1 H.960

2 Introduced by Committee on Health Care

3 Date:

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

5 Statement of purpose of bill as introduced: This bill proposes to address

6 several health care-related topics, including mental health, hospital budget

7 review, expansion of VPharm coverage for certain beneficiaries, and the

8 review and modification of prior authorization requirements.

9 An act relating to miscellaneous health care provisions

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

11 * * * Mental Health * * *

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

13 § 9375. DUTIES

14 (a) The Board shall execute its duties consistent with the principles

15 expressed in section 9371 of this title.

16 (b) The Board shall have the following duties:

17 * * *

18 (15) ~~Collect and review data from each psychiatric hospital licensed~~

19 ~~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consider ways in which psychiatric hospitals can be integrated into systemwide payment and delivery system reform.~~ [Repealed.]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

1 shall collaborate with the hospital and with the Agency of Human Services to
2 prevent duplication of efforts and of reporting requirements. The Board and
3 the Agency shall jointly determine which documents submitted by the hospital
4 to the Agency are appropriate for the Agency to share with the Board.
5 (b) In determining whether and to what extent to exercise discretion in the
6 scope of its budget review for a hospital new to the Board's hospital budget
7 review process, the Board shall consider:
8 (1) any existing fiscal oversight of the hospital by the Agency of Human
9 Services, including any memoranda of understanding between the hospital and
10 the Agency; and
11 (2) the fiscal pressures on the hospital as a result of the COVID-19
12 pandemic.
13 Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT
14 (a) Creation. There is created the Mental Health Integration Council for
15 the purpose of helping to ensure that all sectors of the health care system
16 actively participate in the State's principles for mental health integration
17 established pursuant to 18 V.S.A. § 7251(4) and (8) and as envisioned in the
18 Department of Mental Health's 2020 report "Vision 2030: A 10-Year Plan for
19 an Integrated and Holistic System of Care."
20 (b) Membership.
21 (1) The Council shall be composed of the following members:

1 (A) the Commissioner of Mental Health or designee;
2 (B) the Commissioner of Health or designee;
3 (C) the Commissioner of Vermont Health Access or designee;
4 (D) the Commissioner for Children and Families or designee;
5 (E) the Commissioner of Corrections or designee;
6 (F) the Commissioner of Financial Regulation or designee;
7 (G) the Director of Health Care Reform or designee;
8 (H) the Executive Director of the Green Mountain Care Board or
9 designee;
10 (I) the Secretary of Education or designee;
11 (J) a representative, appointed by the Vermont Medical Society;
12 (K) a representative, appointed by the Vermont Association for
13 Hospitals and Health Systems;
14 (L) a representative, appointed by Vermont Care Partners;
15 (M) a representative, appointed by the Vermont Association of
16 Mental Health and Addiction Recovery;
17 (N) a representative, appointed by Bi-State Primary Care;
18 (O) a representative, appointed by the University of Vermont
19 Medical School;
20 (P) the Chief Executive Officer of OneCare Vermont or designee;
21 (Q) the Health Care Advocate established pursuant to 18 V.S.A.

1 § 9602;

2 (R) the Mental Health Care Ombudsman established pursuant to

3 18 V.S.A. § 7259;

4 (S) a representative, appointed by the insurance plan with the largest

5 number of covered lives in Vermont;

6 (T) two persons who have received mental health services in

7 Vermont, appointed by Vermont Psychiatric Survivors, including one person

8 who has delivered peer services;

9 (U) one family member of a person who has received mental health

10 services, appointed by the Vermont chapter of National Alliance on Mental

11 Illness; and

12 (V) one family member of a child who has received mental health

13 services, appointed by the Vermont Federation of Families for Children's

14 Mental Health.

15 (2) The Council may create subcommittees comprising the Council's

16 members for the purpose of carrying out the Council's charge.

17 (c) Powers and duties. The Council shall address the integration of mental

18 health in the health care system, including:

19 (1) identifying obstacles to the full integration of mental health into a

20 holistic health care system and identifying means of overcoming those

21 barriers;

1 (2) helping to ensure the implementation of existing law to establish full
2 integration within each member of the Council's area of expertise;
3 (3) establishing commitments from non-state entities to adopt practices
4 and implementation tools that further integration;
5 (4) proposing legislation where current statute is either inadequate to
6 achieve full integration or where it creates barriers to achieving the principles
7 of integration; and
8 (5) fulfilling any other duties the Council deems necessary to achieve its
9 objectives.
10 (d) Assistance. The Council shall have the administrative, technical, and
11 legal assistance of Department of Mental Health.
12 (e) Report.
13 (1) On or before December 15, 2021, the Commissioners of Mental
14 Health and of Health shall report on the Council's progress to the Joint Health
15 Reform Oversight Committee.
16 (2) On or before January 15, 2023, the Council shall submit a final
17 written report to the House Committee on Health Care and to the Senate
18 Committee on Health and Welfare with its findings and any recommendations
19 for legislative action, including a recommendation as to whether the term of
20 the Council should be extended.
21 (f) Meetings.

1 (1) The Commissioner of Mental Health shall call the first meeting of
2 the Council.
3 (2) The Commissioner of Mental Health shall serve as chair. The
4 Commissioner of Vermont Health Access shall serve as vice chair.
5 (3) The Council shall meet bimonthly between ~~July 1, 2020~~ *October 1,*
6 *2020* and January 1, 2023.
7 (4) The Council shall cease to exist on July 30, 2023.
8 (g) Compensation and reimbursement. Members of the Council shall be
9 entitled to per diem compensation and reimbursement of expenses as permitted
10 under 32 V.S.A. § 1010 for not more than eight meetings. These payments
11 shall be made from monies appropriated to the Department of Mental Health.
12 Sec. 5. BRATTLEBORO RETREAT; CONDITIONS OF STATE FUNDING
13 (a) Findings. In recognition of the significant need within Vermont's
14 health care system for inpatient psychiatric capacity, the General Assembly has
15 made significant investments in capital funds and in rate adjustments to assist
16 the Brattleboro Retreat in its financial sustainability. The General Assembly
17 has a significant interest in the quality of care provided at the Brattleboro
18 Retreat, which provides 100 percent of the State's inpatient psychiatric care
19 for children and youths, and more than half of the adult inpatient care, of
20 which approximately 50 percent is paid for with State funding.
21 (b) Conditions. As a condition of further State funding, the General

1 mbly requires that the following quality oversight measures be implemented
2 by the Brattleboro Retreat under the oversight of the Department of Mental
3 Health:
4 (1) Give authority and access to a mental health patient representative
5 pursuant to 18 V.S.A. § 7253(1)(J) to provide services on all inpatient units at
6 the Brattleboro Retreat that operate with the support of State funding,
7 regardless of whether a patient is in the custody or temporary custody of the
8 Commissioner.
9 (2) Provide to the Department of Mental Health all certificates of need
10 for emergency involuntary procedures, regardless of whether a patient is in the
11 custody or temporary custody of the Commissioner.
12 (3) Ensure that the mental health patient representative be a regular
13 presenter at the Brattleboro Retreat's employee orientation programming.
14 (c) Patient experience. To the extent feasible, the Department of Mental
15 Health shall meet monthly with the mental health patient representative, the
16 Mental Health Care Ombudsman, and representatives of the Brattleboro
17 Retreat to review patient experiences of care. On or before February 1, 2021,
18 the Department shall report to the House Committee on Health Care and to the
19 Senate Committee on Health and Welfare regarding patient experiences of care
20 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.

1 * * * VPharm Coverage Expansion * * *

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

1 Commitment to Health Section 1115 Medicaid demonstration renewal an
2 expansion of the VPharm coverage for Vermont Medicare beneficiaries with
3 income between 150 and 225 percent of the federal poverty level (FPL) to be
4 the same as the pharmaceutical coverage under the Medicaid program.
5 (b) Within 30 days following approval of the VPharm coverage expansion
6 by the Centers for Medicare and Medicaid Services, the Agency of Human
7 Services shall commence the rulemaking process in accordance with 3 V.S.A.
8 chapter 25 to amend its rules accordingly.
9 * * * Prior Authorization * * *
10 Sec. 8. 18 V.S.A. § 9418b is amended to read:
11 § 9418b. PRIOR AUTHORIZATION
12 * * *
13 (h)(1) A health plan shall review the list of medical procedures and
14 medical tests for which it requires prior authorization at least annually and
15 shall eliminate the prior authorization requirements for those procedures and
16 tests for which such a requirement is no longer justified or for which requests
17 are routinely approved with such frequency as to demonstrate that the prior
18 authorization requirement does not promote health care quality or reduce
19 health care spending to a degree sufficient to justify the administrative costs to
20 the plan.
21 (2) A health plan shall attest to the Department of Financial Regulation

1 and the Green Mountain Care Board annually on or before September 15 that
2 it has completed the review and appropriate elimination of prior authorization
3 requirements as required by subdivision (1) of this subsection.
4 Sec. 9. PRIOR AUTHORIZATION; ELECTRONIC HEALTH RECORDS;
5 REPORT
6 On or before January 15, 2022, the Department of Financial Regulation, in
7 consultation with health insurers and health care provider associations, shall
8 report to the House Committee on Health Care, the Senate Committees on
9 Health and Welfare and on Finance, and the Green Mountain Care Board
10 opportunities to increase the use of real-time decision support tools embedded
11 in electronic health records to complete prior authorization requests for
12 imaging and pharmacy services, including options that minimize cost for both
13 health care providers and health insurers.
14 Sec. 10. PRIOR AUTHORIZATION; ALL-PAYER ACO MODEL; REPORT
15 The Green Mountain Care Board, in consultation with the Department of
16 Vermont Health Access, certified accountable care organizations, payers
17 participating in the All-Payer ACO Model, health care providers, and other
18 interested stakeholders, shall evaluate opportunities for and obstacles to
19 aligning and reducing prior authorization requirements under the All-Payer
20 ACO Model as an incentive to increase scale, as well as potential opportunities
21 to waive additional Medicare administrative requirements in the future. On or

1 before January 15, 2022, the Board shall submit the results of its evaluation to
2 the House Committee on Health Care and the Senate Committees on Health
3 and Welfare and on Finance.
4 Sec. 11. PRIOR AUTHORIZATION; GOLD CARDING; PILOT
5 PROGRAM; REPORTS
6 (a) On or before January 15, 2022, each health insurer with more than
7 1,000 covered lives in this State for major medical health insurance shall
8 implement a pilot program that automatically exempts from or streamlines
9 certain prior authorization requirements for a subset of participating health
10 care providers, some of whom shall be primary care providers.
11 (b) Each insurer shall make available electronically, including on a publicly
12 available website, details about its prior authorization exemption or
13 streamlining program, including:
14 (1) the medical procedures or tests that are exempt from or have
15 streamlined prior authorization requirements for providers who qualify for the
16 program;
17 (2) the criteria for a health care provider to qualify for the program;
18 (3) the number of health care providers who are eligible for the
19 program, including their specialties and the percentage who are primary care
20 providers; and
21 (4) whom to contact for questions about the program or about

1 determining a health care provider's eligibility for the program.
2 (c) On or before January 15, 2023, each health insurer required to
3 implement a prior authorization pilot program under this section shall report to
4 the House Committee on Health Care, the Senate Committees on Health and
5 Welfare and on Finance, and the Green Mountain Care Board:
6 (1) the results of the pilot program, including an analysis of the costs
7 and savings;
8 (2) prospects for the health insurer continuing or expanding the
9 program;
10 (3) feedback the health insurer received about the program from the
11 health care provider community; and
12 (4) an assessment of the administrative costs to the health insurer of
13 administering and implementing prior authorization requirements.
14 Sec. 12. PRIOR AUTHORIZATION; PROVIDER EXEMPTIONS; REPORT
15 On or before September 30, 2021, the Department of Vermont Health
16 Access shall provide findings and recommendations to the House Committee
17 on Health Care, the Senate Committees on Health and Welfare and on Finance,
18 and the Green Mountain Care Board regarding clinical prior authorization
19 requirements in the Vermont Medicaid program, including:
20 (1) a description and evaluation of the outcomes of the prior
21 authorization waiver pilot program for Medicaid beneficiaries attributed to the

1 Vermont Medicaid Next Generation ACO Model;
2 (2)(A) for each service for which Vermont Medicaid requires prior
3 authorization:
4 (i) the denial rate for prior authorization requests; and
5 (ii) the potential for harm in the absence of a prior authorization
6 requirement;
7 (B) based on the information provided pursuant to subdivision (A) of
8 this subdivision (2), the services for which the Department would consider:
9 (i) waiving the prior authorization requirement; and
10 (ii) exempting from prior authorization requirements those health
11 care professionals whose prior authorization requests are routinely granted;
12 (3) the results of the Department's current efforts to engage with health
13 care providers and Medicaid beneficiaries to determine the burdens and
14 consequences of the Medicaid prior authorization requirements and the
15 providers' and beneficiaries' recommendations for modifications to those
16 requirements;
17 (4) the potential to implement systems that would streamline prior
18 authorization processes for the services for which it would be appropriate, with
19 a focus on reducing the burdens on providers, patients, and the Department;
20 (5) which State and federal approvals would be needed in order to make
21 proposed changes to the Medicaid prior authorization requirements; and

1 (6) the potential for aligning prior authorization requirements across
2 payers.
3 * * * Effective Dates * * *
4 Sec. 13. EFFECTIVE DATES
5 This act shall take effect on passage, except:
6 (1) Sec. 4 (Mental Health Integration Council; report) shall take effect
7 on July 1, 2020;
8 (2) Sec. 6 (33 V.S.A. § 2073) shall take effect on the later of January 1,
9 2022 or upon approval of the VPharm coverage expansion by the Centers for
10 Medicare and Medicaid Services; and
11 (3) in Sec. 8, 18 V.S.A. § 9418b(h)(2) (attestation of prior authorization
12 requirement review) shall take effect on July 1, 2021.