H.960

Introduced by Committee on Health Care

Date:

Subject: Health; health insurance; Medicaid; mental health; prior authorization

Statement of purpose of bill as introduced: This bill proposes to address several health care-related topics, including mental health, hospital budget review, expansion of VPharm coverage for certain beneficiaries, and the review and modification of prior authorization requirements.

An act relating to miscellaneous health care provisions

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

* * * Mental Health * * *

Sec. 1. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

(a) The Board shall execute its duties consistent with the principles expressed in section 9371 of this title.

(b) The Board shall have the following duties:

* * *

(15) ~~Collect and review data from each psychiatric hospital licensed pursuant to chapter 43 of this title, which may include data regarding a~~

~~psychiatric hospital's scope of services, volume, utilization, discharges, payer mix, quality, coordination with other aspects of the health care system, and financial condition. The Board's processes shall be appropriate to psychiatric hospitals' scale and their role in Vermont's health care system, and the Board shall consider ways in which psychiatric hospitals can be integrated into systemwide payment and delivery system reform.~~ [Repealed.]

* * *

Sec. 2. 18 V.S.A. § 9451 is amended to read:

§ 9451 DEFINITIONS

As used in this subchapter:

(1) "Hospital" means a general hospital licensed under chapter 43 of this title, except a hospital that is conducted, maintained, or operated by the State of Vermont.

* * *

Sec. 3. HOSPITAL BUDGET REVIEW; TRANSITIONAL PROVISIONS

(a) For any hospital whose budget newly comes under Green Mountain Care Board review as a result of the amendments to 18 V.S.A. § 9451 made by Sec. 2 of this act, the Board may increase the scope of the budget review process set forth in 18 V.S.A. chapter 221, subchapter 7 for the hospital gradually, provided the Board conducts a full review of the hospital's proposed budget not later than the budget for hospital fiscal year 2024. In developing its process for transitioning to a full review of the hospital's budget, the Board

shall collaborate with the hospital and with the Agency of Human Services to prevent duplication of efforts and of reporting requirements. The Board and the Agency shall jointly determine which documents submitted by the hospital to the Agency are appropriate for the Agency to share with the Board.

(b) In determining whether and to what extent to exercise discretion in the scope of its budget review for a hospital new to the Board's hospital budget review process, the Board shall consider:

(1) any existing fiscal oversight of the hospital by the Agency of Human Services, including any memoranda of understanding between the hospital and the Agency; and

(2) the fiscal pressures on the hospital as a result of the COVID-19 pandemic.

Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT

(a) Creation. There is created the Mental Health Integration Council for the purpose of helping to ensure that all sectors of the health care system actively participate in the State's principles for mental health integration established pursuant to 18 V.S.A. § 7251(4) and (8) and as envisioned in the Department of Mental Health's 2020 report "Vision 2030: A 10-Year Plan for an Integrated and Holistic System of Care."

(b) Membership.

(1) The Council shall be composed of the following members:

(A) the Commissioner of Mental Health or designee;

(B) the Commissioner of Health or designee;

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

(D) the Commissioner for Children and Families or designee;

(E) the Commissioner of Corrections or designee;

(F) the Commissioner of Financial Regulation or designee;

(G) the Director of Health Care Reform or designee;

(H) the Executive Director of the Green Mountain Care Board or designee;

(I) the Secretary of Education or designee;

(J) a representative, appointed by the Vermont Medical Society;

(K) a representative, appointed by the Vermont Association for Hospitals and Health Systems;

(L) a representative, appointed by Vermont Care Partners;

(M) a representative, appointed by the Vermont Association of Mental Health and Addiction Recovery;

(N) a representative, appointed by Bi-State Primary Care;

(O) a representative, appointed by the University of Vermont Medical School;

(P) the Chief Executive Officer of OneCare Vermont or designee;

(Q) the Health Care Advocate established pursuant to 18 V.S.A.

§ 9602;

(R) the Mental Health Care Ombudsman established pursuant to 18 V.S.A. § 7259;

(S) a representative, appointed by the insurance plan with the largest number of covered lives in Vermont;

(T) two persons who have received mental health services in Vermont, appointed by Vermont Psychiatric Survivors, including one person who has delivered peer services;

(U) one family member of a person who has received mental health services, appointed by the Vermont chapter of National Alliance on Mental Illness; and

(V) one family member of a child who has received mental health services, appointed by the Vermont Federation of Families for Children's Mental Health.

(2) The Council may create subcommittees comprising the Council's members for the purpose of carrying out the Council's charge.

(c) Powers and duties. The Council shall address the integration of mental health in the health care system, including:

(1) identifying obstacles to the full integration of mental health into a holistic health care system and identifying means of overcoming those barriers;

(2) helping to ensure the implementation of existing law to establish full integration within each member of the Council's area of expertise;

(3) establishing commitments from non-state entities to adopt practices and implementation tools that further integration;

(4) proposing legislation where current statute is either inadequate to achieve full integration or where it creates barriers to achieving the principles of integration; and

(5) fulfilling any other duties the Council deems necessary to achieve its objectives.

(d) Assistance. The Council shall have the administrative, technical, and legal assistance of Department of Mental Health.

(e) Report.

(1) On or before December 15, 2021, the Commissioners of Mental Health and of Health shall report on the Council's progress to the Joint Health Reform Oversight Committee.

(2) On or before January 15, 2023, the Council shall submit a final written report to the House Committee on Health Care and to the Senate Committee on Health and Welfare with its findings and any recommendations for legislative action, including a recommendation as to whether the term of the Council should be extended.

(f) Meetings.

(1) The Commissioner of Mental Health shall call the first meeting of the Council.

(2) The Commissioner of Mental Health shall serve as chair. The Commissioner of Vermont Health Access shall serve as vice chair.

(3) The Council shall meet bimonthly between ~~July 1, 2020~~ *October 1, 2020* and January 1, 2023.

(4) The Council shall cease to exist on July 30, 2023.

(g) Compensation and reimbursement. Members of the Council shall be entitled to per diem compensation and reimbursement of expenses as permitted under 32 V.S.A. § 1010 for not more than eight meetings. These payments shall be made from monies appropriated to the Department of Mental Health.

~~Sec. 5. BRATTLEBORO RETREAT; CONDITIONS OF STATE FUNDING~~

~~(a) Findings. In recognition of the significant need within Vermont's health care system for inpatient psychiatric capacity, the General Assembly has made significant investments in capital funds and in rate adjustments to assist the Brattleboro Retreat in its financial sustainability. The General Assembly has a significant interest in the quality of care provided at the Brattleboro Retreat, which provides 100 percent of the State's inpatient psychiatric care for children and youths, and more than half of the adult inpatient care, of which approximately 50 percent is paid for with State funding.~~

~~(b) Conditions. As a condition of further State funding, the General~~

mbly requires that the following quality oversight measures be implemented by the Brattleboro Retreat under the oversight of the Department of Mental Health:

(1) Give authority and access to a mental health patient representative pursuant to 18 V.S.A. § 7253(1)(J) to provide services on all inpatient units at the Brattleboro Retreat that operate with the support of State funding, regardless of whether a patient is in the custody or temporary custody of the Commissioner.

(2) Provide to the Department of Mental Health all certificates of need for emergency involuntary procedures, regardless of whether a patient is in the custody or temporary custody of the Commissioner.

(3) Ensure that the mental health patient representative be a regular presenter at the Brattleboro Retreat's employee orientation programming.

(c) Patient experience. To the extent feasible, the Department of Mental Health shall meet monthly with the mental health patient representative, the Mental Health Care Ombudsman, and representatives of the Brattleboro Retreat to review patient experiences of care. On or before February 1, 2021, the Department shall report to the House Committee on Health Care and to the Senate Committee on Health and Welfare regarding patient experiences of care at the Brattleboro Retreat.

Sec. 5. BRATTLEBORO RETREAT; CONDITIONS OF STATE FUNDING

(a) Findings. In recognition of the significant need within Vermont's

health care system for inpatient psychiatric capacity, the General Assembly has made significant investments in capital funds and in rate adjustments to assist the Brattleboro Retreat in its financial sustainability. The General Assembly has a significant interest in the quality of care provided at the Brattleboro Retreat, which provides 100 percent of the State's inpatient psychiatric care for children and youth, and more than half of the adult inpatient care, of which approximately 50 percent is paid for with State funding.

(b) Conditions. As a condition of further State funding, the General Assembly requires that the following quality oversight measures be implemented by the Brattleboro Retreat under the oversight of the Department of Mental Health:

(1) allow the existing mental health patient representative under contract with the Department pursuant to 18 V.S.A. § 7253(1)(J) to have full access to inpatient units to ensure that the mental health patient representative is available to individuals who are not in the custody of the Commissioner;

(2) in addition to existing policies regarding the provision of certificates of need for emergency involuntary procedures, provide to the Department deidentified certificates of need for emergency involuntary procedures used on individuals who are not in the custody of the Commissioner; and

(3) ensure that the mental health patient representative be a regular presenter at the Brattleboro Retreat's employee orientation programming.

(c)(1) Patient Experience and Quality of Care. To support proactive, continuous quality and practice improvement and to ensure timely access to high quality patient care, the Department and the Brattleboro Retreat shall:

(A) to the extent feasible by the Department, meet jointly each month with the mental health patient representative contracted pursuant to 18 V.S.A. § 7253(1)(J) and the mental health care ombudsman established pursuant to 18 V.S.A. § 7259 to review patient experiences of care; and

(B) identify clinical teams within the Department and the Brattleboro Retreat to meet monthly for discussions on quality issues, including service delivery, clinical practices, practice improvement and training, case review, admission and discharge coordination, and other patient care and safety topics.

(2) On or before February 1, 2021, the Department shall report to the House Committee on Health Care and to the Senate Committee on Health and Welfare regarding patient experiences and quality of care at the Brattleboro Retreat.

Sec. 6. 33 V.S.A. § 2073 is amended to read:

§ 2073. VPHARM ASSISTANCE PROGRAM

(a) ~~Effective January 1, 2006, the~~ The VPharm program is established as a State pharmaceutical assistance program to provide supplemental pharmaceutical coverage to Medicare beneficiaries. The supplemental coverage under subsection (c) of this section shall provide ~~only~~ the same pharmaceutical coverage as the Medicaid program to enrolled individuals whose income is not greater than ~~150~~ 225 percent of the federal poverty guidelines ~~and only coverage for maintenance drugs for enrolled individuals whose income is greater than 150 percent and no greater than 225 percent of the federal poverty guidelines~~.

(b) Any individual with income ~~no~~ not greater than 225 percent of the federal poverty guidelines participating in Medicare Part D, having secured the low income subsidy if the individual is eligible and meeting the general eligibility requirements established in section 2072 of this title, shall be eligible for VPharm.

* * *

Sec. 7. SUPPLEMENTAL VPHARM COVERAGE; GLOBAL COMMITMENT WAIVER RENEWAL; RULEMAKING

(a) The Agency of Human Services shall request approval from the Centers for Medicare and Medicaid Services to include in Vermont's Global

Commitment to Health Section 1115 Medicaid demonstration renewal an expansion of the VPharm coverage for Vermont Medicare beneficiaries with income between 150 and 225 percent of the federal poverty level (FPL) to be the same as the pharmaceutical coverage under the Medicaid program.

(b) Within 30 days following approval of the VPharm coverage expansion by the Centers for Medicare and Medicaid Services, the Agency of Human Services shall commence the rulemaking process in accordance with 3 V.S.A. chapter 25 to amend its rules accordingly.

* * * Prior Authorization * * *

Sec. 8. 18 V.S.A. § 9418b is amended to read:

§ 9418b. PRIOR AUTHORIZATION

* * *

(h)(1) A health plan shall review the list of medical procedures and medical tests for which it requires prior authorization at least annually and shall eliminate the prior authorization requirements for those procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending to a degree sufficient to justify the administrative costs to the plan.

(2) A health plan shall attest to the Department of Financial Regulation

and the Green Mountain Care Board annually on or before September 15 that it has completed the review and appropriate elimination of prior authorization requirements as required by subdivision (1) of this subsection.

Sec. 9. PRIOR AUTHORIZATION; ELECTRONIC HEALTH RECORDS; REPORT

On or before January 15, 2022, the Department of Financial Regulation, in consultation with health insurers and health care provider associations, shall report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Green Mountain Care Board opportunities to increase the use of real-time decision support tools embedded in electronic health records to complete prior authorization requests for imaging and pharmacy services, including options that minimize cost for both health care providers and health insurers.

Sec. 10. PRIOR AUTHORIZATION; ALL-PAYER ACO MODEL; REPORT

The Green Mountain Care Board, in consultation with the Department of Vermont Health Access, certified accountable care organizations, payers participating in the All-Payer ACO Model, health care providers, and other interested stakeholders, shall evaluate opportunities for and obstacles to aligning and reducing prior authorization requirements under the All-Payer ACO Model as an incentive to increase scale, as well as potential opportunities to waive additional Medicare administrative requirements in the future. On or

before January 15, 2022, the Board shall submit the results of its evaluation to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 11. PRIOR AUTHORIZATION; GOLD CARDING; PILOT PROGRAM; REPORTS

(a) On or before January 15, 2022, each health insurer with more than 1,000 covered lives in this State for major medical health insurance shall implement a pilot program that automatically exempts from or streamlines certain prior authorization requirements for a subset of participating health care providers, some of whom shall be primary care providers.

(b) Each insurer shall make available electronically, including on a publicly available website, details about its prior authorization exemption or streamlining program, including:

(1) the medical procedures or tests that are exempt from or have streamlined prior authorization requirements for providers who qualify for the program;

(2) the criteria for a health care provider to qualify for the program;

(3) the number of health care providers who are eligible for the program, including their specialties and the percentage who are primary care providers; and

(4) whom to contact for questions about the program or about

determining a health care provider's eligibility for the program.

(c) On or before January 15, 2023, each health insurer required to implement a prior authorization pilot program under this section shall report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Green Mountain Care Board:

(1) the results of the pilot program, including an analysis of the costs and savings;

(2) prospects for the health insurer continuing or expanding the program;

(3) feedback the health insurer received about the program from the health care provider community; and

(4) an assessment of the administrative costs to the health insurer of administering and implementing prior authorization requirements.

Sec. 12. PRIOR AUTHORIZATION; PROVIDER EXEMPTIONS; REPORT

On or before September 30, 2021, the Department of Vermont Health Access shall provide findings and recommendations to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Green Mountain Care Board regarding clinical prior authorization requirements in the Vermont Medicaid program, including:

(1) a description and evaluation of the outcomes of the prior authorization waiver pilot program for Medicaid beneficiaries attributed to the

Vermont Medicaid Next Generation ACO Model;

(2)(A) for each service for which Vermont Medicaid requires prior authorization:

(i) the denial rate for prior authorization requests; and

(ii) the potential for harm in the absence of a prior authorization requirement;

(B) based on the information provided pursuant to subdivision (A) of this subdivision (2), the services for which the Department would consider:

(i) waiving the prior authorization requirement; and

(ii) exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted;

(3) the results of the Department's current efforts to engage with health care providers and Medicaid beneficiaries to determine the burdens and consequences of the Medicaid prior authorization requirements and the providers' and beneficiaries' recommendations for modifications to those requirements;

(4) the potential to implement systems that would streamline prior authorization processes for the services for which it would be appropriate, with a focus on reducing the burdens on providers, patients, and the Department;

(5) which State and federal approvals would be needed in order to make proposed changes to the Medicaid prior authorization requirements; and

(6) the potential for aligning prior authorization requirements across payers.

* * * Effective Dates * * *

Sec. 13. EFFECTIVE DATES

This act shall take effect on passage, except:

(1) Sec. 4 (Mental Health Integration Council; report) shall take effect on July 1, 2020;

(2) Sec. 6 (33 V.S.A. § 2073) shall take effect on the later of January 1, 2022 or upon approval of the VPharm coverage expansion by the Centers for Medicare and Medicaid Services; and

(3) in Sec. 8, 18 V.S.A. § 9418b(h)(2) (attestation of prior authorization requirement review) shall take effect on July 1, 2021.