
This act summary is provided for the convenience of the public and members of the General Assembly. It is intended to provide a general summary of the act and may not be exhaustive. It has been prepared by the staff of the Office of Legislative Counsel without input from members of the General Assembly. It is not intended to aid in the interpretation of legislation or to serve as a source of legislative intent.

Act No. 140 (H.960). Health; health insurance; Medicaid; mental health; prior authorization

An act relating to miscellaneous health care provisions

This act expands the types of hospitals subject to the Green Mountain Care Board's (GMCB) hospital budget review to include psychiatric care hospitals not operated by the State and allows for a gradual increase in the scope of the GMCB's review of the budgets newly within its authority. The act also requires the GMCB to conduct a limited review of the budget of each designated agency and each specialized service agency.

The act creates a 23-member Mental Health Integration Council to help ensure that all sectors of the health care system actively participate in integrating mental health in the health care system. The Council is chaired by the Commissioner of Mental Health or designee, with the Commissioner of Health or designee serving as Vice Chair. The act directs the Council to meet every other month until January 1, 2023 and to submit a progress report by December 15, 2021, with the final report due by January 15, 2023.

The act sets specific quality oversight measures as conditions of further State funding for the Brattleboro Retreat. It also requires the Department of Mental Health and the Brattleboro Retreat to take certain actions in order to support proactive, continuous quality and practice improvement and to ensure timely access to high-quality care. The act requires the Department of Mental Health to report to legislative committees of jurisdiction by February 1, 2021 regarding patient experiences and quality of care at the Retreat. It requires the Agency of Human Services and the Retreat to submit an interim report to the legislative committees by October 1, 2020 describing the steps the Retreat is taking to improve communications and relations with its employees, with a final report due by February 1, 2021 that must also include the Retreat's assessment of its efforts to improve communications and relations with its employees and explain how the Retreat plans to handle them in the future.

The act expands VPharm coverage for Medicare beneficiaries with income of 150–225% of the federal poverty level (FPL) to be the same as for Medicare beneficiaries with income of 150% FPL or less, to take effect on the later of January 1, 2022 or upon receipt of federal approval for the expansion. The act directs the Agency of Human Services to request approval for the VPharm expansion as part of the next Global Commitment to Health waiver negotiations with the federal Centers for Medicare and Medicaid Services.

The act requires commercial health insurance plans to review the medical procedures and tests for which they require prior authorization at least annually and eliminate the ones that are no longer justified or are approved so routinely as to no longer serve a purpose, and requires each plan to attest to the Department of Financial Regulation and GMCB annually by September 15 that it has completed the review and appropriate elimination of its prior authorization requirements. The act requires the Department of Financial Regulation, in consultation with health insurers and health care provider associations, to report to the legislative committees of jurisdiction by January 15, 2022 regarding ways to increase use of real-time decision support tools embedded in electronic health records to complete prior authorization requests for imaging and pharmacy services. It requires the GMCB, in consultation with the Department of Vermont Health Access (DVHA), accountable care organizations, payers participating in the All-Payer ACO Model, health care providers, and others, to evaluate opportunities for and obstacles to aligning and reducing prior authorization requirements under the All-Payer ACO Model as an incentive to increase scale, along with potential opportunities to waive other Medicare administrative requirements in the future. The GMCB must report the results of this evaluation to the legislative committees by January 15, 2022. The act requires each health insurer with more than 1,000 covered lives in Vermont to implement a pilot program by January 15, 2022 that automatically exempts from or streamlines certain prior authorization requirements for a subset of participating health care providers, some of whom must be primary care providers, and to report on the prior authorization pilot programs to the legislative committees by January 15, 2023. The act also requires DVHA to provide findings and recommendations to legislative committees by September 30, 2021 regarding clinical prior authorization requirements for Medicaid.

The act extends or expands, or both, certain provisions enacted as part of 2020 Acts and Resolves No. 91 that allow for health care-related regulatory flexibility during and immediately following the COVID-19 pandemic. It requires the Department of Financial Regulation to convene a working group to develop recommendations for health insurance and Medicaid coverage of health care services delivered by telephone after the COVID-19 state of emergency ends, with a report due to the legislative committees by December 1, 2020. It also requires the Vermont Program for Quality in Health Care, Inc. (VPQHC) to consult with its Statewide Telehealth Workgroup, the Department of Public Service, and organizations representing health care providers and consumers to identify areas of the State with particular broadband needs related to health care and opportunities to use federal funds and other funds to increase access to clinically appropriate telehealth services.

Multiple effective dates, beginning on July 1, 2020