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MEMORANDUM

TO: Representative William Lippert, Chair, House Committee on Health Care

FROM: Nissa L. James, Ph.D., Health Care Director, Department of Vermont Health Access

CC: Andrea De La Bruere, Commissioner, Department of Vermont Health Access
Ena Backus, Director, Office of Health Care Reform, Agency of Human Services
Jenney Samuelson, Secretary, Agency of Human Services
Senator Virginia Lyons, Chair, Senate Committee on Health and Welfare

DATE: January 19, 2022

SUBJECT: Response to the Provisions under the Jurisdiction of the House Committee on Health Care in H.654 – An act relating to extending COVID-19 health care regulatory flexibility.

The Department of Vermont Health Access and Agency of Human Services provide the following information for consideration by the House Committee on Health Care related to the proposed extension of certain COVID-19 health care regulatory flexibility provisions found in 2020 Acts and Resolves Nos. 91 and 140 and 2021 Acts and Resolves No. 6:

- The Agency of Human Services has confirmed with the Department for Children and Families that they will be pursuing rulemaking to amend rules to ensure support of children and families receiving benefits and services so the extension of the provision for waiving/permitting variances is not needed at this time;
- The Department and Agency affirm their commitment to ensuring health care and human service providers can effectively and efficiently deliver care for Vermont Medicaid members during and after the federal COVID-19 public health emergency. **However, the Department respectfully requests that the language for the Medicaid provider enrollment flexibilities be amended to permissive language in alignment with other sections.** For example, "Vermont Medicaid shall consider relaxing Medicaid provider enrollment requirements … during the period a federal COVID-19 public health emergency is declared." This would align with the State's federal approval through the Section 1135 waiver for provider enrollment flexibilities and allow the State to avoid a provider enrollment backlog that could pose numerous issues for the Medicaid program once the public health emergency ends. **The Centers for Medicare and Medicaid Services has**

approved Vermont Medicaid's revalidation of providers during the COVID-19 public health emergency. However, while the Centers for Medicare and Medicaid Services has approved this, Vermont Medicaid recognizes that during the pandemic, it is of the utmost importance to avoid any additional administrative burden that would prevent Vermont Medicaid providers from delivering health care services. Thus, providers can be offered the opportunity to request additional time or cease revalidation until a future time; this would alleviate the concern for any future backlog that could impact provider participation, and potentially availability of providers to care for Vermont Medicaid members, with the Vermont Medicaid program while also being responsive to provider requests for additional time or ceasing revalidation until a future time.

- **The Department of Vermont Health Access respectfully requests that in consideration of the provision related to the refilling of chronic maintenance medications, the language be amended to be permissive in alignment with the language used for other sections**. Alternatively, the provision could be allowed to terminate. As you may recall, the Department previously recommended that this provision be allowed to terminate because a termination of this provision is not anticipated to result in an impact for Vermont Medicaid members. This is because Vermont Medicaid already had a policy for allowing an early refill, or refills, when the reason(s) can be documented, thus demonstrating the need. If a Vermont Medicaid-participating pharmacist needs an early refill override, the pharmacist can call the Pharmacy Help Desk for authorization under the Department's existing policy.
- **The Department and Agency request that any waiver of telehealth requirements relating to HIPAA-compliant connections or informed consent requirements include "to the extent permitted by federal law or guidance regarding enforcement discretion."**
- The Agency of Human Services fully supports the extension of pharmacist authority to order and administer COVID-19 tests.
- The Agency of Human Services has confirmed with the Board of Medical Practice that the Board of Medical Practice agrees with the recommendations reflected in the table for extension of the expiration date of the sections that affect the Board. In short, the table shows all but one of the sections of Act 6 that relate to the Board of Medical Practice being extended through March 31, 2023. The exception is found in the last row of page 4 of the table, which states recommendations about Section 1 of Act 6 of 2021. Only with regard to telehealth practitioners, the Board recommends following the recommendations of the Act 21 Telehealth Work Group report rather than extending Act 6 for another year.[1]
- **The Agency of Human Services requests that the Committee consider including language that allows for flexibility to ensure compliance with Section 9817 of the American Rescue Plan Act and any subsequent federal policy guidance that may be issued**[2]. For example:

  Section 9817 of the American Rescue Plan Act, which provides 10% enhanced Federal Medical Assistance Percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS), includes maintenance of effort requirements that could impact the State's funding if eligibility or

[1] Time Limited Provisions Related to COVID-19 with Recommendations.

[2] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21003.pdf

other changes to HCBS programs (including mental health and substance use disorder treatment services) that were in place on April 1, 2021 are made. Changes to flexibilities should be reviewed for potential impact. Requirements are included in the SMDL # 21-003 and copied below:

"CMS expects states to demonstrate compliance with section 9817 of the ARP, beginning April 1, 2021, and until the state funds equivalent to the amount of federal funds attributable to the increased FMAP are fully expended. To demonstrate compliance with the requirement not to supplant existing state funds expended for Medicaid HCBS, states must:

1. *Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;*
2. *Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and*
3. *Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021."*