Prior authorization language for HHC discussion (NOT EDITED)

* * * Prior Authorization * * *

Sec. A. 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. B. PRIOR AUTHORIZATION; ELECTRONIC HEALTH RECORDS; REPORT

On or before January 15, 2021, 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. C. 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, 2021, 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. D. PRIOR AUTHORIZATION; GOLD CARDING; PILOT PROGRAM; REPORTS

(a)(1) On or before January 15, 2021, 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.

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

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

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

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

(D) whom to contact for questions about the program or about determining a health care provider's eligibility for the program.

(3) On or before January 15, 2022, 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:

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

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

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

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

Sec. E. 33 V.S.A. § 1901c is added to read:

§ 1901c. PRIOR AUTHORIZATION; PROVIDER EXEMPTIONS; REPORT

On or before September 30, 2020, 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 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 for service 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 request;

(B) based on the information provided pursuant to subdivision (A) of this subdivision (2), the services for which the Department would consider waiving the prior authorization requirement;

(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;

(6) opportunities to expand the pilot program created pursuant to 33 V.S.A. § 1999(f) to exempt prescribers from the prior authorization requirement of the preferred drug list program if the prescriber meets certain compliance standards; and

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