DVHA Language – Medicaid and Exchange Related:

Sec. E.306 2014 Acts and Resolves No. 179, Sec. E.306.1 is amended to read:
Sec. E. 306.1 EMERGENCY RULES
(a) The Agency of Human Services shall adopt rules pursuant to 3 V.S.A. chapter 25 prior to June 30, ~~2015~~ 2016 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: Federal rules regulating the operation of the Vermont Health Benefit Exchange will continue to be promulgated after June 30, 2015. Providing an extension to emergency rulemaking authority through the end of the 2016 state fiscal year will help to ensure that the State can comply with timelines set in forthcoming federal regulations.

Sec. E.307 2013 Acts and Resolves No. 79, Sec. 53(d), as amended by 2014 Acts and Resolves No. 179, Sec. E.307, is further amended to read:
(d) Secs. 31 (Healthy Vermonters) and 32 (VPharm) shall take effect on January 1, 2014, except that the Department of Vermont Health Access may continue to calculate household income under the rules of the Vermont Health Access Plan after that date if the system for calculating modified adjusted gross income for the Healthy Vermonters and VPharm programs is not operational by that date, but no later than December 31, ~~2015~~ 2016.
EXPLANATION: Providing an extension until December 31, 2016 to convert eligibility determination for VPharm and Healthy Vermonters programs to Modified Adjusted Gross Income (MAGI) will help ensure a successful transition process and will avoid unanticipated consequences of converting eligibility methods at a time when the rules for eligibility are still very new and the operability of the system is undergoing improvement daily.

Sec. E.307.1 33 V.S.A. Sec. 2001(c) is amended to read:
(c) The Commissioner of Vermont Health Access shall report ~~quarterly~~ annually on or before August 31 to the Health ~~Care~~ Reform Oversight Committee concerning ~~the following aspects of~~ the Pharmacy Best Practices and Cost Control Program. Topics covered in the report will 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. ~~:~~
~~(1) the efforts undertaken to educate health care providers about the preferred drug list and the Program's utilization review procedures;~~
~~(2) the number of prior authorization requests made; and~~
~~(3) the number of utilization review events (other than prior authorization requests).~~
EXPLANATION: DVHA finds that the quarterly report as required by 33 V.S.A. § 2001(c) is narrow in its scope, and there are many additional areas of pharmacy operations on which DVHA could report that would provide significantly greater insight into the performance of the DVHA's Pharmacy Benefit Program.

Sec. E.307.2 33 V.S.A. Sec. 1901f is amended to read:
Sec. 1901f. Medicaid program enrollment and expenditure reports
By ~~January 30, April 30, July 30~~ March 1, June 1, September 1, and ~~October 30~~ December 1 of each year, the Commissioner of Vermont Health Access or designee shall submit to the General Assembly a quarterly report on enrollment and total expenditures by Medicaid eligibility group for all programs paid for by the Department of Vermont Health Access during the preceding calendar quarter and for the fiscal year to date. Total expenditures for Medicaid-related programs paid for by other departments within the Agency of Human Services shall be included in this report by Medicaid eligibility group to the extent such information is available.
EXPLANATION: DVHA requests that the due dates for the quarterly enrollment and expenditures reports be pushed back one month to allow adequate time for the creation and review of the reports, as the necessary data is not available until the day before the report is currently due.

Cost Shift related Language

Sec. E.307.3 BLUEPRINT FOR HEALTH: PAYMENT INCREASES
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall:
(1) increase payments to the Blueprint for Health's community health teams under section 705 of Title 18 by $541,078 in Global Commitment Funds;
(2) adjust payments for community health teams under section 705 of Title 18 to reflect revised patient attribution and market share of insurers and Medicaid. Payments may be modified as set forth in section 702(b) of Title 18 and insurers shall participate in the new payment amounts as required by section 706 of Title 18. The Department shall increase its payments to reflect increased enrollment in Medicaid by an amount up to $467,833 in Global Commitment Funds.
(b) Beginning January 1, 2016, the Department of Vermont Health Access shall increase payments to primary care medical homes under 18 V.S.A. § 704 by $3,500,000 in Global Commitment Funds.
EXPLANATION: Invests in Blueprint for Health to support primary care, support delivery reform in primary care, and improve health outcomes. Increases payments to Blueprint for Health's community health teams and primary care medical homes. Also, has DVHA adjust insurer payments to reflect new market share, including Medicaid.

Sec. E.307.4 HOME HEALTH: PAYMENT INCREASES
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall modify reimbursement methodologies and amounts to home health agencies as defined in 8 V.S.A. § 4095 to provide prospective payments and to include a quality component and increasing available funding by $1,250,000 in Global Commitment Funds.
EXPLANATION: Begins a payment reform for home health agencies and increases Medicaid reimbursement to home health agencies to invest in better health outcomes.

Sec. E.307.5 HEALTH HOME INVESTMENT
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall increase health home funding by $5,000,000 in Global Commitment Funds to invest in delivery system reform.
EXPLANATION: Invest in better health outcomes through increased funding for health care delivery reform.

Sec. E.307.6 COST SHIFT: INCREASE REIMBURSEMENT TO MEDICARE LEVELS
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall increase reimbursement as follows to address the Medicaid cost shift:
(1) for in-state outpatient services as defined in 42 U.S.C. § 1396d(a)(2) by $10,000,000;
(2) for primary care services by $5,000,000;
(3) for inpatient hospital services as defined in 42 U.S.C. § 1396d(a)(1) for Dartmouth Hitchcock Medical Center by $1,500,000;
(4) for non-primary care professional services as defined in 42 U.S.C. §1396d by $9,000,000.
(b) Beginning July 1, 2015, the Department of Vermont Health Access is appropriated $29,768,988 to account for an increase in Medicaid caseload. This appropriation is included in Sec. B.307 of this act.
EXPLANATION: Increase Medicaid reimbursement and support increased caseload to help address Medicaid cost shift and invest in better health outcomes.

Sec. E.307.7 COST SHIFT ACCOUNTABILITY
(a)(1) In fiscal year 2016 the amount of $25,500,000 in Global Commitment Funds is appropriated in this act to the Agency of Human Services to address health care inflation and reduce costs shifted to private insurers due to the underpayment of health care providers by Medicaid. This amount annualizes to approximately $51,000,000.
(2) In fiscal year 2016 the amount of $29,768,988 in Global Commitment Funds is appropriated in this act to the Agency of Human Services to address Medicaid enrollment and a reduction in the uninsured, which will reduce uncompensated care and bad debt assumed by health care providers. This amount reflects a full year cost.

(3) The Green Mountain Care Board (GMCB) shall account for the impact on the cost shift of these investments through its regulatory authority over hospital budgets and health insurer rates. The GMCB shall include its assessment of the impacts in its annual report as required by 9375(d) of Title 18.
(4) Any hospital service corporation established under chapter 123 of Title 8 and medical service corporation established under chapter 125 of Title 8 shall adjust their reimbursement to health care providers and premiums or administrative fees charged to account for the impact of investing funds in Medicaid provider reimbursement in order to ensure the cost shift is reduced to the fullest extent possible.
EXPLANATION: Directs the Green Mountain Care Board to ensure that the increases in Medicaid reimbursements and for a reduction of the uninsured are accounted for in hospital charges and in private insurance premiums.

Sec. E.307.8 REPEALS
(a) 2000 Acts and Resolves No. 152, Sec. 117b, as amended by 2013 Acts and Resolves No. 79, Sec. 42 is repealed July 1, 2015.
EXPLANATION: Repeals report required by the Department of Vermont Health Access on the cost shift, because the Green Mountain Care Board is required to report on the cost shift by 18 VSA 9375(d).