Prior authorization/administrative workload provisions 2011-2016

18 V.S.A. § 9374(e)(3) (added by 2016 Act and Resolves No. 113, Sec. 9):

(3) To the extent funds are available, the Board may examine, on its own or through collaboration or contracts with third parties, the effectiveness of existing requirements for health care professionals, such as quality measures and prior authorization, and evaluate alternatives that improve quality, reduce costs, and reduce administrative burden.

2016 Acts and Resolves No. 113, Sec. 10:

Sec. 10. PRIMARY CARE PROFESSIONAL ADVISORY GROUP

(a) The Green Mountain Care Board shall establish a primary care professional advisory group to provide input and recommendations to the Board. The Board shall seek input from the primary care professional advisory group to address issues related to the administrative burden facing primary care professionals, including:

(1) identifying circumstances in which existing reporting requirements for primary care professionals may be replaced with more meaningful measures that require minimal data entry;

(2) creating opportunities to reduce requirements for primary care professionals to provide prior authorization for their patients to receive radiology, medication, and specialty services; and

(3) developing a uniform hospital discharge summary for use across the State.

(b) The Green Mountain Care Board shall provide an update on the advisory group's work in the annual report the Board submits to the General Assembly in accordance with 18 V.S.A. § 9375(d).

(c) The Board may seek assistance from organizations representing primary care professionals. Members of the advisory group who are not State employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year. The advisory group shall cease to exist on July 1, 2018.

2016 Acts and Resolves No. 112, Sec. 1:

Sec. 1. GREEN MOUNTAIN CARE BOARD; PERFORMANCE MEASURES

The Green Mountain Care Board, in consultation with the Agency of Human Services and the Vermont Medical Society, shall survey and catalogue all existing performance measures required of primary care providers in Vermont, including the Centers for Medicare and Medicaid Services' quality measures. The Board shall develop a plan to align performance measures across programs that impact primary care. The plan's goal shall be to reduce the administrative burden of reporting requirements for providers while balancing the need to evaluate quality of and access to care adequately. The Board shall

submit the plan to the Senate Committee on Health and Welfare and to the House Committee on Health Care on or before January 15, 2017.

18 V.S.A. § 9377a (added by 2013 Acts and Resolves No. 79, Sec. 40a):

§ 9377a. PRIOR AUTHORIZATION PILOT PROGRAM

(a) The Green Mountain Care Board shall develop and implement a pilot program or programs for the purpose of measuring the change in system costs within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The program shall be designed to measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. In developing the pilot program proposal, the Board shall collaborate with health care professionals and health insurers throughout the State or regionally.

(b) The Board shall submit an update regarding implementation of prior authorization pilot programs as part of its annual report under subsection 9375(d) of this title.

18 V.S.A. § 9418b (last substantial revision was in 2012 Acts and Resolves No. 171, Sec. 11h, which added subsec. (g)):

§ 9418b. PRIOR AUTHORIZATION

* * *

(c) A health plan shall furnish, upon request from a health care provider, a current list of services and supplies requiring prior authorization.

(d) A health plan shall post a current list of services and supplies requiring prior authorization to the insurer's website.

* * *

(g)(1) Notwithstanding any provision of law to the contrary, on and after March 1, 2014, when requiring prior authorization for prescription drugs, medical procedures, and medical tests, a health plan shall accept for each prior authorization request either:

(i) the national standard transaction information, such as HIPAA 278 standards, for sending or receiving authorizations electronically; or

(ii) a uniform prior authorization form developed pursuant to subdivisions (2) and (3) of this subsection.

(B) A health plan shall have the capability to accept both the national standard transaction information and the uniform prior authorization forms developed pursuant to subdivisions (2) and (3) of this subsection.

(2)(A) No later than September 1, 2013, the Department of Financial Regulation shall develop a clear, uniform, and readily accessible prior authorization form for prior authorization requests for medical procedures and medical tests.

(B) No later than September 1, 2013, the Department of Financial Regulation shall develop clear, uniform, and readily accessible forms for prior authorization requests for prescription drugs after determining the appropriate number of forms.

(3) Each uniform prior authorization form developed pursuant to subdivision (2) of this subsection shall meet the following criteria, where applicable:

(A) The form shall include the core set of common data requirements for nonclinical information for prior authorization included in the HIPAA 278 standard transaction, national standards for prior authorization and electronic prescriptions, or both. The Department shall revise the form as needed to ensure that national standards are adopted and incorporated as soon as such standards are available and final.

(B) The form shall be made available electronically by the Department and by the health plan.

(C) The completed form or its data elements may be submitted electronically from the prescribing health care provider to the health plan.

(D) The Department shall develop the form in consultation with the Department of Vermont Health Access and with input from interested parties from at least one public meeting.

(E) The Department shall consider input on the proposed form from the national ASC X-12 workgroup, if available.

(F) In developing the uniform prior authorization forms, the Department shall take into consideration the following:

(i) existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services, by the Department of Vermont Health Access, and by insurance and Medicaid departments and agencies in other states; and

(ii) national standards related to electronic prior authorization.

(4) A health plan shall respond to a completed prior authorization request from a prescribing health care provider within 48 hours for urgent requests and within two business days of receipt for non-urgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If a health plan does not, within the time limits set forth in this section, respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information, the prior authorization request shall be deemed to have been granted.

2011 Acts and Resolves No. 51, Sec. 4:

Sec. 4. ELECTRONIC PRIOR AUTHORIZATION

The commissioner of Vermont health access and the Vermont information technology leaders (VITL), in collaboration with health insurers, prescribers, representatives of the independent pharmacy community, and other interested parties, shall evaluate the use of electronic means for requesting and granting prior authorization for prescription drugs. No later than January 15, 2012, the commissioner and VITL shall report their findings to the senate committee on health and welfare and the house committee on health care and make recommendations for processes to develop standards for electronic prior authorizations.

(Link to report: http://legislature.vermont.gov/assets/Documents/Reports/276572.PDF)

2011 - 18 V.S.A. § 9491 (added by 2011 Acts and Resolves No. 48, Sec. 12a):

§ 9491. HEALTH CARE WORKFORCE; STRATEGIC PLAN

(a) The director of health care reform in the agency of administration shall oversee the development of a current health care workforce development strategic plan that continues efforts to ensure that Vermont has the health care workforce necessary to provide care to all Vermont residents. The director of health care reform may designate an entity responsible for convening meetings and for preparing the draft strategic plan. The Green Mountain Care board established in chapter 220 of this title shall review the draft strategic plan and shall approve the final plan and any subsequent modifications.

(b) The director or designee shall collaborate with the area health education centers, the workforce development council established in 10 V.S.A. § 541, the prekindergarten-16 council established in 16 V.S.A. § 2905, the department of labor, the department of health, the department of Vermont health access, and other interested parties, to develop and maintain the plan. The director of health care reform shall ensure that the strategic plan includes recommendations on how to develop Vermont's health care workforce, including:

* * *

(5) identify factors which either hinder or assist in recruitment or retention of health care professionals, including an examination of the processes for prior authorizations, and make recommendations for further improving recruitment and retention efforts.

* * *

(c) Beginning January 15, 2013, the director or designee shall provide the strategic plan approved by the Green Mountain Care board to the general assembly and shall provide periodic updates on modifications as necessary.

33 V.S.A. § 2031 (added by 2010 Acts and Resolves No. 146, Sec. C34):

§ 2031. CREATION OF CLINICAL UTILIZATION REVIEW BOARD

(a) No later than June 15, 2010, the Department of Vermont Health Access shall create a Clinical Utilization Review Board to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the Department regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the State's Medicaid programs.

* * *

(c) The Board shall have the following duties and responsibilities:

* * *

(G) considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

(2) Recommend to the Commissioner of Vermont Health Access the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, postservice claim review, and frequency limits. Recommendations shall be consistent with the Department's existing utilization processes, including those related to transparency, timeliness, and reporting. Prior to submitting final recommendations to the Commissioner of Vermont Health Access, the Board shall ensure time for public comment is available during the Board's meeting and identify other methods for soliciting public input.

* * *

33 V.S.A. § 1999 (added by 2002 Acts and Resolves No. 127, Sec. 1, some revisions since then):

§ 1999. CONSUMER PROTECTION RULES; PRIOR AUTHORIZATION

* * *

(d) The Agency may include prescription drugs prescribed for the treatment of severe and persistent mental illness, including schizophrenia, major depression, or bipolar disorder, in the prior authorization process after the Health Care Oversight Committee has reviewed the report as provided for in 2005 Acts and Resolves No. 71, Sec. 305(a)(2)(A).

(e)(1) The prior authorization process shall be designed to minimize administrative burdens on prescribers, pharmacists, and consumers. The provisions of this section shall apply to the Program's prior authorization process.

(2) The prior authorization process shall ensure real-time receipt of requests, by telephone, voicemail, facsimile, electronic transmission, or mail on a 24-hour basis, seven days a week.

(3) The prior authorization process shall provide an in-person response to emergency requests by a prescriber with telephone answering queues that do not exceed 10 minutes.

(4) Any request for authorization or approval of a drug that the prescriber indicates, including the clinical reasons for the request, is for an emergency or urgent condition shall be responded to in no more than four hours from the time the Program or participating health benefit plan receives the request.

(5) In emergency circumstances, or if the response to a request for prior authorization is not provided within the time period established in subdivision (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed to be authorized by the Program or the participating health benefit plan, provided it is a prescription drug approved by the Food and Drug Administration, and provided, for drugs dispensed to a Medicaid beneficiary, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services.

(6) The Program or participating plan shall provide to participating providers a prior authorization request form for each enrolled beneficiary, known to be a patient of the provider, designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription, and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider, and if feasible at least one form capable of being copied shall contain known patient information.

(f) The Program's prior authorization process shall require that the prescriber, not the pharmacy, request a prior authorization exemption to the requirements of this section. No later than December 31, 2004, the Commissioner shall create a pilot program designed to exempt a prescriber from the prior authorization requirement of the preferred drug list program if the Program determines that the prescriber has met compliance standards established by the Department in consultation with the Drug Utilization Review Board. This exemption does not apply to drugs that require prior authorization for clinical reasons.

33 V.S.A. § 2001(a) (added by 2002 Acts and Resolves No. 127, Sec. 1, some revisions since then):

§ 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 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 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.