA) estimates that it will save $2.2 million by requiring prior authorization for outpatient psychotherapy after 24 visits and asserts that the change is intended to "keep provider payments and methodologies on par with the private insurance community." The private insurance community in Vermont discontinued the use of all prior authorizations for mental health visits in 2014 after new regulations were promulgated under the federal parity law. Vermont's parity law bans the State from establishing visit limits that place a greater burden on access to treatment for a mental condition than on access to treatment for other health conditions. Prior authorization requirements place burdens on access to treatment. Federal parity regulations specifically interpret the use of prior authorization as a barrier to access that is not permitted unless the prior authorization requirements apply across a majority of other services as well. The House Committee on Health Care proposes the following language as an alternative, which is aimed at addressing the same issue and presumes the same projected savings without violating federal and State parity laws:

Sec. X. OUTPATIENT PSYCHOTHERAPY; UTILIZATION REVIEW

Following a Medicaid beneficiary's 20th outpatient psychotherapy visit in the same calendar year, the Department of Vermont Health Access shall review the individual's case to determine whether he or she may benefit from enhanced case management services in order to ensure that the individual is receiving appropriate, high-quality, coordinated care that is tailored to the individual's specific health care needs.

B. House Committee on Health Care priorities

The House Committee on Health Care considers enhanced access to high quality health care in Vermont to be a fundamental public policy priority as outlined in the Act 48 principles. In order to ensure continued implementation of these principles, we have identified four major Committee priorities for the FY17 budget.

1. Access to Medicaid

The Committee's first priority is sustaining Vermont's existing commitment to the Medicaid program, both in its role as a health insurer and in providing financial assistance to qualifying individuals enrolled in the Vermont Health Benefit Exchange. We want to clarify that cost increases in the Medicaid program are not the result of excessive spending on health care services or over-utilization by Medicaid beneficiaries, and do not mean the program's finances are being managed poorly. The main reason for the increase in Medicaid spending is that Vermont is meeting its commitment to increase the number of Vermonters with health care coverage, and the proof is Vermont's uninsured rate, which at 3.7 percent is the second-lowest in the nation.

As a result of the Medicaid coverage expansion made possible under the Affordable Care Act, Vermont now provides Medicaid coverage to adults up to 138 percent of the federal poverty level. It is important to understand that failing to uphold the General Assembly's commitment to Medicaid coverage for the new adult population would leave this group without access to affordable health coverage, because they are ineligible under federal law for financial assistance through the Vermont Health Benefit Exchange. Failure to uphold our commitment could also drive up costs in other areas, including hospital free care and bad debt, overuse of emergency rooms, and even increased pressure on law enforcement.

The Committee believes there may be room for savings in some areas, and we are committed to exploring opportunities for additional short- and long-term savings within the Medicaid program. Examples of these opportunities may include purchasing Medicare supplemental policies for dual eligible individuals and establishing co-payments for the expansion population and for non-emergency use of emergency rooms. The reality of budget pressures mean that there are other priorities that we support but we may not be able to pursue this year despite our recognition of their importance, including rate increases for primary care providers and dentists. We hope and believe that support for our four priority areas, when implemented, will begin to address these important areas of concern.

2. Office of the Health Care Advocate

Another vital element of our commitment to ensuring that Vermonters have access to high-quality health care services is the Office of the Health Care Advocate. The Office of the Health Care Advocate provides services to all Vermonters at no charge, including guidance in

navigating Medicaid and commercial health insurance systems, assistance to individuals in resolving complaints with health insurers, and representation of consumer interests before the General Assembly and the Green Mountain Care Board. Of critical note is its ongoing role in assisting Vermonters who are having trouble with Vermont Health Connect, which would make any reduction in these services this year particularly ill-advised. The adequacy of funding for the Office is frequently uncertain, and loss of federal funding will expose the Office to a loss for FY17 of $160,716 over last year's budget. In order to ensure sufficient funding for the Office of the Health Care Advocate in FY17, including the $160,716, the Committee has forwarded a recommended structure for FY17 funding to the House Committee on Ways and Means and looks forward to their review and analysis.

In order to establish sustainable funding for the Office of the Health Care Advocate into the future, the Committee recommends including the following language in the budget:

Sec. X. HEALTH CARE ADVOCATE FUNDING; REPORT

On or before December 15, 2016, the Director of Health Care Reform in the Agency of Administration shall present to the House Committees on Health Care, on Ways and Means, and on Appropriations and the Senate Committees on Health and Welfare, on Finance, and on Appropriations sustainable funding options for the Office of the Health Care Advocate. In developing the options, the Director of Health Care Reform shall consider the amounts and mechanisms that would be necessary to establish consumer financing for the Office of the Health Care Advocate.

3. Vermont Health Benefit Exchange

It is critical to stabilize the Vermont Health Benefit Exchange and to ensure its long-term sustainability. The Committee on Health Care recommends an analysis to determine the best course of action as follows:

Sec. X. VERMONT HEALTH BENEFIT EXCHANGE TECHNOLOGY; SUSTAINABILITY ANALYSIS; REPORT

(a) The Joint Fiscal Office, through a contract with an independent third party, shall provide a report to the General Assembly on or before December 1, 2016 with its analysis of the near-term functionality and the long-term sustainability of the technology for Vermont's Health Benefit Exchange. This analysis shall provide recommendations for improving the function, efficiency, reliability, operations, and customer experience of the technology going forward. The report shall include an evaluation of the investment value of existing components of the Exchange technology and the contractor's assessment of the feasibility and cost-effectiveness of leveraging existing components of the Vermont Health Benefit Exchange as part of the technology for a larger, integrated eligibility system, including reviewing changes other states have made to the Exchange components of their technology infrastructure. The analysis and report shall provide a comparison of the investments required to ensure a sustainable State-based Exchange through further investment in Vermont Health Connect's current technology, reviewing opportunities to build on other states' Exchange technology, as well as the investments that would be required to transition to a fully or partially federally facilitated Exchange.

(b) The General Assembly shall provide ongoing oversight and review of the analysis and report.

4. Green Mountain Care Board and All-Payer Model

The Committee places a priority on continuing to build the foundation for reform to ensure the long-term sustainability of an accessible, high-quality health care system, which we believe may be achieved through the Green Mountain Care Board's efforts to establish an All-Payer Model. The Committee is also actively developing policy parameters applicable to proceeding with an All-Payer Model. If the All-Payer Model moves forward, it is essential that the Board has adequate staffing to implement it fully. Although Vermont does not yet have an official commitment from the federal government for its participation in the All-Payer Model, the Committee believes that full funding of the Board's staffing request as described in Sec. E.100(a)(2) is appropriate, in addition to the funds for positions carried over from the Board's FY16 budget. The Committee also recommends that the Committee on Appropriations pay attention to the timing of the development of the All-Payer Model and remain cognizant of the funds appropriated in the FY16 and FY17 budgets when considering future funds to appropriate for its implementation.

The Committee on Health Care plans to develop legislation establishing regulatory oversight for the Green Mountain Care Board over accountable care organizations (ACOs) in Vermont, which will continue to exist even if the All-Payer Model does not come to fruition. The Committee, the Board, and others continue to discuss the staffing and other financial requirements this additional regulatory authority would require. The Committee has requested, but not yet received, projections from the Green Mountain Care Board for taking on this additional regulatory responsibility.

Additional health care reform initiatives

Exploring the All-Payer Model is the Committee's main health care reform priority. It is the centerpiece of achieving the so-called "triple aim" of health care: improving population health, improving the patient experience of care, and reducing per capita health care costs.

The Committee also recognizes that increased access to equitable and affordable health care coverage remains important. Even as the All-Payer Model is explored, a majority of the Committee acknowledges that there may be value in the House Committee on Appropriations and the House Committee on Health Care considering the potential expansion of health care coverage for all Vermonters up to age 26 through the Dr. Dynasaur program and/or implementation of universal primary care.

Additional proposals

Housing, homelessness, and health care

The Committee heard compelling testimony about the partnership between the University of Vermont Medical Center and the Champlain Housing Trust that has created options for homeless Vermonters being discharged from the hospital. These investments are reducing emergency room visits and re-hospitalization and seem to be cost-effective. We urge the House Committee on Appropriations to direct the Agency of Human Services, Vermont Housing and Conservation Board, Vermont Housing Finance Agency, and their partners to contract with a national technical assistance provider to help design a comprehensive roadmap to reducing homelessness. We believe there is potential to reduce pressure on the Medicaid budget but need a thorough analysis to fully understand the cost-benefit potential.

Department of Liquor Control compliance plan

The Committee requests that the Committee on Appropriations consider including in the budget the following language, which is designed to improve the tobacco licensees' compliance with the statutory ban on selling tobacco products to minors:

Sec. X. DEPARTMENT OF LIQUOR CONTROL; COMPLIANCE PLAN

The Department of Liquor Control shall develop a detailed plan by which the Department anticipates achieving at least 94 percent compliance in its tests of tobacco licensees' compliance with the prohibition on sales of tobacco products to minors. On or before January 15, 2017, the Department shall submit its plan to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare.