Introduced by Committee on Health and Welfare

Date:

Subject: Health; health care reform; pharmacy benefit managers; substance abuse; hospitals; Green Mountain Care Board

Statement of purpose of bill as introduced: This bill proposes to establish specific standards by which pharmacy benefit managers would set the maximum allowable cost for prescription drug reimbursement and require health insurers and pharmacy benefit managers to permit plan beneficiaries to fill prescriptions at the pharmacy of their choice. It would create a comprehensive system of care for the administration of substance abuse prevention, intervention, treatment, and recovery services. The bill would require hospitals to provide notice to individuals placed in observation status and to alert individuals receiving observation services about the potential financial implications. It would direct the Agency of Human Services to adopt a prospective payment system for home health agencies for each 60-day episode of care. The bill proposes to require the Green Mountain Care Board to create an online database through which consumers may compare the cost and quality of health care services around the State. It would also require pharmacies to post in the store and online the actual cost of the 20 most commonly prescribed medications. The bill would require updates on the Vermont Health Care Innovation Project, establish a working group to identify

ways to reduce paperwork requirements for health care providers, and direct the Agency of Human Services to identify overlap and duplication in the delivery of services.

An act relating to health care reform, pharmacy benefit managers, price transparency, and a substance abuse system of care

It is hereby enacted by the General Assembly of the State of Vermont:

* * * Pharmacy Benefit Managers * * *

Sec. 1. 18 V.S.A. chapter 79 is amended to read:

CHAPTER 79. PHARMACY ~~AUDITS~~ BENEFIT MANAGERS

Subchapter 1. General

§ 3801. DEFINITIONS

As used in this ~~subchapter~~ chapter:

(1)(A) "Health insurer" shall have the same meaning as in section 9402 of this title and shall include:

(i) a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations;

(ii) an employer, a labor union, or another group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont; and

(iii) except as otherwise provided in section 3805 of this title, the State of Vermont and any agent or instrumentality of the State that offers, administers, or provides financial support to State government.

(B) The term "health insurer" shall not include Medicaid or any other Vermont public health care assistance program.

(2) "Health plan" means a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont.

(3) "Maximum allowable cost" means the per unit drug product reimbursement amount, excluding dispensing fees, for a group of therapeutically and pharmaceutically equivalent multisource generic drugs.

(4) "Pharmacy" means any individual or entity licensed or registered under 26 V.S.A. chapter 36.

~~(4)~~(5) "Pharmacy benefit management" means an arrangement for the procurement of prescription drugs at a negotiated rate for dispensation within this State to beneficiaries, the administration or management of prescription drug benefits provided by a health plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits:

(A) mail service pharmacy;

(B) claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

(C) clinical formulary development and management services;

(D) rebate contracting and administration;

(E) certain patient compliance, therapeutic intervention, and generic substitution programs; and

(F) disease or chronic care management programs.

~~(5)~~(6) "Pharmacy benefit manager" means an entity that performs pharmacy benefit management. The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.

(7) "Price index" means any variable, including average wholesale price, wholesale acquisition cost, or average manufacturer's price, used by a pharmacy benefit manager in determining drug product reimbursement.

~~(6)~~(8) "Responsible party" means the entity, including a health insurer or pharmacy benefit manager, responsible for payment of claims for health care services other than:

(A) the individual to whom the health care services were rendered;

(B) that individual's guardian or legal representative; or

(C) the ~~agency of human services~~ Agency of Human Services, its agents, and contractors.

Subchapter 2. Pharmacy Audits

§ 3802. PHARMACY RIGHTS DURING AN AUDIT

* * *

Subchapter 3. Maximum Allowable Cost

§ 3811. CONTRACT PROVISIONS

Each contract between a pharmacy benefit manager and a contracted pharmacy shall include:

(1) the sources used by the pharmacy benefit manager to calculate the drug product reimbursement rate paid for all covered drugs available under the pharmacy health benefit plan administered by the pharmacy benefit manager;

(2) the price index methodology used to establish the drug product reimbursement rate; and

(3) the process to appeal, investigate, and resolve disputes regarding the drug product reimbursement rate.

§ 3812. MAXIMUM ALLOWABLE COST

For each drug for which a pharmacy benefit manager establishes a maximum allowable cost in order to determine the reimbursement rate, the pharmacy benefit manager shall do all of the following:

(1) Ensure that the drug is available nationwide from at least three manufacturers of Food and Drug Administration Orange Book "AB" rated equivalent multisource drugs.

(2) Ensure that maximum allowable cost applies only when a drug is available for purchase without limitations by all pharmacists in the State from licensed national or regional wholesalers, and that it will not apply if the drug is unavailable for a period of 14 calendar days or more.

(3) Make available, in a format that is readily accessible and understandable by a pharmacist, a list of the drugs subject to maximum allowable cost, the actual maximum allowable cost for each drug, and the source used to determine the maximum allowable cost.

(4) Update the maximum allowable cost list at least once every seven calendar days.

(5) Establish or maintain a reasonable process for an administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable cost as:

(A) not meeting the requirements of this section; or

(B) being below the cost at which the pharmacy obtained or may obtain the drug.

(6)(A) Respond in writing to any appealing pharmacy provider as to the merits of the dispute within seven calendar days after receipt of an appeal. If, upon appeal, the pharmacy benefit manager finds in favor of the appealing pharmacy, the pharmacy benefit manager shall adjust the maximum allowable cost to no less than the actual acquisition cost retroactive to the dispensing date

of the original claim and make adjustments to all similar claims in all pharmacies in the pharmacy benefit manager's network. If, upon appeal, the pharmacy benefit manager finds against the appealing pharmacy, the pharmacy benefit manager shall provide the appealing pharmacy with the National Drug Code of an alternative product on the maximum allowable cost list that is available for purchase without limitations.

(B) If an appealing pharmacy can prove that its actual acquisition cost exceeded the pharmacy benefit manager's maximum allowable cost, the pharmacy benefit manager shall adjust the maximum allowable cost to no less than the actual acquisition cost retroactive to the dispensing date of the original claim. If no maximum allowable cost is available for a drug, the pharmacy benefit manager shall reimburse the pharmacy no less than the proven actual acquisition cost.

Subchapter 4. Benefit Administration

§ 3821. CHOICE OF PHARMACY

(a) A health insurer or pharmacy benefit manager shall permit a plan beneficiary to fill a prescription at the pharmacy of his or her choice and shall not impose differential cost-sharing requirements based on the choice of pharmacy or otherwise promote the use of one pharmacy over another.

(b) A health insurer or pharmacy benefit manager shall not condition the reimbursement for dispensing prescription drugs in any way based on whether

a pharmacy or pharmacist participates in the health insurer's or pharmacy benefit manager's network or other contractual agreement.

* * * Substance Abuse System of Care * * *

Sec. 2. 18 V.S.A. chapter 94 is redesignated to read:

CHAPTER 94. ~~DIVISION OF ALCOHOL AND DRUG ABUSE PROGRAMS~~ SUBSTANCE ABUSE PREVENTION AND CARE

Sec. 3. 18 V.S.A. chapter 94, subchapters 1, 2, 3, and 4 are added to read:

Subchapter 1. System of Care

§ 4811. PRINCIPLES

The General Assembly adopts the following principles pertaining to substance abuse prevention, intervention, treatment, and recovery services:

(1) The State of Vermont's substance abuse system of care shall reflect effectiveness, ease of access, evidence-based practices, and the highest standards of care.

(2) A coordinated continuum of substance abuse prevention, intervention, treatment, and recovery services shall be provided throughout the State, including by the Agency of Human Services, hospitals, preferred providers, alcohol and drug abuse counselors, regardless of whether or not the counselor is affiliated with a preferred provider, and community and peer partners to ensure that services are available to individuals at all stages of addiction.

(3) Programs addressing substance abuse prevention, intervention, treatment, or recovery shall be responsive to changes in demonstrated need, service delivery practices, and funding resources.

(4) To the extent possible, the delivery of substance abuse services shall be integrated into Vermont's health care system.

(5) The delivery of substance abuse services shall be consistent throughout the State in terms of both access to care and the type of services offered.

(6) Recognizing the ongoing challenges and potential for relapse among individuals with a substance abuse disorder, services addressing both episodic and chronic substance abuse disorders shall be accessible throughout the State.

(7) The Commissioners of Health and of Vermont Health Access shall ensure that oversight and accountability are built into all aspects of the system of care for substance abuse services.

§ 4812. DEFINITIONS

As used in this chapter:

(1) "Alcohol and drug abuse counselor" means the same as in 26 V.S.A. chapter 62.

(2) "Alcoholism" means alcohol use disorder as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or its predecessor.

(3) "Approved substance abuse treatment program" means a treatment program which is approved by the Department of Health's Division of Alcohol and Drug Abuse Programs as qualified to provide treatment for substance abuse.

(4) "Client" means a person who receives treatment services from an approved substance abuse treatment program, substance abuse crisis team, or alcohol and drug abuse counselor.

(5) "Detoxification" means the planned withdrawal of an individual from a state of acute or chronic intoxication as described in the placement guidelines of the American Society of Addiction Medication.

(6) "Incapacitated" means that a person, as a result of his or her use of alcohol or other drugs, is in a state of intoxication or of mental confusion resulting from withdrawal such that the person:

(A) appears to need medical care or supervision by approved substance abuse treatment program personnel, as defined in this section, to ensure his or her safety; or

(B) appears to present a direct active or passive threat to the safety of others.

(7) "Intoxicated" means a condition in which the mental or physical functioning of an individual is substantially impaired as a result of the presence of alcohol or other drugs in his or her system.

(8) "Law enforcement officer" means a law enforcement officer certified by the Vermont Criminal Justice Training Council as provided in 20 V.S.A. §§ 2355–2358 or appointed by the Commissioner of Public Safety as provided in 20 V.S.A. § 1911.

(9) "Licensed hospital" means a hospital licensed under chapter 43 of this title.

(10) "Person who abuses alcohol" means a person suffering from the condition of alcoholism.

(11) "Person who abuses drugs or alcohol" means anyone who drinks alcohol or consumes other drugs to an extent or with a frequency that impairs or endangers his or her health or the health and welfare of others.

(12) "Protective custody" means a civil status in which an incapacitated person is detained by a law enforcement officer for the purposes of:

(A) ensuring the safety of the individual or the public, or both; and

(B) assisting the individual to return to a functional condition.

(13) "Secretary" means the Secretary of Human Services or the Secretary's designee.

(14) "Substance abuse" means the misuse of alcohol or other drugs consistent with the description of substance use disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or its predecessor.

(15) "Substance abuse crisis team" means an organization approved by the Secretary to provide emergency treatment and transportation services to persons who abuse drugs or alcohol pursuant to the provisions of this chapter.

(16) "System of care" means the continuum of substance abuse prevention, intervention, treatment, and recovery services offered consistently throughout geographically diverse regions of the State.

(17) "Treatment" means the broad range of medical, detoxification, residential, outpatient, aftercare, care coordination, and follow-up services which are needed by persons who abuse drugs or alcohol and may include a variety of other medical, social, vocational, and educational services relevant to the rehabilitation of these persons.

§ 4813. DIVISION OF ALCOHOL AND DRUG ABUSE PROGRAMS

(a) The Division of Alcohol and Drug Abuse Programs shall plan, operate, and evaluate a consistent, effective, and comprehensive continuum of substance abuse programs. These programs shall coordinate care with Vermont's health, mental health, and human services systems. All duties, responsibilities, and authority of the Division shall be carried out and exercised by and within the Department of Health.

(b) Under the direction of the Commissioner of Health, the Deputy Commissioner of Alcohol and Drug Abuse Programs shall review, approve, and coordinate all alcohol and drug programs developed or administered by

any State agency or department, except for alcohol and drug education programs developed by the Agency of Education in conjunction with the Alcohol and Drug Abuse Council pursuant to 16 V.S.A. § 909.

(c)(1) Any federal or private funds received by the State for purposes of alcohol and drug treatment shall be in the budget of and administered by the Agency of Human Services.

(2) To the extent possible, funds shall be used in a manner that creates a comprehensive and coordinated network of services throughout the State.

(d) With regard to alcohol and drug treatment, the Commissioner of Health may contract with the Secretary of State for the provision of adjudicative services of one or more administrative law officers and other investigative, legal, and administrative services related to licensure and discipline of alcohol and drug abuse counselors.

§ 4814. SYSTEM OF CARE

(a) The Commissioner of Health shall coordinate and supervise a continuum of geographically diverse substance abuse services throughout the State that shall include at least the following:

(1) prevention programming and services, including initiatives to deter substance use among youths;

(2) Screening, Brief Intervention, Referral to Treatment (SBIRT) in health care and human services settings;

(3) treatment, including medicated-assisted treatment, outpatient services by a licensed alcohol and drug abuse counselor regardless of whether the counselor is affiliated with a preferred provider, inpatient and residential services, and transitional housing;

(4) peer recovery services and centers;

(5) coordination of complex care between health, mental health, and human services systems; and

(6) licensure of alcohol and drug abuse counselors pursuant to 26 V.S.A. § 3235.

(b) The Commissioners of Health, of Mental Health, and of Vermont Health Access, in consultation with preferred providers and other community partners, shall develop and implement a plan aimed at creating a cohesive substance abuse system of care in Vermont. The plan shall foster a unified provider network in which providers are reimbursed for comprehensive services that are responsive to patient needs. The plan shall balance the delivery of episodic and chronic treatment services, and case management services shall be available to chronically lapsing patients to ensure consistency in treatment and recovery over time.

§ 4815. REPORTING REQUIREMENTS

The Department of Health, in consultation with the Departments of Mental Health and of Vermont Health Access, shall report annually on or before

January 15 to the Senate Committee on Health and Welfare and to the House Committee on Human Services on the following:

(1) timeliness and extent to which individuals with a substance abuse disorder receive appropriate services;

(2) utilization across the continuum of substance abuse prevention, intervention, treatment, and recovery services and the population served;

(3) individual experience of care and satisfaction;

(4) individual recovery in terms of clinical, social, and legal outcomes;

(5) success rate of each group of providers caring for persons with a substance abuse disorder;

(6) gaps in services or quality of care; and

(7) projection of future needs within the State's substance abuse system of care.

Subchapter 2. Abuse of Alcohol

§ 4821. DECLARATION OF POLICY

(a) It is the policy of the State of Vermont that persons who abuse alcohol are correctly perceived as persons with health and social problems rather than as persons committing criminal transgressions against the welfare and morals of the public.

(b) The General Assembly therefore declares that:

(1) persons who abuse alcohol shall no longer be subjected to criminal prosecution solely because of their consumption of alcoholic beverages or other behavior related to consumption which is not directly injurious to the welfare or property of the public; and

(2) persons who abuse alcohol shall be treated as sick persons and shall be provided adequate and appropriate medical and other humane rehabilitative services congruent with their needs.

§ 4822. AUTHORITY AND ACCOUNTABILITY FOR ALCOHOL ABUSE SERVICES; RULES FOR ACCEPTANCE INTO TREATMENT

(a) The Secretary shall have the authority and accountability for providing or arranging for the provision of a comprehensive system of alcohol abuse prevention and treatment services.

(b) All State funds appropriated specifically for the prevention and treatment of alcohol abuse and any federal or private funds that are received by the State for these purposes shall be in the budget of and be administered by a single governmental unit designated by the Secretary. This provision does not apply to the programs of the Department of Corrections.

(c) The Secretary shall adopt rules and standards pursuant to 3 V.S.A. chapter 25 for the implementation of the provisions of this chapter. In

establishing rules regarding admissions to alcohol treatment programs, the Secretary shall adhere to the following guidelines:

(1) A client shall be initially assigned or transferred to outpatient treatment, unless he or she is found to require medical treatment, detoxification, or residential treatment.

(2) A person shall not be denied treatment solely because he or she has withdrawn from treatment against medical advice on a prior occasion or because he or she has relapsed after earlier treatment.

(3) An individualized treatment plan shall be prepared and maintained on a current basis for each client.

(4) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a program or a form of treatment shall have other appropriate treatments available.

Subchapter 3. Alcohol and Drug Abuse Treatment Council

§ 4831. ALCOHOL AND DRUG ABUSE TREATMENT COUNCIL

(a) Creation. There is created an alcohol and drug abuse treatment council to foster coordination and integration of substance abuse services across the substance abuse system of care.

(b) Membership. The Council shall be composed of the following ten members:

(1) the Secretary of Human Services or designee;

(2) the Deputy Commissioner of the Department of Health's Division of Alcohol and Drug Abuse Programs;

(3) the Commissioner of Mental Health or designee;

(4) the Commissioner of Vermont Health Access or designee;

(5) the Director of the Blueprint or designee;

(6) a representative of the preferred providers, appointed by the Governor;

(7) two licensed alcohol and drug abuse counselors serving different regions of the State, appointed by the Governor;

(8) a high school administrator or practicing teacher involved in substance abuse prevention services, appointed by the Governor; and

(9) a member of the peer community involved in recovery services, appointed by the Governor.

(c) Report. Annually on or before January 15, the Council shall submit a written report to the House Committee on Human Services and to the Senate Committee on Health and Welfare with its findings and any recommendations for legislative action.

(d) Meetings.

(1) The Secretary of Human Services shall call the first meeting of the Council to occur on or before September 1, 2015.

(2) The Council shall select a chair and vice chair from among its members at the first meeting.

(3) A majority of the membership shall constitute a quorum.

(e) Reimbursement. Members of the Council who are not employees of the State of Vermont and who are not otherwise compensated or reimbursed for their attendance shall be entitled to per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010 for no more than four meetings annually.

§ 4832. ADMINISTRATIVE SUPPORT

The Agency of Human Services shall provide the Council with such administrative support as is necessary for it to accomplish the purposes of this chapter.

§ 4833. POWERS AND DUTIES

The Council shall assess substance abuse services and service delivery in the State, including the following:

(1) the effectiveness of existing substance abuse services in Vermont and opportunities for improved treatment; and

(2) strategies for enhancing the coordination and integration of substance abuse services across the system of care.

Subchapter 4. Law Enforcement and Incarceration

§ 4841. TREATMENT AND SERVICES

(a) When a law enforcement officer encounters a person who, in the judgment of the officer, is intoxicated as defined in section 4812 of this title, the officer may assist the person, if he or she consents, to his or her home, to an approved substance abuse treatment program, or to some other mutually agreeable location.

(b) When a law enforcement officer encounters a person who, in the judgment of the officer, is incapacitated as defined in section 4812 of this title, the person shall be taken into protective custody by the officer. The officer shall transport the incapacitated person directly to an approved substance abuse treatment program with detoxification capabilities, or to the emergency room of a licensed general hospital for treatment, except that if a substance abuse crisis team or an alcohol and drug abuse counselor exists in the vicinity and is available, the person may be released to the team or counselor at any location mutually agreeable between the officer and the team or counselor. The period of protective custody shall end when the person is released to a substance abuse crisis team, an alcohol and drug abuse counselor, a clinical staff person of an approved substance abuse treatment program with detoxification capabilities, or a professional medical staff person at a licensed general hospital emergency room. The person may be released to his or her own

devices if, at any time, the officer judges him or her to be no longer incapacitated. Protective custody shall in no event exceed 24 hours.

(c) If an incapacitated person is taken to an approved substance abuse treatment program with detoxification capabilities and the program is at capacity, the person shall be taken to the nearest licensed general hospital emergency room for treatment.

(d) A person judged by a law enforcement officer to be incapacitated, and who has not been charged with a crime, may be lodged in protective custody in a secure facility not operated by the Department of Corrections for up to 24 hours or until judged by the person in charge of the facility to be no longer incapacitated, if and only if:

(1) the person refuses to be transported to an appropriate facility for treatment or, if once there, refuses treatment or leaves the facility before he or she is considered by the responsible staff of that facility to be no longer incapacitated; or

(2) no approved substance abuse treatment program with detoxification capabilities and no staff physician or other medical professional at the nearest licensed general hospital can be found who will accept the person for treatment.

(e) A person shall not be lodged in a secure facility under subsection (d) of this section without first being evaluated and found to be indeed incapacitated

by a substance abuse crisis team, an alcohol and drug abuse counselor, a clinical staff person of an approved substance abuse treatment program with detoxification capabilities, or a professional medical staff person at a licensed general hospital emergency room.

(f) Except for a facility operated by the Department of Corrections, a lockup facility shall not refuse to admit an incapacitated person in protective custody whose admission is requested by a law enforcement officer, in compliance with the conditions of this section.

(g) Notwithstanding subsection (d) of this section, a person under 18 years of age who is judged by a law enforcement officer to be incapacitated and who has not been charged with a crime shall not be held at a lockup facility or community correctional center. If needed treatment is not readily available, the person shall be released to his or her parent or guardian. If the person has no parent or guardian in the area, arrangements shall be made to house him or her according to the provisions of 33 V.S.A. chapter 53. The official in charge of an adult jail or lockup facility shall notify the Deputy Commissioner of Alcohol and Drug Abuse Programs of any person under 18 years of age brought to an adult jail or lockup facility pursuant to this chapter.

(h) If an incapacitated person in protective custody is lodged in a secure facility, his or her family or next of kin shall be notified as promptly as

possible. If the person is an adult and requests that there be no notification, his or her request shall be respected.

(i) A taking into protective custody under this section is not an arrest.

(j) Law enforcement officers, persons responsible for supervision in a secure facility, members of a substance abuse crisis team, and alcohol and drug abuse counselors who act under the authority of this section are acting in the course of their official duty and are not criminally or civilly liable therefor, unless for gross negligence or willful or wanton injury.

§ 4842. INCARCERATION FOR INEBRIATION PROHIBITED

A person who has not been charged with a crime shall not be incarcerated in a facility operated by the Department of Corrections on account of the person's inebriation.

Sec. 4. SUBSTANCE ABUSE SYSTEM OF CARE PLAN

On or before January 15, 2016, the Commissioners of Health, of Mental Health, and of Vermont Health Access shall present the plan developed pursuant to 18 V.S.A. § 4814(b) to the Senate Committee on Health and Welfare and to the House Committee on Human Services. The Commissioners shall also update the Committees on their respective Departments' progress implementing the plan to date.

Sec. 5. SUBSTANCE ABUSE REPORT; DATA SETS AND BENCHMARKS

On or before November 15, 2015, the Commissioner of Health shall submit a report to the Chairs of the Senate Committee on Health and Welfare and of the House Committee on Human Services identifying those data sets necessary to respond to the reporting requirements in 18 V.S.A. § 4815, and identifying which data sets, if any, overlap with existing data collection by the Department or providers. The Commissioner shall also identify any other benchmarks pertaining to the substance abuse system that will enable members of the General Assembly better assess the system.

Sec. 6. REPORT; SUBSTANCE ABUSE PREVENTION IN SCHOOLS

On or before January 15, 2016, the Secretary of Education shall report to the Senate Committee on Health and Welfare and to the House Committee on Human Services regarding:

(1) the status of the comprehensive health education program as it pertains to substance abuse;

(2) all other Agency initiatives aimed at preventing or treating substance abuse among students; and

(3) recommendations as to whether separating academic and support services offered by substance abuse prevention counselors in schools would be cost-effective and improve student outcomes.

Sec. 7. REPORT; SERVICES FOR MENTAL HEALTH, SUBSTANCE ABUSE, AND CO-OCCURRING DISORDERS

On or before January 15, 2016, the Department of Mental Health and the Department of Health's Division of Alcohol and Drug Abuse Programs, in consultation with stakeholders, shall survey and report on those services provided to individuals with a mental health, substance abuse, or co-occurring disorder by designated agencies and the Blueprint for Health's community health teams. The report shall:

(1) catalogue services for individuals with mental health, substance abuse, and co-occurring disorders to identify where, if any, gaps in services or overlapping services exist;

(2) propose any structural changes necessary to foster a collaborative relationship between the designated agencies and community health teams; and

(3) survey the relative pay scales of providers employed by the designated agencies and community health teams by provider type and county.

* * * Notice of Hospital Observation Status * * *

Sec. 8. 18 V.S.A. § 1905 is amended to read:

§ 1905. LICENSE REQUIREMENTS

Upon receipt of an application for license and the license fee, the licensing agency shall issue a license when it determines that the applicant and hospital facilities meet the following minimum standards:

* * *

(22) All hospitals shall provide oral and written notice to each individual that the hospital places in observation status as required by section 1911a of this title.

Sec. 9. 18 V.S.A. § 1911a is added to read:

1911a. NOTICE OF HOSPITAL OBSERVATION STATUS

(a) Each hospital shall provide oral and written notice to each individual that the hospital places in observation status as soon as possible but no later than 24 hours following such placement, unless the individual is discharged or leaves the hospital before the 24-hour period expires. The written notice shall be a uniform form developed by the Department of Health for use in all hospitals.

(b) Each oral and written notice shall include:

(1) a statement that the individual is under observation as an outpatient and is not admitted to the hospital as an inpatient;

(2) a statement that observation status may affect the individual's Medicare, Medicaid, or private insurance coverage for hospital services, including medications and pharmaceutical supplies, and for rehabilitative services at a skilled nursing facility if needed upon discharge from the hospital; and

(3) a statement that the individual may contact his or her health insurance provider, the Office of the Health Care Advocate, or the Vermont State Health Insurance Assistance Program to understand better the implications of placement in observation status.

(c) Each written notice shall include the name and title of the hospital representative who gave oral notice, the date and time oral notice was given, and contact information for the Office of the Health Care Advocate and the Vermont State Health Insurance Assistance Program.

(d) Oral and written notice shall be provided in a manner that is understood by the individual placed in observation status or by his or her legal guardian or authorized representative.

(e) Each written notice shall be signed and dated by the individual placed in observation status, or if applicable by his or her legal guardian or authorized representative, to verify receipt and an understanding of the oral and written notice.

* * * Prospective Payments for Home Health Services * * *

Sec. 10. FINDINGS

The General Assembly finds that:

(1) In Vermont, the State reimburses home health agencies over $34 million annually in Medicaid fee-for-service payments.

(2) In October 2000, the federal Centers for Medicare and Medicaid Services adopted a prospective payment system for Medicare that pays home health agencies a predetermined rate for each 60-day episode of home health care regardless of the number of visits the patient receives during that period.

(3) Medicare's prospective payment system provides home health agencies with incentives to provide the appropriate level of care to achieve positive outcomes for Medicare patients.

(4) Vermont Medicaid's fee-for-service model encourages more services instead of more efficient services.

(5) Home health services reimbursed under the Vermont Medicaid program are currently delivered in a manner that limits the services clients may receive.

(6) Losses at Vermont's home health agencies are becoming unsustainable because Medicaid reimbursement rates are far below the cost of delivering services.

(7) A Medicaid prospective payment system model will support Vermont's payment reform efforts by providing more flexible, integrated, and improved services to clients, reducing administrative costs at home health agencies, and containing costs while providing greater financial predictability to home health agencies and to the State.

Sec. 11. 33 V.S.A. § 1901h is added to read:

§ 1901h. PROSPECTIVE PAYMENT; HOME HEALTH SERVICES

(a) On or before January 1, 2016, the Agency of Human Services shall implement a prospective payment system to replace the fee-for-service system for home health agencies that provide services under Medicaid, including nursing, therapies, licensed nursing assistants, nutritionists, and hospice care; that provide pediatric rehabilitation services, including physical therapy, occupational therapy, and speech-language pathology; and that provide services under the Choices for Care program.

(b) The prospective payment system shall:

(1) pay home health agencies a predetermined rate for each 60-day episode of home health care, which shall be adjusted annually for inflation;

(2) be budget neutral;

(3) not adjust payments based on patient acuity;

(4) not limit the number of episodes of care;

(5) eliminate the need for prior authorization for pediatric rehabilitation services;

(6) establish risk corridors of three percent, such that if a home health agency's profits exceed three percent, the excess shall be paid to the Agency of Human Services or placed in a flexible fund for new or noncovered services,

while if a home health agency's losses exceed three percent, the Agency of Human Services shall pay the difference to the home health agency; and

(7) require home health agencies to report data to the Agency of Human Services to evaluate the prospective payment system payment methodology, including:

(A) details of each episode, including identifying patient visits by discipline and providing the name of the certifying physician, the date on which care began, and the primary diagnosis;

(B) costs reflecting revenue from services rendered under the prospective payment system, the home health agency's total expenses, and gains and losses;

(C) information regarding health outcomes; and

(D) monitoring and reporting on acute care hospitalization, emergency care, and nursing home admissions using existing internal and external resources.

(c) As used in this section, "home health agency" means an entity that has received a certificate of need from the State to provide home health services and is certified to provide services pursuant to 42 U.S.C. § 1395x(o).

* * * Consumer Access to Health Care Cost Information * * *

Sec. 12. 18 V.S.A. § 9410a is added to read:

§ 9410a. HEALTH CARE QUALITY AND PRICE COMPARISON

(a)(1) The Green Mountain Care Board shall establish a website allowing health care consumers to compare the price of medical care in Vermont by insurance plan and by service or procedure, including office visits, emergency care, radiologic services, and preventive care such as mammography and colonoscopy, as well as comparing the cost of prescription drugs. The website shall also enable consumers to compare quality across providers. The Board may develop and administer the comparison website itself or through a contract with a third party.

(2) The website shall allow a consumer to compare price by selecting a specific service or procedure, insurance plan, and geographic region of the State. Based on the criteria specified, the website shall provide the consumer with an estimate for each provider of the amount the consumer would pay for the service or procedure, an estimate of the amount the insurance would pay, and an estimate of the combined payments.

(3) For consumers without health insurance or who choose to compare costs without selecting an insurance plan, the website shall provide the average cost for the service or procedure in the specified geographic region.

(b) Cost data for the comparison website shall be derived from the unified health care database established in section 9410 of this title.

(c) The Department of Vermont Health Access shall ensure that the website for the Vermont Health Benefit Exchange includes a prominently placed link to the comparison website established by this section to allow health care consumers to make informed decisions about the health care services they receive.

Sec. 13. 18 V.S.A. § 4634 is amended to read:

§ 4634. PRESCRIPTION DRUG PRICE DISCLOSURE

(a) Upon request, a pharmacy shall disclose to any consumer or health care provider the usual and customary retail price of a prescription drug.

(b) With each prescription dispensed, a pharmacy shall disclose to the consumer, in writing, the price of the prescription and any payment toward the price required of the consumer.

(c) Each pharmacy shall display on or near the pharmacy counter and on the pharmacy website, if any, the usual and customary retail price of the 20 most commonly prescribed prescription medications dispensed at that pharmacy, as well as the average price for each of those prescription medications.

(d) ~~For purposes of~~ As used in this section:

(1) "Price of the prescription" means the amount charged by the pharmacy to the consumer or, if applicable, to the consumer's health benefit plan.

(2) "Usual and customary retail price" means the total price charged to a consumer who does not have prescription drug coverage under a health benefit plan.

~~(d)~~(e) In addition to any other remedy provided by law, the ~~attorney general~~ Attorney General may file an action in ~~superior court~~ Superior Court for a violation of this section. In any such action, the ~~attorney general~~ Attorney General shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Protection Act, 9 V.S.A. chapter 63. Each violation of this section constitutes a separate civil violation for which the ~~attorney general~~ Attorney General may obtain relief.

* * * Reports * * *

Sec. 14. VERMONT HEALTH CARE INNOVATION PROJECT; UPDATES

The Project Director of the Vermont Health Care Innovation Project (VHCIP) shall provide an update at least quarterly to the House Committees on Health Care and on Ways and Means, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee

regarding VHCIP implementation and the use of the federal State Innovation Model (SIM) grant funds. The Project Director's update shall include information regarding:

(1) the VHCIP pilot projects and other initiatives undertaken using SIM grant funds, including a description of the projects and initiatives, the timing of their implementation, the results achieved, and the replicability of the results;

(2) how the VHCIP projects and initiatives fit with other payment and delivery system reforms planned or implemented in Vermont;

(3) how the VHCIP projects and initiatives meet the goals of improving health care access and quality and reducing costs;

(4) how the VHCIP projects and initiatives will reduce administrative costs;

(5) how the VHCIP projects and initiatives compare to the principles expressed in 2011 Acts and Resolves No. 48;

(6) what will happen to the VHCIP projects and initiatives when the SIM grant funds are no longer available; and

(7) how to protect the State's interest in any health information technology functions, processes, or other intellectual property developed through the VHCIP.

Sec. 15. REDUCING PAPERWORK; WORKING GROUP

(a) The Green Mountain Care Board, in coordination with the Agency of Human Services, shall convene a working group to evaluate the information requirements of the quality and satisfaction surveys and other forms required by Medicare, the Blueprint for Health, accountable care organizations, the federal Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant, adverse childhood experience surveys, and other programs and initiatives.

(b) The working group shall recommend strategies for aligning survey questions and other required forms across programs and initiatives in order to reduce the administrative burden on health care providers in completing all of the required surveys and forms. It shall also establish a process to ensure that future surveys and forms are aligned across programs and initiatives, to the extent that doing so is within the State's control.

(c) On or before December 1, 2015, the working group shall report its recommendations to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee.

Sec. 16. REDUCING DUPLICATION OF SERVICES; REPORT

(a) The Agency of Human Services shall evaluate the services offered by each entity licensed, administered, or funded by the State, including the

designated agencies, to provide services to individuals receiving home- and community-based long-term care services or who have developmental disabilities, mental health needs, or substance use disorder. The Agency shall determine areas in which programs or services are overlapping, duplicative, or otherwise not delivered in the most efficient and cost-effective manner and shall develop recommendations for consolidation or other modification to maximize high-quality services, efficiency, and appropriate use of public funds.

(b) On or before January 15, 2016, the Agency shall report its findings and recommendations to the House Committee on Human Services and the Senate Committee on Health and Welfare.

* * * Repeals * * *

Sec. 17. REPEALS

(a) 18 V.S.A. §§ 4801–4807 (Division of Alcohol and Drug Abuse Programs) are repealed on July 1, 2015.

(b) 18 V.S.A. § 4808 (treatment and services) is repealed on July 1, 2017.

* * * Effective Dates * * *

Sec. 18. EFFECTIVE DATES

(a) Sec. 1 (pharmacy benefit managers) shall take effect on passage.

(b) Secs. 2–7 (substance abuse system of care) act shall take effect on July 1, 2015, except 18 V.S.A. §§ 4841 (treatment and services) and 4842 (incarceration for inebriation prohibited) shall take effect on July 1, 2017.

(c) Secs. 8 and 9 (notice of hospital observation status) shall take effect on July 1, 2015.

(d) Secs. 10 and 11 (prospective payments for home health services) shall take effect on passage.

(e) Secs. 12 and 13 (consumer access to health care cost information) shall take effect on passage. The Green Mountain Care Board shall ensure the website required by Sec. 1 is operational on or before October 1, 2015, and pharmacies shall display the information required by Sec. 2 on or before July 1, 2015.

(f) Secs. 14–16 (reports), 17 (repeals) and this section shall take effect on passage.