No. 25. An act relating to Next Generation Medicaid ACO pilot project reporting requirements.

(H.507)

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

Sec. 1. NEXT GENERATION MEDICAID ACO PILOT PROJECT REPORTS

(a) On or before June 15, September 15, and December 15, 2017, the Department of Vermont Health Access shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, the Green Mountain Care Board, and the Office of the Health Care Advocate written updates on the implementation of the Next Generation Medicaid ACO pilot using a reporting template developed by the Department in consultation with the Office of Legislative Council and the Joint Fiscal Office. The updates shall include the following information:

(1) the amount of Medicaid funds provided by the Department to the accountable care organization in each of the three months preceding the month of the report, except that for the June report, the Department shall report the amount of Medicaid funds provided in each month since the beginning of the pilot;

(2) the amount of funds expended by the accountable care organization on behalf of attributed Medicaid beneficiaries in each of the three months preceding the month of the report, except that for the June report, the

Department shall report the amount of funds expended on behalf of attributed Medicaid beneficiaries in each month since the beginning of the pilot;

(3) the extent to which the accountable care organization has met the quality indicators specified in the Next Generation Medicaid ACO pilot project agreement signed on February 1, 2017 for which quarterly data is available;

(4) the extent to which the Department and the accountable care organization have met the reporting benchmarks identified in the Department's Next Generation Medicaid ACO Year 1 (2017) Operational Timeline;

(5) to the extent data is available, a comparison of:

(A) utilization of health care services by service category and by care management level for the Medicaid population attributed to the ACO during the pilot year with the utilization of services for the same population in prior years; and

(B) utilization of health care services by service category and by care management level for the Medicaid population attributed to the ACO during the pilot year with the utilization of services for Medicaid beneficiaries not attributed to the ACO;

(6) statistical information regarding the numbers and topics of patient and provider complaints, grievances, and appeals for attributed Medicaid beneficiaries and participating providers, as well as any available information regarding patient and provider satisfaction with the pilot;

(7) current information on the size of the participating provider network since the beginning of the pilot and since the previous report, if applicable; and

(8) any change in the size of the Medicaid population attributed to the ACO since the beginning of the pilot and since the previous report, if applicable.

(b) In addition to the written updates required by subsection (a) of this section, the Department of Vermont Health Access shall provide testimony on implementation of the Next Generation Medicaid ACO pilot project at a meeting of the Health Reform Oversight Committee at least once every two months or more frequently if so requested by the Committee. The testimony shall include the information specified in subsection (a) of this section, as well as any other information the Department deems relevant to the Committee's oversight of the pilot project during the 2017 legislative interim. The Committee shall also provide an opportunity for the Office of the Health Care Advocate to testify at the same meetings as the Department regarding issues related to the pilot project, including information on complaints, grievances, and appeals reported to or requiring investigation or other action by the Office.

Sec. 2. ALL-PAYER MODEL AND ACCOUNTABLE CARE ORGANIZATION REPORTS

On or before June 15, September 15, and December 15, 2017, the Green Mountain Care Board shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate

Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, and the Office of the Health Care Advocate written updates on the Board's progress in meeting the benchmarks identified in the Board's Year 0 (2017) All-Payer ACO Model Timeline regarding implementation of the All-Payer Model and the Board's preparations for regulating accountable care organizations.

Sec. 3. 2016 Acts and Resolves No. 165, Sec. 6 is amended to read:

Sec. 6. OUT-OF-POCKET PRESCRIPTION DRUG LIMITS; 2018 PILOT; REPORTS

(a) The Department of Vermont Health Access shall convene an advisory group to develop options for bronze-level qualified health benefit plans to be offered on the Vermont Health Benefit Exchange for the 2018 and 2019 plan ~~year~~ years, including:

(1) one or more plans with a higher out-of-pocket limit on prescription drug coverage than the limit established in 8 V.S.A. § 4089i; and

(2) two or more plans with an out-of-pocket limit at or below the limit established in 8 V.S.A. § 4089i.

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(c)(1) The advisory group shall meet at least six times prior to the Department submitting plan designs to the Green Mountain Care Board for approval.

(2) In developing the standard qualified health benefit plan designs for the 2018 and 2019 plan ~~year~~ years, the Department of Vermont Health Access shall present the recommendations of the advisory committee established pursuant to subsection (a) of this section to the Green Mountain Care Board.

(d)(1) Prior to the date on which qualified health plan forms must be filed with the Department of Financial Regulation pursuant to 8 V.S.A. § 4062, a health insurer offering qualified health benefit plans on the Vermont Health Benefit Exchange shall seek approval from the Green Mountain Care Board to modify the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more nonstandard bronze-level plans. In considering an insurer's request, the Green Mountain Care Board shall provide an opportunity for the advisory group established in subsection (a) of this section, and any other interested party, to comment on the recommended modifications.

(2)(A) Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the Green Mountain Care Board may approve modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more bronze-level plans for the 2018 and 2019 plan ~~year~~ years only.

(B) For the 2018 and 2019 plan ~~year~~ years, the Department of Vermont Health Access shall certify at least two standard bronze-level plans that include the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, as long as the plans comply with federal requirements. Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the

Department may certify one or more bronze-level qualified health benefit plans with modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for the 2018 and 2019 plan ~~year~~ years only.

(e)(1)(A) For each individual enrolled in a bronze-level qualified health benefit plan for plan years 2016 and 2017 who had out-of-pocket prescription drug expenditures during the 2016 plan year that met the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, the health insurer shall, absent an alternative plan selection or plan cancellation by the individual, automatically reenroll the individual in a bronze-level qualified health benefit plan for plan year 2018 with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i.

(B) For each individual enrolled in a bronze-level qualified health benefit plan for plan years 2017 and 2018 who had out-of-pocket prescription drug expenditures during the 2017 plan year that met the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, the health insurer shall, absent an alternative plan selection or plan cancellation by the individual, automatically reenroll the individual in a bronze-level qualified health benefit plan for plan year 2019 with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i.

(2) Prior to reenrolling an individual in a plan pursuant to subdivision (1) of this subsection, the health insurer shall notify the individual of the insurer's intent to reenroll ~~automatically~~ the individual automatically in a

bronze-level qualified health benefit plan for the forthcoming plan year ~~2018~~ with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i unless the individual contacts the insurer to select a different plan, and of the availability of bronze-level plans with higher out-of-pocket prescription drug limits. The health insurer shall collaborate with the consumer organization members of the advisory group established in subsection (a) of this section as to the notification's form and content.

(f)(1) The Director of Health Care Reform in the Agency of Administration, in consultation with the Department of Vermont Health Access and the Office of Legislative Council, shall determine whether the Secretary of the U.S. Department of Health and Human Services has the authority under 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 (ACA), to waive annual limitations on out-of-pocket expenses or actuarial value requirements for bronze-level plans, or both. On or before October 1, 2016, the Director shall present information to the Health Reform Oversight Committee regarding the authority of the Secretary of the U.S. Department of Health and Human Services to waive out-of-pocket limits and actuarial value requirements, the estimated costs of applying for a waiver, and alternatives to a waiver for preserving the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

(2) If the Director of Health Care Reform determines that the Secretary has the necessary authority, then on or before March 1, ~~2017~~ 2019, the Commissioner of Vermont Health Access, with the Director's assistance, shall apply for a waiver of the cost-sharing or actuarial value limitations, or both, in order to preserve the availability of bronze-level qualified health benefit plans that meet Vermont's out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

(g) On or before February 15, 2017, the Department of Vermont Health Access shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) an overview of the cost-share increase trend for bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange for the 2014 through 2017 plan years that were subject to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i;

(2) detailed information regarding lower cost-sharing amounts for selected services that will be available in bronze-level qualified health benefit plans in the 2018 and 2019 plan ~~year~~ years due to the flexibility to increase the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i pursuant to subdivision (d)(2) of this section;

(3) a comparison of the bronze-level qualified health benefit plans offered in the 2018 and 2019 plan ~~year~~ years in which there will be flexibility

in the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i with the plans in which there will not be flexibility;

(4) information about the process engaged in by the advisory group established in subsection (a) of this section and the information considered to determine modifications to the cost-sharing amounts in all bronze-level qualified health benefit plans for the 2018 and 2019 plan ~~year~~ years, including prior year utilization trends, feedback from consumers and health insurers, Health Benefit Exchange outreach and education efforts, and relevant national studies;

(5) cost-sharing information for standard bronze-level qualified health benefit plans from states with federally facilitated exchanges compared to those on the Vermont Health Benefit Exchange; and

(6) an overview of the outreach and education plan for enrollees in bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange.

(h) On or before February 1, 2018, the Department of Vermont Health Access shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) enrollment trends in bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange; and

(2) recommendations from the advisory group established pursuant to subsection (a) of this section regarding ~~continuation of the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i~~:

(A) whether there is a need for flexibility in the design of bronze-level plans on the Vermont Health Benefit Exchange for plan years after plan year 2019; and

(B) if there is a continued need for flexibility in the design of bronze plans, options for enabling that flexibility without limiting or eroding the value or availability of the protection afforded by the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

Sec. 4. EFFECTIVE DATE

This act shall take effect on passage.

Date Governor signed bill: May 4, 2017