EMERGENCY RULE # 20-E22

Administrative Procedures – Emergency Rule Filing

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" (CVR 04-000-001) adopted by the Office of the Secretary of State, this emergency filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, the Legislative Committee on Administrative Rules and a copy with the Chair of the Interagency Committee on Administrative Rules.

All forms requiring a signature shall be original signatures of the appropriate adopting authority or authorized person, and all filings are to be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

This emergency rule may remain in effect for a total of 180 days from the date it first takes effect.

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801(b)(11) for a definition), I believe there exists an imminent peril to public health, safety or welfare, requiring the adoption of this emergency rule.

The nature of the peril is as follows (*PLEASE USE ADDITIONAL SHEETS IF SPACE IS INSUFFICIENT*). The nature of the peril is the COVID-19 outbreak that is the subject of the all-hazard State of Emergency proclaimed by the Governor on March 13, 2020, and extended to November 15, 2020.

I approve the contents of this filing entitled:

Access to Health Care Services During the COVID-19 Pandemic

/s/ Michael S. Pieciak , on 10/22/20

(signature) (date)

Printed Name and Title:
Michael S. Pieciak, Commissioner of Financial Regulation

RECEIVED BY: _______

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)

1. TITLE OF RULE FILING:
   Access to Health Care Services During the COVID-19 Pandemic

2. ADOPTING AGENCY:
   Department of Financial Regulation

3. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

Name: Sebastian Arduengo

Agency: Department of Financial Regulation

Mailing Address: 89 Main Street, Montpelier, VT 05620 - 3101

Telephone: 802 828 - 4846 Fax: 802 828 - 5593

E-Mail: Sebastian.Arduengo@vermont.gov

Web URL*(WHERE THE RULE WILL BE POSTED)*:
https://dfr.vermont.gov/about-us/legal-general-counsel/proposed-rules-and-public-comment

4. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

Name: Gavin Boyles

Agency: Department of Financial Regulation

Mailing Address: 89 Main Street, Montpelier, VT 05620 - 3101

Telephone: 802 272 - 2338 Fax: 802 828 - 1919

E-Mail:

5. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

6. LEGAL AUTHORITY / ENABLING LEGISLATION:
   (THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).
   This rule is issued under the authority vested in the Commissioner of Financial Regulation by Acts 91, 140, and 159 of 2020.

7. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
   Acts 91, 140, and 159 of 2020 require the Commissioner to consider adopting and gives the Commissioner authority to adopt emergency rules to:

   (1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;
   (2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and
   (3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

8. CONCISE SUMMARY (**150 WORDS OR LESS**):
   The emergency rule:
   (1) requires health insurers to provide coverage for clinically appropriate health care services delivered remotely through telehealth or audio-only telephone through telehealth or audio-only telephone on the same basis as in-person consultations;
   (2) requires health insurers to provide coverage of COVID-19 diagnosis, testing, and treatment without member cost-sharing; and
   (3) suspends prescription drug deductible requirements for medications that may be considered preventative care for the purposes of 26 U.S.C. § 223(c)(2)(C).

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

The emergency rule is necessary to provide continuing economic relief and access to care for Vermonters during the ongoing COVID-19 pandemic.

10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The emergency rule is not arbitrary because:
(1) required coverage of COVID-19 diagnosis, testing, and treatment is limited to claims in which COVID-19 or suspected exposure to COVID-19 is the primary diagnosis;
(2) required coverage of telehealth and audio-only telephone services allows providers to continue to be reimbursed for services delivered via telephone and telehealth and expands access to care during the ongoing COVID-19 pandemic; and
(3) suspension of prescription drug deductibles relies on a list of preventative medications created by the IRS that may be covered by high-deductible health plans before enrollees have met the deductible.

11. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

The emergency rule primarily affects health insurers, pharmacy benefit managers, and members of health insurance plans.

12. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

The Department anticipates that the emergency rule will provide substantial financial relief to Vermonters. Although the Department expects insurers to absorb substantial costs as a result of the emergency rule, these costs constitute a small fraction of the net income generated by insurers from April to June 2020, when claims were lower than expected due to the pandemic.

13. A HEARING IS NOT SCHEDULED .

14. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION NEEDED FOR THE NOTICE OF RULEMAKING.

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

15. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
10/15/2020

16. EMERGENCY RULE EFFECTIVE: 10/22/2020

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL
(A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE):
07/21/2021

18. NOTICE OF THIS EMERGENCY RULE SHOULD NOT BE PUBLISHED IN THE WEEKLY NOTICES OF RULEMAKING IN THE NEWSPAPERS OF RECORD.

19. KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

Health Insurance

Telehealth

Audio-only Telephone

COVID-19

Testing

Treatment

Prescription Deductibles

Administrative Procedures – Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Access to Health Care Services During the COVID-19 Pandemic
2. ADOPTING AGENCY:
   Department of Financial Regulation
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT -** Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment as long as the rule is replaced with other text.
   - **NEW RULE -** A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT .OF AN EXISTING RULE**

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE)*:

   The emergency rule supercedes the following emergency rules:

   1) H-2020-02-E, SOS Log # 20-E04; Effective 3/30/20;
   2) H-2020-03-E, SOS Log # 20-E07; Effective 4/14/20;
   3) H-2020-04-E, SOS Log # 20-E11; Effective 5/29/20.

State of Vermont
Agency of Administration
Office of the Secretary
Pavilion Office Building
109 State Street
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322
[fax] 802-828-3320

Susanne R. Young, Secretary

MEMORANDUM

TO: **Jim Condos, Secretary of State**

FROM: **Kristin L. Clouser, ICAR Chair**

Kristin Clouser Digitally signed by Kristin Clouser Date: 2020.10.23 12:12:03 -04'00'

DATE: **October 22, 2020**

RE: **Emergency Rule Titled 'Access to Health Care Services During the COVID-19 Pandemic' by the Department of Financial Regulation**

The use of rulemaking procedures under the provisions of 3 V.S.A. §844 is appropriate for this rule. I have reviewed the proposed rule provided by the Department of Financial Regulation and agree that emergency rulemaking is necessary.

Administrative Procedures – Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

---

1. TITLE OF RULE FILING:

   Access to Health Care Services During the COVID-19 Pandemic

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   The Department anticipates that the emergency rule will provide substantial financial relief to Vermonters. The amount saved will vary depending on individual healthcare utilization and the COVID-19 infection rate in Vermont.

   Based on auditing data and cost estimates provided by Blue Cross Blue Shield of Vermont (BCBSVT), the

Department anticipates the following costs to health insurers:

(1) COVID-19 Diagnosis, Treatment, and Prevention: The cost of waiving member cost-sharing has ranged from approximately $200 to $1200 per claim. To date, BCBSVT has spent approximately $580,000 on COVID-19 related claims. Assuming that the COVID-19 infection rate in Vermont remains low, the Department anticipates insurers spending less than $1 million on COVID-19 related claims through June 1, 2021;

(2) Suspension of Prescription Drug Deductibles: BCBSVT estimated that suspending prescription deductibles for prevantative medications would cost approximately $225,000 per month, inclusive of suspending deductibles for insulin. Because Blue Cross Blue Shield of Vermont has more members than all other Vermont health insurers combined, the Department anticipates that their costs will be substantially less.

(3) Implementation: Because insurers have already implemented the Department's current emergency rules, the Department does not anticipate any implementation costs.

Because insurers were able to add tens of millions of dollars to their reserves due to a substantial reduction in claims volume from April to June 2020, the Department anticipates that insurers will be able to pay for costs required by the emergency rule out of reserves without materially affecting rates in future years.

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

The Department does not anticipate that the emergency rule will have an impact on schools.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   None.

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   None.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Only health insurers and pharmacy benefit managers are required to comply with the emergency rule; none of these entities are small businesses.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   Without the emergency rule, consumer protections to ensure access to healthcare services required by emergency rules H-2020-02-E (20-E04), H-2020-03-E (20-E07, and H-2020-04-E (20-E11) would expire by the end of October 2020. Material interruption or delay in the provision of healthcare services during the COVID-19 pandemic would have devastating economic consequences for individual patients and for Vermont's economy.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*
   In light of the urgency of the Department's continuing response to the COVID-19 pandemic, the analysis described herein is sufficent to enact the emergency rule. The cost of the substantive changes are minimal or a net positive to Vermonters.

Administrative Procedures – Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

---

1. TITLE OF RULE FILING:

   Access to Health Care Services During the COVID-19 Pandemic

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   None.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   None.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   None.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   None.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   None.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   None.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ENVIRONMENTAL IMPACT ANALYSIS.*
   The emergency rule is not expected to have any environmental impacts. Therefore, this analysis is sufficent.

Administrative Procedures – Public Input

Instructions:

In completing the public input statement, an agency describes the strategy prescribed by ICAR to maximize public input, what it did do, or will do to comply with that plan to maximize the involvement of the public in the development of the rule.

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Access to Health Care Services During the COVID-19 Pandemic

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. PLEASE DESCRIBE THE STRATEGY PRESCRIBED BY ICAR TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE:

   Despite the unprecedented urgency of addressing the COVID-19 crisis, the Department of Financial Regulation sought extensive comment on the emergency rule.

   In drafting the emergency rule, the Department solicited input from a broad array of stakeholders, including the Bi-State Primary Care Association, Vermont Care Partners, Vermont Medical Society, Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Office of the Health Care Advocate, Vermont Care Partners, Vermont Assocation of Adult Day Centers, Blue Cross Blue Shield of Vermont, MVP Health Care, Cigna, and Aetna.

   The Department has also been in constant communication with industry and the provider community, including weekly calls related to the Department's response to the COVID-19 pandemic.

4. PLEASE LIST THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

Because the emergency rule represents a repeal and reissue of the Department's previously adopted emergency rules, the Department solicited written comment from stakeholders on remaining issues that were left unaddressed in previous rulemaking. The Department both responded by email to the comments, and made changes to the draft rule where appropriate. Stakeholder comments and the Department's response will be appended to this filing.

In addition, the emergency rule will be posted on the Department's website.

Finally, the Department will ensure the availiabity of materials relating to this rule online and in paper form, and work with stakeholders to educate members of the public.

5. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Bi-State Primary Care Association, Vermont Care Partners, Vermont Medical Society, Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Office of the Health Care Advocate, Vermont Care Partners, Vermont Assocation of Adult Day Centers, Blue Cross Blue Shield of Vermont, MVP Health Care, Cigna, and Aetna.

Administrative Procedures – Incorporation by Reference

THIS FORM IS ONLY REQUIRED WHEN INCORPORATING MATERIALS BY REFERENCE. PLEASE REMOVE PRIOR TO DELIVERY IF IT DOES NOT APPLY TO THIS RULE FILING:

Instructions:

In completing the incorporation by reference statement, an agency describes any materials that are incorporated into the rule by reference and how to obtain copies.

This form is only required when a rule incorporates materials by referencing another source without reproducing the text within the rule itself (e.g. federal or national standards, or regulations).

Incorporated materials will be maintained and available for inspection by the Agency.

---

1. TITLE OF RULE FILING:

   Access to Health Care Services During the COVID-19 Pandemic

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. DESCRIPTION (*DESCRIBE THE MATERIALS INCORPORATED BY REFERENCE*):

   This rule incorporates the following laws and regulations of the United States and the State of Vermont:

   Executive Order 01-20;

   Title 8, sections 4089b and 4100k of the Vermont Statutes Annotated (V.S.A.);

   Title 18 V.S.A., sections 4601 and 9402;

   Title 26, section 223 and Title 42, section 1395x of the United States Code (U.S.C.);

Internal Revenue Service (IRS) Notices 2004-23, 2004-50, 2013-57, and 2019-45.

4. FORMAL CITATION OF MATERIALS INCORPORATED BY REFERENCE: E.O. 01-20; 8 V.S.A. § 4089b; 8 V.S.A. § 4100k; 18 V.S.A. § 9402, 18 V.S.A. § 4601, 26 U.S.C. § 223, 42 U.S.C. § 1395x, and IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

5. OBTAINING COPIES: *EXPLAIN WHERE THE PUBLIC MAY OBTAIN THE MATERIAL(S) IN WRITTEN OR ELECTRONIC FORM, AND AT WHAT COST)*:

   All of the cited materials are available online at the following links:

   Vermont Statutes Annotated:

   https://legislature.vermont.gov/statutes/

   United States Code:

   https://uscode.house.gov/

   IRS Notices:

   https://www.irs.gov/downloads/notices

   Although all cited materials are readily available online, members of the public may obtain printed copies by contacting the Department by phone at 802-828-3301.

6. MODIFICATIONS (*PLEASE EXPLAIN ANY MODIFICATION TO THE INCORPORATED MATERIALS E.G., WHETHER ONLY PART OF THE MATERIAL IS ADOPTED AND IF SO, WHICH PART(S)ARE MODIFIED)*:

   No modifications have been made to the cited material.

Run Spell Check

BERLIN HQ
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
802 255 4550

October 14, 2020

Via Email Only
E. Sebastian Arduengo
Assistant General Counsel
Director of External Appeals
Department of Financial Regulation
Sebastian.Arduengo@vermont.gov

Dear Sebastian:

Thank you for the opportunity to provide feedback on the draft Department of Financial Regulation Emergency Rule H-2020-06-E. In general, Blue Cross and Blue Shield of Vermont (BCBSVT) supports this draft rule in its current form.

We have made comments or posed questions on a few items in the attached version of the draft rule.

Please do not hesitate to contact us with any questions about our feedback.

Sincerely,

Lisa Fearon
Contracting Counsel & Provider Contracting Team Lead

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2020-06-E

ACCESS TO HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

Section 1. Purpose.

(a) This emergency rule is adopted under Acts 91, 140, and [H.795] of 2020 and in response to the continuing State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 and extended thereafter regarding the outbreak of COVID-19.

(b) Under Act 140 of 2020 § 8, this emergency rule shall be in effect until July 1, 2021.

(c) This emergency rule rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

(d) The purposes of this emergency rule are to:

(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in Executive Order 01-20; 8 V.S.A. § 4100k; 18 V.S.A. §§ 4601 and 9402; 26 U.S.C. § 223; and 42 U.S.C. § 1395x, and accompanying IRS guidance, including IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.

(a) Coverage of COVID-19 Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) COVID-19 tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

Commented [RH1]: Does it make sense to refer to FFCF and CARES here to make it clear that this is consistent witl both of those pieces of legislation?

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis. Consistent with section 6001(a) of the Families First Coronavirus Response Act, health insurers shall process all claims for tests for influenza, pneumonia, or other respiratory illness during an encounter for COVID-19 diagnostic testing without member cost-sharing.

(c) Office and Hospital Charges Associated with COVID-19 Testing. Health insurers shall process office and hospital charges associated with an encounter for COVID-19 testing without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis; or

(2) Z20.828: Contact with and (suspected) exposure to other viral communicable diseases.

(d) Administration. Health insurers shall establish appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas;

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

(g) Out-of-Network Services. Consistent with § 5.1(K)2 of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c), and (d) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection.

Commented [RH2]: Recommend removing "all" becaus it seems to encourage arguing about what additional step: could theoretically be possible.

Commented [RH3]: Is (f) intentionally excluded?

Commented [RH4]: BCBSVT supports adding a prohibition against balance billing by the provider, like the is with Rule 09-03 emergency services. This makes it clear to the provider that they must fight with the insurer, not t member.

Section 4. Suspension of Prescription Drug Deductibles for Preventative Medications.

(a) Applicability. Self-insured or publicly funded health care benefit plans offered by public and private entities are encouraged but not required to comply with this section.

(b) Generic Drugs. Health insurers shall suspend prescription drug deductibles for all generic drugs classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C).

Commented [RH5]: This should be limited to those drug that are on the existing formulary. BCBSVT believes that it has all of these covered, but we were thinking about thing like dosages, etc.

(c) Brand and Biological Drugs. Health insurers shall suspend prescription drug deductibles for brand and biological drugs classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C) when no generic drug alternative is available in that drug class.

(d) Effect of Suspension. Deductibles suspended under this section shall not at any time be due or payable, and no insurer may make any attempt to collect such deductibles at any time.

Section 5. Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store and Forward Means.

(a) Coverage of Telehealth and Audio-Only Telephone Services.

(1) Where clinically appropriate, health insurance plans shall provide coverage for all health care services delivered remotely through telehealth or audio-only telephone by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this paragraph shall include services that are covered when provided in the home by home health agencies.

(2) Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telehealth or audio-only telephone.

(3) A health insurance plan or workers' compensation insurance carrier may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered remotely through telehealth or audio-only telephone so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) A health insurance plan shall cover the same ~~the~~ number of telemedicine consultations as in-person covered services for each covered person.

Commented [RH6]: Is this about benefits? Meaning limits, etc., should be the same? It's not entirely clear wha is intended here.

(5) Health insurance plans may require providers to use telemedicine when clinically appropriate, available, and feasible.

(6) Nothing in this subsection shall be construed to require a health insurance to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(7) Health insurance plans may require practices to notify members in advance that services delivered remotely through telehealth or audio-only telephone will be billed as an in-person visit. Any such notification requirements shall permit providers to notify members during the same call in which services are rendered. No other consent to receive services remotely shall be required.

(8) Health insurance plans shall not require providers to have an existing patient relationship with a member in order for the member to be reimbursed for health care services described in paragraph (1) of this subsection.

(b) Coverage of Telephone Triage Services.

(1) Health insurance plans shall provide coverage and reimbursement for Healthcare Common Procedure Coding System (HCPCS) code G2012 (virtual check-in via telephone) to allow providers to receive payment for brief virtual communication services used to determine whether an office visit or other service is needed.

(2) Health insurance plans shall not charge a deductible, co-payment, or coinsurance for telephone triage services.

(c) Coverage of Store and Forward Services. Health insurance plans shall provide coverage and reimbursement for store and forward HCPCS code G2010 (remote evaluation of a recorded video or images to determine whether an office visit or other service is needed without member cost-sharing.

(d) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consistent with guidance issued by the Office for Civil Rights at the Department of Health and Human Services (HHS) announcing enforcement discretion for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency, health insurance plans and workers' compensation insurance carriers shall permit providers to utilize any non-public facing remote communication product that is available to communicate with patients.

Further guidance is available on the HHS website at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

(e) Mental Health Parity. Health insurance plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition

Commented [LF7]: Can this language be changed to jus talk about a phone call? "Virtual communication" is broad than just brief telephonic check-ins.

delivered remotely through telehealth, audio-only telephone, store-and-forward, and brief telecommunication services than for access to treatment for other health conditions; the co-payment for primary mental health care or services shall be no greater than the co-payment for care or services provided by a primary care provider under an insured's policy; and the co-payment for specialty mental health care or services shall be no greater than the co-payment applicable to care or services provided by a specialist provider under an insured's policy.

(f) Physical Location of Remote Services. Health insurance plans and workers' compensation insurance carriers may not deny or limit coverage or reimbursement of health care services delivered remotely through telehealth, audio-only telephone, store-and-forward, or brief telecommunication services based solely on the physical location of the patient or provider.

Commented [LF8]: What are "primary mental health ca or services"? Is this a reference to DFR Regulation I-2013-01?

Commented [LF9]: BCBSVT cannot, under our license with the BCBSA, contract with a provider physically outsid of VT (or a contiguous county) that is doing telemedicine services only. Complying with this rule is easy if the provid is contracted with the local blue plan and the member has Blue Card benefits. But the provider would be out-of-network if he/she is not contracted with the local Blue pla even if the provider is contracted with the local Blue Plan, that doesn't help if the member doesn't have Blue Card benefits. Maybe we'd need to enter single case agreemen if a member insists on receiving a service from an OON telemedicine-only provider.

Section 6. Claims Retroactivity.

Health insurance plans shall process and reimburse appropriate claims for services described in sections 3 and 5 of this emergency rule retroactively to a date no later than March 13, 2020.

Section 7. Severability.

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

Section 8. Conflict with Federal Law.

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

Section 9. Effective Date.

This emergency rule shall become effective October 20, 2020.

To: Sebastian Arduengo, Department of Financial Regulation

From: Jessa Barnard, Vermont Medical Society

Helen Labun, BiState Primary Care Association

Devon Green, Vermont Association of Hospitals and Health Systems

Date: October 14, 2020

Re: Comments on Draft Emergency Rule H-2020-06-E

Thank you for inviting comments on the proposed Emergency Rule H-2020-06-E. The Vermont Medical Society, BiState Primary Care Association and Vermont Association of Hospitals and Heath Systems submit these comments jointly on behalf of our members.

1. **Comments on Section 3, Coverage of COVID-19 Diagnosis, Treatment, and Prevention**

    a. Section (3)(b) states that "health insurers shall process all claims for tests for influenza, pneumonia, or other respiratory illness <u>during an encounter for COVID-19</u> diagnostic testing without member cost-sharing." The October 1, 2020 Health Update from the Department of Health advises clinicians to test all patients presenting with flu symptoms to also be tested for COVID -19 but not necessarily the reverse. We suggest the rule be worded more generally so that all patients being tested for "influenza, pneumonia or other respiratory illness <u>at the same time</u> as COVID-19 diagnostic testing" be processed without member cost-share, so it is not limited to COVID-19 being the primary reason the patient has sought the encounter.

    b. With the removal of Z03.818 from Section 3(c), we are unclear if cost sharing is waived for an associated hospital or office charge if a patient requires testing due to symptoms of other illness (cough, fever). The new CMS guidance states the following:

        Signs and symptoms without definitive diagnosis of COVID-19

        For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

        • R05 Cough

        • R06.02 Shortness of breath

        • R50.9 Fever, unspecified

        If a patient with signs/symptoms associated with COVID-19 also has an <u>actual or suspected contact with or exposure to</u> COVID-19, assign Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code.

Should practices always presume a possible exposure so code Z20.828 is appropriate? This is unclear from the CMS guidance and DFR proposed rule and could potentially leave one of the largest groups of patients presenting for office visits and testing with copays for visits. We suggest how practices should handle this scenario should be clearly stated in the rule.

c. By removing the language in current Emergency Rule H-2020-03-E and Bulletin 214 specifying that testing must be covered when "directed by the state…government" it appears that Section 3 may be removing the requirement to cover without cost share asymptomatic surveillance of health care workers in accordance with state guidelines. It is at least unclear if the reference to 4203 of the CARES Act to cover 'qualifying preventive services' resolves this. We strongly support retaining the requirement that health plans cover with no cost sharing screening of asymptomatic health care workers when required by the State.

2. **Section 5, Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store and Forward Means**

The draft rule proposes to retain the language from current Emergency Rule H-2020-02-E that states: "Health insurance plans may require providers to use telemedicine when clinically appropriate, available, and feasible." We strongly suggest removing this language from the new emergency rule. As discussed by many of our experts speaking to the audio-only workgroup, the selection of an appropriate platform for services – whether in-person, audio-visual, or audio-only - should be based on clinical factors and the clinician's judgment consistent with the standard of care. There has been no mention by the experts or any of the health plans participating on the call that health plans should be making this determination. Further, it is unclear how health plans would determine when telemedicine is "clinically appropriate, available, and feasible" or how a dispute over this determination would be resolved. We have heard no testimony from plans that clinicians have been underutilizing telehealth and should be required to do so in additional circumstances. We believe this language is unnecessary and should be removed.

Thank you for considering these comments. Please reach out to Jessa at 802-917-1460 or jbarnard@vtmd.org if we can provide any further information.

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2020-06-E

ACCESS TO HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

Section 1. Purpose.

(a) This emergency rule is adopted under Acts 91, 140, and [H.795] of 2020 and in response to the continuing State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 and extended thereafter regarding the outbreak of COVID-19.

(b) Under Act 140 of 2020 § 8, this emergency rule shall be in effect until July 1, 2021.

(c) This emergency rule rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

(d) The purposes of this emergency rule are to:

(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Commented [K1]: oPrevious rules required the waiving of Ded only for generic preventive drugs. What is the purpose and relevance to COVD19 to now requiring for all drugs?

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in Executive Order 01-20; 8 V.S.A. § 4100k; 18 V.S.A. §§ 4601 and 9402; 26 U.S.C. § 223; and 42 U.S.C. § 1395x, and accompanying IRS guidance, including IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.

(a) Coverage of COVID-19 Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) COVID-19 tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis. Consistent with section 6001(a) of the Families First Coronavirus Response Act, health insurers shall process all claims for tests for influenza, pneumonia, or other respiratory illness during an encounter for COVID-19 diagnostic testing without member cost-sharing.

Commented [K2]: Please provide clarification on requirement. 6001(a) reads – invitro diagnostic products for detection of COVID19 that are approved by FDA. Items / services furnished during office visit that result in an order for COVID19 test – we do not see anything in this rule relative to Flu, Pneumonia, or Respiratory Illness

(c) Office and Hospital Charges Associated with COVID-19 Testing. Health insurers shall process office and hospital charges associated with an encounter for COVID-19 testing without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis; **or**

(2) Z20.828: Contact with and (suspected) exposure to other viral communicable diseases.

(d) Administration. Health insurers shall establish all appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

Commented [K3]: oOur interpretation is this is a standard visit and our standard provider contracts apply appropriately.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

Commented [K4]: We are not aware of any specific treatment that is available in an outpatient setting. Please provide additional detail.

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas;

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

Commented [K5]: Confirm this is specifically for coverage of the vaccine when available

(g) Out-of-Network Services. Consistent with § 5.1(K)2 of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c), and (d) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection.

Section 4. Suspension of Prescription Drug Deductibles for Preventative Medications.

(a) Applicability. Self-insured or publicly funded health care benefit plans offered by public and private entities are encouraged but not required to comply with this section.

(b) Generic Drugs. Health insurers shall suspend prescription drug deductibles for all generic drugs classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C).

(c) Brand and Biological Drugs. Health insurers shall suspend prescription drug deductibles for brand and biological drugs classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C) when no generic drug alternative is available in that drug class.

(d) Effect of Suspension. Deductibles suspended under this section shall not at any time be due or payable, and no insurer may make any attempt to collect such deductibles at any time.

Section 5. Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store and Forward Means.

(a) Coverage of Telehealth and Audio-Only Telephone Services.

(1) Where clinically appropriate, health insurance plans shall provide coverage for all health care services delivered remotely through telehealth or audio-only telephone by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this paragraph shall include services that are covered when provided in the home by home health agencies.

(2) Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telehealth or audio-only telephone.

(3) A health insurance plan or workers' compensation insurance carrier may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered remotely through telehealth or audio-only telephone so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) A health insurance plan shall cover the same the number of telemedicine consultations as in-person covered services for each covered person.

(5) Health insurance plans may require providers to use telemedicine when clinically appropriate, available, and feasible.

Commented [KK6]: We disagree that phone only telehealth is par with in person visits. Higher level services such as 99214-99215 cannot be reasonably performed over the phone. If this requirement were to be in effect, it should be accompanied by a provider requirement to monitor and ensure the quality of the care being delivered by phone. Exception that is reasonable is mental health services, but even there, there remain privacy concerns.

Commented [KK7]: See above comment.

(6) Nothing in this subsection shall be construed to require a health insurance to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(7) Health insurance plans may require practices to notify members in advance that services delivered remotely through telehealth or audio-only telephone will be billed as an in-person visit. Any such notification requirements shall permit providers to notify members during the same call in which services are rendered. No other consent to receive services remotely shall be required.

(8) Health insurance plans shall not require providers to have an existing patient relationship with a member in order for the member to be reimbursed for health care services described in paragraph (1) of this subsection.

(b) Coverage of Telephone Triage Services.

(1) Health insurance plans shall provide coverage and reimbursement for Healthcare Common Procedure Coding System (HCPCS) code G2012 (virtual check-in via telephone) to allow providers to receive payment for brief virtual communication services used to determine whether an office visit or other service is needed.

(2) Health insurance plans shall not charge a deductible, co-payment, or coinsurance for telephone triage services.

Commented [KK8]: How does this differ from audio only visits? And members will be confused about the difference.

(c) Coverage of Store and Forward Services. Health insurance plans shall provide coverage and reimbursement for store and forward HCPCS code G2010 (remote evaluation of a recorded video or image) to determine whether an office visit or other service is needed without member cost-sharing.

(d) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consistent with guidance issued by the Office for Civil Rights at the Department of Health and Human Services (HHS) announcing enforcement discretion for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency, health insurance plans and workers' compensation insurance carriers shall permit providers to utilize any non-public facing remote communication product that is available to communicate with patients.

Further guidance is available on the HHS website **at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html**

(e) Mental Health Parity. Health insurance plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition

delivered remotely through telehealth, audio-only telephone, store-and-forward, and brief telecommunication services than for access to treatment for other health conditions; the co-payment for primary mental health care or services shall be no greater than the co-payment for care or services provided by a primary care provider under an insured's policy; and the co-payment for specialty mental health care or services shall be no greater than the co-payment applicable to care or services provided by a specialist provider under an insured's policy.

(f) Physical Location of Remote Services. Health insurance plans and workers' compensation insurance carriers may not deny or limit coverage or reimbursement of health care services delivered remotely through telehealth, audio-only telephone, store-and-forward, or brief telecommunication services based solely on the physical location of the patient or provider.

Section 6. Claims Retroactivity.

Health insurance plans shall process and reimburse appropriate claims for services described in sections 3 and 5 of this emergency rule retroactively to a date no later than March 13, 2020.

Section 7. Severability.

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

Section 8. Conflict with Federal Law.

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

Section 9. Effective Date.

This emergency rule shall become effective October 20, 2020.

Commented [KK9]: Not supported by CMS regs in a non-SOE state. We do not know what the future CMS requirements will be post SOE. Since this rule indicates it applies until July 1, 2021, it may be beyond the SOE

Commented [K10]:

Commented [K11R10]: There are a few items that appear to be above and beyond previous rules. Why would new items need to be retro adjusted to 3/13?

Commented [K12]: Why is there an effective date of Oct 20 if this is intended to be rules that have already been in place and this updated rule is just to extend the timeframe?

Subject: Re: COVID-19 Working Group

Date: Wednesday, October 21, 2020 at 2:20:30 PM Eastern Daylight Time

From: Arduengo, Sebastian

CC: Boyles, Gavin

BCC: Sara Teachout, Rebecca Heintz, Cooney, Christine M HHHH, Kennedy, Jeanne, Gail Zatz, Coddington, Kimberly, LarrabeeS@aetna.com, Kate McIntosh, MD, Helen Labun, Devon Green, jill@vnavt.org, Jessa Barnard, Tessler, Julie, Laura@mmrvt.com, Jill Sudhoff-Guerin, Mike Fisher, Kaili Kuiper, Eric Schultheis, Georgia Maheras, Julia Shaw, Jim Dandeneau, Kilby, Kimberly, Van Fleet, Anna, Rickard, Jill, Garand, Lucie, Burns, Dillion, Houlihan, Dana, Margaret Laggis, Menard-Oneil, Christine L, Gile, Jamie, Susan Ridzon, Backus, Ena, Hill, Hillary, Livingston, Shayla, Susan, Cretowski, Lucie Garand

Attachments: DFR Emergency Rule H-2020-06-E.docx, REDLINE DFR Emergency Rule H-2020-06-E.docx

Good afternoon everyone,

I wanted to extend a big thank you for your thoughtful comments, reply to a few of them, and share a final draft based on your feedback along with a redline from the last version we shared.

- Section 1(d)(2): We got a comment asking why we changed the language of H-2020-04-E relating to suspending prescription drug deductibles. The language in the purpose is word for word from Act 91 and unchanged from H-2020-04-E.
- Section 3(a): We got a comment asking about referring to the FFCRA and CARES Acts in this section. Because the tri-agency guidance on interpretation of the FFCRA and CARES Act doesn't align with the coding guidance issued by CMS it's less ambiguous to just say that the procedure codes associated with PCR testing and sample collection should be covered without member cost sharing.
- Section 3(b):
  - The reference to section 6001(a) of the FFCRA is meant to be read in the context of Q5 of the tri-agency guidance.
  - Providers commented that VDH guidelines advise clinicians to test patients presenting with flu symptoms for COVID-19, but not the reverse. Saying that flu tests "related to the furnishing and administration" COVID-19 tests should be covered without cost-sharing appears to be more consistent with the VDH guidance and Q5 of the tri-agency guidance.
  - We also got a comment from payers about specifically excluding large viral panels from coverage. We agree that the clinical value of these panels is . . . dubious. But, with more of these panels coming onto the market specifically excluding current multi-viral panels invites future uncertainty and could result in consumer harm. If payers don't think these panels are medically necessary, they should deny the claim and, if necessary, we'll resolve the issue in the external appeals process.
- Section 3(c):
  - We got a comment about whether member cost-sharing for is waived if a patient requires testing due to symptoms of other illness, such as cough, or whether practices should always presume a possible exposure to COVID-19. Both DFR and DVHA decided to rely on the language in guideline I.C.1.g.1.f: "During the COVID-19 pandemic, a screening code is generally not appropriate. *For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19*[.]"
  - We added the new code for contact with and (suspected) exposure to COVID-19 which will be implemented on 1/1/21.

    - We also added a reference to the FFCRA to clarify our expectation that items and services related to COVID-19 testing should be covered without member cost-sharing—See Q7 of the FFCRA guidance. Special thanks to Helen and Jessa for answering my questions about other services provided with COVID-19 testing.
- Section 3(f): As we discussed when adopted H-2020-03-E, this section is intended to refer to vaccines when they are available.
- Section 3(g): We clarified that members cannot be balance billed for out of network services related to diagnosis, testing or treatment of COVID-19.
- Section 4(b),(c): We clarified that the prescription drug deductible suspension only applies to drugs on the insurer's formulary.
- Section 5(a)(4): Based on a couple of your comments, we're removing this paragraph. The language of paragraph (a)(1) makes clear that health insurance plans must cover services delivered remotely through telehealth or audio-only telephone to the same extent that the plan would cover the services if they were delivered in person.
- Section 5(a)(5): We're removing the provision allowing insurers to require providers to use telemedicine where appropriate. To our knowledge it was never used and just created ambiguity.
- Section 5(f): With respect to mental health parity, the language in this emergency rule and H-2020-02-E is based on 8 V.S.A. § 4089b and the terms used there in are meant to have the same meaning. We've therefore added section 4089b to the list of statutes referred to in the definitions section.
- Section 5(g): We got comments from the payers about contracting issues with telemedicine-only providers situated outside of the service area. I think we might have discussed this when we adopted H-2020-02-E back in May, but the intent is to allow providers to work from home without affecting coverage or reimbursement. If there are other reasons to deny or limit coverage of remote services, that's fine.
- Section 6: Our emergency rules extended claims retroactivity back to the state of emergency (3/13/2020). Since claims from that early in the pandemic have been processed we're removing this section.

We'll submit both your comments and this response in our emergency rule filing.

E. Sebastian Arduengo
Assistant General Counsel
Director of External Appeals
Department of Financial Regulation
89 Main St.
Montpelier, VT 05620
(802) 828-4846
Sebastian.Arduengo@vermont.gov

From: "Arduengo, Sebastian" <Sebastian.Arduengo@vermont.gov> on behalf of "Arduengo, Sebastian" <Sebastian.Arduengo@vermont.gov>
Date: Wednesday, October 14, 2020 at 1:53 PM
Cc: Gavin Boyles <Gavin.Boyles@vermont.gov>
Subject: Re: COVID-19 Working Group

Hi all,

Just a reminder to get any comment back to me today.

Thanks,

E. Sebastian Arduengo
Assistant General Counsel
Director of External Appeals
Department of Financial Regulation
89 Main St.
Montpelier, VT 05620
(802) 828-4846
Sebastian.Arduengo@vermont.gov

From: Arduengo, Sebastian <Sebastian.Arduengo@vermont.gov>
Date: Wednesday, October 7, 2020 at 10:31 AM
To:
Cc: Boyles, Gavin <Gavin.Boyles@vermont.gov>
Subject: COVID-19 Working Group

Good morning everyone,

Thanks to everyone for your thoughts about flu season, the new codes for COVID-19, and asymptomatic testing. I wanted especially thank Kim Coddington for following up with the additional encounter codes for asymptomatic testing.

Because our coding bulletin is set to expire soon, and the Legislature gave us authority to extend our emergency rules through the end of June 2021, we'd like to incorporate our coding guidance into rule and reissue emergency rules H-2020-02-E (telehealth), H-2020-03-E (COVID-19 testing, treatment, and prevention), and H-2020-04-E (suspension of prescription drug deductibles) as one rule.

We'd like to share the following draft with you for comment, which includes the following changes from our current guidance:

- Incorporating the language of Bulletin 214 (the coding guidance) to eliminate any confusion about what testing is supposed to be covered. Consistent with CMS's new coding guidance (attached) we are only requiring insurers to cover office and hospital charges related to COVID-19 testing when the primary diagnosis is z20.828 or u07.1—bottom of page 1.
- Including language about flu testing to say that it has to be covered without cost-sharing per the terms of the FFCRA—top of page 2.
- To align with Vermont Medicaid we are removing language about antibody testing from our guidance. However, we still expect insurers to cover antibody testing consistent with the CARES Act and the FFCRA.
- Removing references to worker's comp carriers for telehealth coverage as we've since confirmed with the Labor Department that the medical fee schedule does not distinguish between telehealth and in person visits—pages 4, 5, and 6.
- Changing store and forward language from H-2020-02-E because the store and forward language in Act 91 is already in effect—bottom of page 4.

There are minor grammatical changes in section 5 from our previous guidance, but they're not meant to be substantive. Please forgive the lack of a redline; I couldn't get it to work well after merging in 4 different documents.

The deadline for comment is next Wednesday, **October 14**.

Thanks,

E. Sebastian Arduengo
Assistant General Counsel
Director of External Appeals
Department of Financial Regulation
89 Main St.
Montpelier, VT 05620
(802) 828-4846
Sebastian.Arduengo@vermont.gov

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2020-06-E

ACCESS TO HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

Section 1. Purpose.

(a) This emergency rule is adopted under Acts 91, 140, and 159 of 2020 and in response to the continuing State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 and extended thereafter regarding the outbreak of COVID-19.

(b) Under Act 140 of 2020 § 8, this emergency rule shall be in effect until July 1, 2021.

(c) This emergency rule rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

(d) The purposes of this emergency rule are to:

(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in Executive Order 01-20; 8 V.S.A. §§ 4089b, 4100k; 18 V.S.A. §§ 4601 and 9402; 26 U.S.C. § 223; and 42 U.S.C. § 1395x, and accompanying IRS guidance, including IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.

(a) Coverage of COVID-19 (SARS-CoV-2) Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) Tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis.

(1) Health insurers shall process all claims for FDA-authorized combined influenza and SARS-CoV-2 testing with procedure codes 87636, 87637, 0240U, and 0241U without member cost-sharing;

(2) Consistent with section 6001(a) of the Families First Coronavirus Response Act (FFCRA), health insurers shall process all medically necessary claims for other testing for influenza, pneumonia, or respiratory illness related to the furnishing or administration of COVID-19 diagnostic testing without member cost-sharing.

(c) Services Associated with COVID-19 Testing. Consistent with section 6001(a)(2) of the FFCRA, Health insurers shall process items and services related to the furnishing or administration of COVID-19 diagnostic testing, including facility fees, without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis;

(2) Prior to January 1, 2021—Z20.828: Contact with and (suspected) exposure to other viral communicable diseases; and

(3) After January 1, 2021—Z20.822: Contact with and (suspected) exposure to COVID-19; Contact with and (suspected) exposure to SARSCoV-2.

(d) Administration. Health insurers shall establish appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas.

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

(g) Out-of-Network Services. Consistent with § 5.1(K)(2) of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c),

(e), and (f) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection. There shall be no additional liability to the member.

Section 4. Suspension of Prescription Drug Deductibles for Preventive Medications.

(a) Applicability. Self-insured or publicly funded health care benefit plans offered by public and private entities are encouraged but not required to comply with this section.

(b) Generic Drugs. Health insurers shall suspend prescription drug deductibles for all generic drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C).

(c) Brand and Biological Drugs. Health insurers shall suspend prescription drug deductibles for brand and biological drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C) when no generic drug alternative is available in that drug class.

(d) Effect of Suspension. Deductibles suspended under this section shall not at any time be due or payable, and no insurer may make any attempt to collect such deductibles at any time.

Section 5. Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store-and-Forward Means.

(a) Coverage of Telehealth and Audio-Only Telephone Services.

(1) Where clinically appropriate, health insurance plans shall provide coverage for all health care services delivered remotely through telehealth or audio-only telephone by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this paragraph shall include services that are covered when provided in the home by home health agencies.

(2) Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telehealth or audio-only telephone.

(3) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered remotely through

telehealth or audio-only telephone so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) Nothing in this subsection shall be construed to require a health insurance to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(5) Health insurance plans may require practices to notify members in advance that services delivered remotely through telehealth or audio-only telephone will be billed as an in-person visit. Any such notification requirements shall permit providers to notify members during the same call in which services are rendered. No other consent to receive services remotely shall be required.

(6) Health insurance plans shall not require providers to have an existing patient relationship with a member in order for the member to be reimbursed for health care services described in paragraph (1) of this subsection.

(b) Coverage of Telephone Triage Services.

(1) Health insurance plans shall provide coverage and reimbursement for Healthcare Common Procedure Coding System (HCPCS) code G2012 (virtual check-in via telephone) to allow providers to receive payment for telephone calls used to determine whether an office visit or other service is needed.

(2) Health insurance plans shall not charge a deductible, co-payment, or coinsurance for telephone triage services.

(c) Coverage of Store-and-Forward Services. Health insurance plans shall provide coverage and reimbursement for store-and-forward HCPCS code G2010 (remote evaluation of a recorded video or image) to determine whether an office visit or other service is needed without member cost-sharing.

(d) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consistent with guidance issued by the Office for Civil Rights at the Department of Health and Human Services (HHS) announcing enforcement discretion for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency, health insurance plans shall permit providers to utilize any non-public facing remote communication product that is available to communicate with patients.

Further guidance is available on the HHS website at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

(e) Mental Health Parity. Consistent with 8 V.S.A. § 4089b, health insurance plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition delivered remotely through telehealth, audio-only telephone, store-and-forward, and brief telecommunication services than for access to treatment for other health conditions; the co-payment for primary mental health care or services shall be no greater than the co-payment for care or services provided by a primary care provider under an insured's policy; and the co-payment for specialty mental health care or services shall be no greater than the co-payment applicable to care or services provided by a specialist provider under an insured's policy.

(f) Physical Location of Remote Services. Health insurance plans may not deny or limit coverage or reimbursement of health care services delivered remotely through telehealth, audio-only telephone, store-and-forward, or brief telecommunication services based solely on the physical location of the patient or provider.

Section 6. Severability.

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

Section 7. Conflict with Federal Law.

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

Section 8. Effective Date.

This emergency rule shall become effective on adoption.

Annotated Text

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2020-06-E

ACCESS TO HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

Section 1. Purpose.

(a) This emergency rule is adopted under Acts 91, 140, and 159 of 2020 and in response to the continuing State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 and extended thereafter regarding the outbreak of COVID-19.

(b) Under Act 140 of 2020 § 8, this emergency rule shall be in effect until July 1, 2021.

(c) This emergency rule rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

(d) The purposes of this emergency rule are to:

(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in Executive Order 01-20; 8 V.S.A. §§ 4089b, 4100k; 18 V.S.A. §§ 4601 and 9402; 26 U.S.C. § 223; and 42 U.S.C. § 1395x, and accompanying IRS guidance, including IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.

(a) Coverage of COVID-19 (SARS-CoV-2) Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) Tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

Commented [AS1]: The language in subsection (a) is in all of our emergency rules related to covid. We references to legislation passed since March.

Commented [AS2]: Act 140 § 8 waives portions of the VT APA that prohibit supplanting an emergency rule with another emergency rule. The logic is that the pandemic will last longer than six months but will still be temporary in nature (hopefully).

Commented [AS3]: The rule will take the place of all of our current guidance.

Commented [AS4]: This language is all taken from Act 91.

Commented [AS5]: We got a comment asking why we changed the language of H-2020-04-E relating to suspending prescription drug deductibles. The language in the purpose is word for word from Act 91 and unchanged from H-2020-04-E.

Commented [AS6]: All of these executive orders, statutes, and regulations were referenced in our prior guidance

Commented [AS7]: We got a comment asking about referring to the FFCRA and CARES Acts in this section. Because the tri-agency guidance on interpretation of the FFCRA and CARES Act doesn't align with the coding guidance issued by CMS it's less ambiguous to just say that the procedure codes associated with PCR testing and sample collection should be covered without member cost sharing.

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis.

(1) Health insurers shall process all claims for FDA-authorized combined influenza and SARS-CoV-2 testing with procedure codes 87636, 87637, 0240U, and 0241U without member cost-sharing;

(2) Consistent with section 6001(a) of the Families First Coronavirus Response Act (FFCRA), health insurers shall process all medically necessary claims for other testing for influenza, pneumonia, or respiratory illness related to the furnishing or administration of COVID-19 diagnostic testing without member cost-sharing.

(c) Services Associated with COVID-19 Testing. Consistent with section 6001(a)(2) of the FFCRA, Health insurers shall process items and services related to the furnishing or administration of COVID-19 diagnostic testing, including facility fees, without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis;

(2) Prior to January 1, 2021—Z20.828: Contact with and (suspected) exposure to other viral communicable diseases; and

(3) After January 1, 2021—Z20.822: Contact with and (suspected) exposure to COVID-19: Contact with and (suspected) exposure to SARSCoV-2.

(d) Administration. Health insurers shall establish appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas.

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

(g) Out-of-Network Services. Consistent with § 5.1(K)(2) of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c),

Commented [AS8]: This language is taken from Bulletin 214. We removed the language in H-2020-03-E related to testing because it just created uncertainty in the market.

Commented [AS9]: The reference to section 6001(a) of the FFCRA is meant to be read in the context of Q5 of the tri-agency guidance.

Commented [AS10]: Providers commented that VDH guidelines advise clinicians to test patients presenting with flu symptoms for COVID-19, but not the reverse. Saying that flu tests "related to the furnishing and administration" COVID-19 tests should be covered without cost-sharing appears to be more consistent with the VDH guidance and Q5 of the tri-agency guidance.

Commented [AS11]: We added a reference to the FFCRA to clarify our expectation that items and services related to COVID-19 testing should be covered without member cost-sharing—See Q7 of the FFCRA guidance.

Commented [AS12]: We got a comment about whether member cost-sharing for is waived if a patient requires testing due to symptoms of other illness, such as cough, or whether practices should always presume a possible exposure to COVID-19. Both DFR and DVHA decided to rely on the language in guideline I.C.1.g.1.f: "During the COVID-19 pandemic, a screening code is generally not appropriate. *For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19*[.]"

Commented [AS13]: We added the new code for contact with and (suspected) exposure to COVID-19 which will be implemented on 1/1/21.

Commented [AS14]: Language from Bulletin 214.

Commented [AS15]: Language from H-2020-03-E.

Commented [AS16]: This section is intended to refer to vaccines when they are available.

(e), and (f) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection. There shall be no additional liability to the member.

Commented [AS17]: We clarified that members cannot be balance billed for out of network services related to diagnosis, testing or treatment of COVID-19.

Section 4. Suspension of Prescription Drug Deductibles for Preventive Medications.

Commented [AS18]: Language from H-2020-04-E.

(a) Applicability. Self-insured or publicly funded health care benefit plans offered by public and private entities are encouraged but not required to comply with this section.

(b) Generic Drugs. Health insurers shall suspend prescription drug deductibles for all generic drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C).

Commented [AS19]: We clarified that the prescription drug deductible suspension only applies to drugs on the insurer's formulary.

(c) Brand and Biological Drugs. Health insurers shall suspend prescription drug deductibles for brand and biological drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C) when no generic drug alternative is available in that drug class.

(d) Effect of Suspension. Deductibles suspended under this section shall not at any time be due or payable, and no insurer may make any attempt to collect such deductibles at any time.

Section 5. Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store-and-Forward Means.

Commented [AS20]: Language from H-2020-02-E with non-substantive grammatical changes except that references to workers' compensation carriers were removed in subsections (a), (b), and (d) where I have highlighted.

(a) Coverage of Telehealth and Audio-Only Telephone Services.

(1) Where clinically appropriate, health insurance plans shall provide coverage for all health care services delivered remotely through telehealth or audio-only telephone by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this paragraph shall include services that are covered when provided in the home by home health agencies.

Commented [AS21]: The language of paragraph (a)(1) makes clear that health insurance plans must cover services delivered remotely through telehealth or audio-only telephone to the same extent that the plan would cover the services if they were delivered in person.

Commented [AS22]: We removed a provision allowing insurers to require providers to use telemedicine where appropriate. To our knowledge it was never used and just created ambiguity.

(2) Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telehealth or audio-only telephone.

(3) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered remotely through

telehealth or audio-only telephone so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) Nothing in this subsection shall be construed to require a health insurance to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(5) Health insurance plans may require practices to notify members in advance that services delivered remotely through telehealth or audio-only telephone will be billed as an in-person visit. Any such notification requirements shall permit providers to notify members during the same call in which services are rendered. No other consent to receive services remotely shall be required.

(6) Health insurance plans shall not require providers to have an existing patient relationship with a member in order for the member to be reimbursed for health care services described in paragraph (1) of this subsection.

(b) Coverage of Telephone Triage Services.

(1) Health insurance plans shall provide coverage and reimbursement for Healthcare Common Procedure Coding System (HCPCS) code G2012 (virtual check-in via telephone) to allow providers to receive payment for telephone calls used to determine whether an office visit or other service is needed.

(2) Health insurance plans shall not charge a deductible, co-payment, or coinsurance for telephone triage services.

(c) Coverage of Store-and-Forward Services. Health insurance plans shall provide coverage and reimbursement for store-and-forward HCPCS code G2010 (remote evaluation of a recorded video or image) to determine whether an office visit or other service is needed without member cost-sharing.

(d) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consistent with guidance issued by the Office for Civil Rights at the Department of Health and Human Services (HHS) announcing enforcement discretion for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency, health insurance plans shall permit providers to utilize any non-public facing remote communication product that is available to communicate with patients.

Further guidance is available on the HHS website at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

(e) Mental Health Parity. Consistent with 8 V.S.A. § 4089b, health insurance plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition delivered remotely through telehealth, audio-only telephone, store-and-forward, and brief telecommunication services than for access to treatment for other health conditions; the co-payment for primary mental health care or services shall be no greater than the co-payment for care or services provided by a primary care provider under an insured's policy; and the co-payment for specialty mental health care or services shall be no greater than the co-payment applicable to care or services provided by a specialist provider under an insured's policy.

Commented [AS23]: With respect to mental health parity, the language in this emergency rule and H-2020-02-E is based on 8 V.S.A. § 4089b and the terms used there in are meant to have the same meaning. We've therefore added section 4089b to the list of statutes referred to in the definitions section.

(f) Physical Location of Remote Services. Health insurance plans may not deny or limit coverage or reimbursement of health care services delivered remotely through telehealth, audio-only telephone, store-and-forward, or brief telecommunication services based solely on the physical location of the patient or provider.

Commented [AS24]: We got comments from the payers about contracting issues with telemedicine-only providers situated outside of the service area. I think we might have discussed this when we adopted H-2020-02-E back in May, but the intent is to allow providers to work from home without affecting coverage or reimbursement.

Section 6. Severability.

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

Section 7. Conflict with Federal Law.

Commented [AS25]: We added a conflicts section to avoid issues with ERISA or with a federal testing plan, should such a plan advance through Congress.

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

Section 8. Effective Date.

This emergency rule shall become effective on adoption.

Clean Copy

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2020-06-E

ACCESS TO HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

Section 1. Purpose.

(a) This emergency rule is adopted under Acts 91, 140, and 159 of 2020 and in response to the continuing State of Emergency declared by the Governor of the State of Vermont on March 13, 2020 and extended thereafter regarding the outbreak of COVID-19.

(b) Under Act 140 of 2020 § 8, this emergency rule shall be in effect until July 1, 2021.

(c) This emergency rule rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

(d) The purposes of this emergency rule are to:

(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expand patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in Executive Order 01-20; 8 V.S.A. §§ 4089b, 4100k; 18 V.S.A. §§ 4601 and 9402; 26 U.S.C. § 223; and 42 U.S.C. § 1395x, and accompanying IRS guidance, including IRS Notices 2004-23, 2004-50, 2013-57, and 2019-45.

Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.

(a) Coverage of COVID-19 (SARS-CoV-2) Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) Tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis.

(1) Health insurers shall process all claims for FDA-authorized combined influenza and SARS-CoV-2 testing with procedure codes 87636, 87637, 0240U, and 0241U without member cost-sharing;

(2) Consistent with section 6001(a) of the Families First Coronavirus Response Act (FFCRA), health insurers shall process all medically necessary claims for other testing for influenza, pneumonia, or respiratory illness related to the furnishing or administration of COVID-19 diagnostic testing without member cost-sharing.

(c) Services Associated with COVID-19 Testing. Consistent with section 6001(a)(2) of the FFCRA, Health insurers shall process items and services related to the furnishing or administration of COVID-19 diagnostic testing, including facility fees, without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis;

(2) Prior to January 1, 2021—Z20.828: Contact with and (suspected) exposure to other viral communicable diseases; and

(3) After January 1, 2021—Z20.822: Contact with and (suspected) exposure to COVID-19; Contact with and (suspected) exposure to SARSCoV-2.

(d) Administration. Health insurers shall establish appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas.

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

(g) Out-of-Network Services. Consistent with § 5.1(K)(2) of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c),

(e), and (f) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection. There shall be no additional liability to the member.

Section 4. Suspension of Prescription Drug Deductibles for Preventive Medications.

(a) Applicability. Self-insured or publicly funded health care benefit plans offered by public and private entities are encouraged but not required to comply with this section.

(b) Generic Drugs. Health insurers shall suspend prescription drug deductibles for all generic drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C).

(c) Brand and Biological Drugs. Health insurers shall suspend prescription drug deductibles for brand and biological drugs on their existing formularies classified as preventive care for purposes of 26 U.S.C. § 223(c)(2)(C) when no generic drug alternative is available in that drug class.

(d) Effect of Suspension. Deductibles suspended under this section shall not at any time be due or payable, and no insurer may make any attempt to collect such deductibles at any time.

Section 5. Coverage of Health Care Services Delivered Through Telehealth, Telephone, or Store-and-Forward Means.

(a) Coverage of Telehealth and Audio-Only Telephone Services.

(1) Where clinically appropriate, health insurance plans shall provide coverage for all health care services delivered remotely through telehealth or audio-only telephone by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this paragraph shall include services that are covered when provided in the home by home health agencies.

(2) Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telehealth or audio-only telephone.

(3) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered remotely through

telehealth or audio-only telephone so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) Nothing in this subsection shall be construed to require a health insurance to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(5) Health insurance plans may require practices to notify members in advance that services delivered remotely through telehealth or audio-only telephone will be billed as an in-person visit. Any such notification requirements shall permit providers to notify members during the same call in which services are rendered. No other consent to receive services remotely shall be required.

(6) Health insurance plans shall not require providers to have an existing patient relationship with a member in order for the member to be reimbursed for health care services described in paragraph (1) of this subsection.

(b) Coverage of Telephone Triage Services.

(1) Health insurance plans shall provide coverage and reimbursement for Healthcare Common Procedure Coding System (HCPCS) code G2012 (virtual check-in via telephone) to allow providers to receive payment for telephone calls used to determine whether an office visit or other service is needed.

(2) Health insurance plans shall not charge a deductible, co-payment, or coinsurance for telephone triage services.

(c) Coverage of Store-and-Forward Services. Health insurance plans shall provide coverage and reimbursement for store-and-forward HCPCS code G2010 (remote evaluation of a recorded video or image) to determine whether an office visit or other service is needed without member cost-sharing.

(d) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consistent with guidance issued by the Office for Civil Rights at the Department of Health and Human Services (HHS) announcing enforcement discretion for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency, health insurance plans shall permit providers to utilize any non-public facing remote communication product that is available to communicate with patients.

Further guidance is available on the HHS website at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

(e) Mental Health Parity. Consistent with 8 V.S.A. § 4089b, health insurance plans may not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition delivered remotely through telehealth, audio-only telephone, store-and-forward, and brief telecommunication services than for access to treatment for other health conditions; the co-payment for primary mental health care or services shall be no greater than the co-payment for care or services provided by a primary care provider under an insured's policy; and the co-payment for specialty mental health care or services shall be no greater than the co-payment applicable to care or services provided by a specialist provider under an insured's policy.

(f) Physical Location of Remote Services. Health insurance plans may not deny or limit coverage or reimbursement of health care services delivered remotely through telehealth, audio-only telephone, store-and-forward, or brief telecommunication services based solely on the physical location of the patient or provider.

Section 6. Severability.

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

Section 7. Conflict with Federal Law.

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

Section 8. Effective Date.

This emergency rule shall become effective on adoption.

No. 91. An act relating to Vermont's response to COVID-19.

(H.742)

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

* * * Supporting Health Care and Human Service Provider Sustainability* * *

Sec. 1. AGENCY OF HUMAN SERVICES; HEALTH CARE AND HUMAN SERVICE PROVIDER SUSTAINABILITY

During a declared state of emergency in Vermont as a result of COVID-19, the Agency of Human Services shall consider waiving or modifying existing rules, or adopting emergency rules, to protect access to health care services, long-term services and supports, and other human services under the Agency's jurisdiction. In waiving, modifying, or adopting rules, the Agency shall consider the importance of the financial viability of providers that rely on funding from the State, federal government, or Medicaid, or a combination of these, for a major portion of their revenue.

Sec. 2. AGENCY OF HUMAN SERVICES; TEMPORARY PROVIDER TAX MODIFICATION AUTHORITY

(a) During a declared state of emergency in Vermont as a result of COVID-19 and for a period of six months following the termination of the state of emergency, the Secretary of Human Services may modify payment of all or a prorated portion of the assessment imposed on hospitals by 33 V.S.A. § 1953, and may waive or modify payment of all or a prorated portion of the

assessment imposed by 33 V.S.A. chapter 19, subchapter 2 for one or more other classes of health care providers, if the following two conditions are met:

(1) the action is necessary to preserve the ability of the providers to continue offering necessary health care services; and

(2) the Secretary has obtained the approval of the Joint Fiscal Committee and the Emergency Board as set forth in subsections (b) and (c) of this section.

(b)(1) If the Secretary proposes to waive or modify payment of an assessment in accordance with the authority set forth in subsection (a) of this section, the Secretary shall first provide to the Joint Fiscal Committee:

(A) the Secretary's rationale for exercising the authority, including the balance between the fiscal impact of the proposed action on the State budget and the needs of the specific class or classes of providers; and

(B) a plan for mitigating the fiscal impact to the State.

(2) Upon the Joint Fiscal Committee's approval of the plan for mitigating the fiscal impact to the State, the Secretary may waive or modify payment of the assessment as proposed unless the mitigation plan includes one or more actions requiring the approval of the Emergency Board.

(c)(1) If the mitigation plan includes one or more actions requiring the approval of the Emergency Board, the Secretary shall obtain the Emergency Board's approval for the action or actions prior to waiving or modifying payment of the assessment.

(2) Upon the Emergency Board's approval of the action or actions, the Secretary may waive or modify payment of the assessment as proposed.

* * * Protections for Employees of Health Care Facilities
and Human Service Providers * * *

Sec. 3. PROTECTIONS FOR EMPLOYEES OF HEALTH CARE FACILITIES AND HUMAN SERVICE PROVIDERS

In order to protect employees of a health care facility or human service provider who are not licensed health care professionals from the risks associated with COVID-19, all health care facilities and human service providers in Vermont, including hospitals, federally qualified health centers, rural health clinics, residential treatment programs, homeless shelters, home- and community-based service providers, and long-term care facilities, shall follow guidance from the Vermont Department of Health regarding measures to address employee safety, to the extent feasible.

* * * Compliance Flexibility * * *

Sec. 4. HEALTH CARE AND HUMAN SERVICE PROVIDER REGULATION; WAIVER OR VARIANCE PERMITTED

Notwithstanding any provision of the Agency of Human Services' administrative rules or standards to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, the Secretary of Human Services may waive or permit variances from the following State rules and standards governing providers of health care services and human services as

necessary to prioritize and maximize direct patient care, support children and families who receive benefits and services through the Department for Children and Families, and allow for continuation of operations with a reduced workforce and with flexible staffing arrangements that are responsive to evolving needs, to the extent such waivers or variances are permitted under federal law:

(1) Hospital Licensing Rule;

(2) Hospital Reporting Rule;

(3) Nursing Home Licensing and Operating Rule;

(4) Home Health Agency Designation and Operation Regulations;

(5) Residential Care Home Licensing Regulations;

(6) Assisted Living Residence Licensing Regulations;

(7) Home for the Terminally Ill Licensing Regulations;

(8) Standards for Adult Day Services;

(9) Therapeutic Community Residences Licensing Regulations;

(10) Choices for Care High/Highest Manual;

(11) Designated and Specialized Service Agency designation and provider rules;

(12) Child Care Licensing Regulations;

(13) Public Assistance Program Regulations;

(14) Foster Care and Residential Program Regulations; and

(15) other rules and standards for which the Agency of Human Services is the adopting authority under 3 V.S.A. chapter 25.

Sec. 5. GREEN MOUNTAIN CARE BOARD RULES; WAIVER OR VARIANCE PERMITTED

Notwithstanding any provision of 18 V.S.A. chapter 220 or 221, 8 V.S.A. § 4062, 33 V.S.A. chapter 18, subchapter 1, or the Green Mountain Care Board's administrative rules, guidance, or standards to the contrary, during a declared state of emergency in Vermont as a result of COVID-19 and for a period of six months following the termination of the state of emergency, the Green Mountain Care Board may waive or permit variances from State laws, guidance, and standards with respect to the following regulatory activities, to the extent permitted under federal law, as necessary to prioritize and maximize direct patient care, safeguard the stability of health care providers, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic:

(1) hospital budget review;

(2) certificates of need;

(3) health insurance rate review; and

(4) accountable care organization certification and budget review.

Sec. 6. MEDICAID AND HEALTH INSURERS; PROVIDER ENROLLMENT AND CREDENTIALING

During a declared state of emergency in Vermont as a result of COVID-19, to the extent permitted under federal law, the Department of Vermont Health Access shall relax provider enrollment requirements for the Medicaid program, and the Department of Financial Regulation shall direct health insurers to relax provider credentialing requirements for health insurance plans, in order to allow for individual health care providers to deliver and be reimbursed for services provided across health care settings as needed to respond to Vermonters' evolving health care needs.

Sec. 7. INVOLUNTARY TREATMENT; DOCUMENTATION AND REPORTING REQUIREMENTS; WAIVER PERMITTED

(a) Notwithstanding any provision of statute or rule to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, the court or the Department of Mental Health may waive any financial penalties associated with a treating health care provider's failure to comply with one or more of the documentation and reporting requirements related to involuntary treatment pursuant to 18 V.S.A. chapter 181, to the extent permitted under federal law.

(b) Nothing in this section shall be construed to suspend or waive any of the requirements in 18 V.S.A. chapter 181 relating to judicial proceedings for involuntary treatment and medication.

* * * Access to Health Care Services and Human Services * * *

Sec. 8. ACCESS TO HEALTH CARE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

It is the intent of the General Assembly to increase Vermonters' access to medically necessary health care services during a declared state of emergency in Vermont as a result of COVID-19. During such a declared state of emergency, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address the following for the duration of the state of emergency:

(1) expanding health insurance coverage for, and waiving or limiting cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) modifying or suspending health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expanding patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Sec. 9. PRESCRIPTION DRUGS; MAINTENANCE MEDICATIONS; EARLY REFILLS

(a) As used in this section, "health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(b) During a declared state of emergency in Vermont as a result of COVID-19, all health insurance plans and Vermont Medicaid shall allow their members to refill prescriptions for chronic maintenance medications early to enable the members to maintain a 30-day supply of each prescribed maintenance medication at home.

(c) As used in this section, "maintenance medication" means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

Sec. 10. PHARMACISTS; CLINICAL PHARMACY; EXTENSION OF PRESCRIPTION FOR MAINTENANCE MEDICATION

(a) During a declared state of emergency in Vermont as a result of COVID-19, a pharmacist may extend a previous prescription for a maintenance medication for which the patient has no refills remaining or for which the authorization for refills has recently expired if it is not feasible to obtain a new prescription or refill authorization from the prescriber.

(b) A pharmacist who extends a prescription for a maintenance medication pursuant to this section shall take all reasonable measures to notify the prescriber of the prescription extension in a timely manner.

(c) As used in this section, "maintenance medication" means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

Sec. 11. PHARMACISTS; CLINICAL PHARMACY; THERAPEUTIC SUBSTITUTION DUE TO LACK OF AVAILABILITY

(a) During a declared state of emergency in Vermont as a result of COVID-19, a pharmacist may, with the informed consent of the patient, substitute an available drug or insulin product for an unavailable prescribed drug or insulin product in the same therapeutic class if the available drug or insulin product would, in the clinical judgment of the pharmacist, have substantially equivalent therapeutic effect even though it is not a therapeutic equivalent.

(b) As soon as reasonably possible after substituting a drug or insulin product pursuant to subsection (a) of this section, the pharmacist shall notify the prescribing clinician of the drug or insulin product, dose, and quantity actually dispensed to the patient.

Sec. 12. BUPRENORPHINE; PRESCRIPTION RENEWALS

During a declared state of emergency in Vermont as a result of COVID-19, to the extent permitted under federal law, a health care professional authorized

to prescribe buprenorphine for treatment of substance use disorder may authorize renewal of a patient's existing buprenorphine prescription without requiring an office visit.

Sec. 13. 24-HOUR FACILITIES AND PROGRAMS; BED-HOLD DAYS

During a declared state of emergency in Vermont as a result of COVID-19, to the extent permitted under federal law, the Agency of Human Services may reimburse Medicaid-funded long-term care facilities and other programs providing 24-hour per day services for their bed-hold days.

* * * Regulation of Professions * * *

Sec. 14. 3 V.S.A. § 129 is amended to read:

§ 129. POWERS OF BOARDS; DISCIPLINE PROCESS

(a) In addition to any other provisions of law, a board may exercise the following powers:

* * *

(10)(A) Issue temporary licenses during a declared state of emergency. The person to be issued a temporary license must be:

(i) currently licensed, in good standing, and not subject to disciplinary proceedings in any other jurisdiction; or

(ii) a graduate of an approved education program during a period when licensing examinations are not reasonably available.

(B) The temporary license shall authorize the holder to practice in Vermont until the termination of the declared state of emergency or 90 days,

whichever occurs first, ~~as long as~~ provided the licensee remains in good standing, and may be reissued by the board if the declared state of emergency continues longer than 90 days.

(C) Fees shall be waived when a license is required to provide services under this subdivision.

* * *

Sec. 15. 26 V.S.A. § 1353 is amended to read:

§ 1353. POWERS AND DUTIES OF THE BOARD

The Board shall have the following powers and duties to:

* * *

(11) During a declared state of emergency:

(A) The Board or the Executive Director of the Board may issue a temporary license to an individual who is currently licensed to practice as a physician, physician assistant, or podiatrist in another jurisdiction, whose license is in good standing, and who is not subject to disciplinary proceedings in any other jurisdiction. The temporary license shall authorize the holder to practice in Vermont until the termination of the declared state of emergency or 90 days, whichever occurs first, provided the licensee remains in good standing, and may be reissued by the Board if the declared state of emergency continues longer than 90 days. Fees shall be waived when a license is required to provide services under this subdivision (A).

(B) The Board or the Executive Director of the Board may waive supervision and scope of practice requirements for physician assistants, including the requirement for documentation of the relationship between a physician assistant and a physician pursuant to section 1735a of this title. The Board or Executive Director may impose limitations or conditions when granting a waiver under this subdivision (B).

Sec. 16. 26 V.S.A. § 1613 is amended to read:

§ 1613. TRANSITION TO PRACTICE

* * *

(c) The Board may waive or modify the collaborative provider agreement requirement as necessary to allow an APRN to practice independently during a declared state of emergency.

Sec. 17. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; OUT-OF-STATE HEALTH CARE PROFESSIONALS

(a) Notwithstanding any provision of Vermont's professional licensure statutes or rules to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, a health care professional, including a mental health professional, who holds a valid license, certificate, or registration to provide health care services in any other U.S. jurisdiction shall be deemed to be licensed, certified, or registered to provide health care services, including

mental health services, to a patient located in Vermont using telehealth or as part of the staff of a licensed facility, provided the health care professional:

(1) is licensed, certified, or registered in good standing in the other U.S. jurisdiction or jurisdictions in which the health care professional holds a license, certificate, or registration;

(2) is not subject to any professional disciplinary proceedings in any other U.S. jurisdiction; and

(3) is not affirmatively barred from practice in Vermont for reasons of fraud or abuse, patient care, or public safety.

(b) A health care professional who plans to provide health care services in Vermont as part of the staff of a licensed facility shall submit or have submitted on the individual's behalf the individual's name, contact information, and the location or locations at which the individual will be practicing to:

(1) the Board of Medical Practice for medical doctors, physician assistants, and podiatrists; or

(2) the Office of Professional Regulation for all other health care professions.

(c) A health care professional who delivers health care services in Vermont pursuant to subsection (a) of this section shall be subject to the imputed jurisdiction of the Board of Medical Practice or the Office of Professional

Regulation, as applicable based on the health care professional's profession, in accordance with Sec. 19 of this act.

(d) This section shall remain in effect until the termination of the declared state of emergency in Vermont as a result of COVID-19 and provided the health care professional remains licensed, certified, or registered in good standing.

Sec. 18. RETIRED HEALTH CARE PROFESSIONALS; BOARD OF MEDICAL PRACTICE; OFFICE OF PROFESSIONAL REGULATION

(a)(1) During a declared state of emergency in Vermont as a result of COVID-19, a former health care professional, including a mental health professional, who retired not more than three years earlier with the individual's Vermont license, certificate, or registration in good standing may provide health care services, including mental health services, to a patient located in Vermont using telehealth or as part of the staff of a licensed facility after submitting, or having submitted on the individual's behalf, to the Board of Medical Practice or Office of Professional Regulation, as applicable, the individual's name, contact information, and the location or locations at which the individual will be practicing.

(2) A former health care professional who returns to the Vermont health care workforce pursuant to this subsection shall be subject to the regulatory

jurisdiction of the Board of Medical Practice or the Office of Professional Regulation, as applicable.

(b) During a declared state of emergency in Vermont as a result of COVID-19, the Board of Medical Practice and the Office of Professional Regulation may permit former health care professionals, including mental health professionals, who retired more than three but less than 10 years earlier with their Vermont license, certificate, or registration in good standing to return to the health care workforce on a temporary basis to provide health care services, including mental health services, to patients in Vermont. The Board of Medical Practice and Office of Professional Regulation may issue temporary licenses to these individuals at no charge and may impose limitations on the scope of practice of returning health care professionals as the Board or Office deems appropriate.

Sec. 19. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; IMPUTED JURISDICTION

A practitioner of a profession or professional activity regulated by Title 26 of the Vermont Statutes Annotated who provides regulated professional services to a patient in the State of Vermont without holding a Vermont license, as may be authorized in a declared state of emergency, is deemed to consent to, and shall be subject to, the regulatory and disciplinary jurisdiction of the Vermont regulatory agency or body having jurisdiction over the regulated profession or professional activity.

Sec. 20. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY AUTHORITY TO ACT FOR REGULATORY BOARDS

(a)(1) During a declared state of emergency in Vermont as a result of COVID-19, if the Director of Professional Regulation finds that a regulatory body attached to the Office of Professional Regulation by 3 V.S.A. § 122 cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Director may exercise the full powers and authorities of that regulatory body, including disciplinary authority.

(2) During a declared state of emergency in Vermont as a result of COVID-19, if the Executive Director of the Board of Medical Practice finds that the Board cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Executive Director may exercise the full powers and authorities of the Board, including disciplinary authority.

(b) The signature of the Director of the Office of Professional Regulation or of the Executive Director of the Board of Medical Practice shall have the same force and effect as a voted act of their respective boards.

(c)(1) A record of the actions of the Director of the Office of Professional Regulation taken pursuant to the authority granted by this section shall be published conspicuously on the website of the regulatory body on whose behalf the Director took the action.

(2) A record of the actions of the Executive Director of the Board of Medical Practice taken pursuant to the authority granted by this section shall be published conspicuously on the website of the Board of Medical Practice.

Sec. 21. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY REGULATORY ORDERS

During a declared state of emergency in Vermont as a result of COVID-19, the Director of Professional Regulation and the Commissioner of Health may issue such orders governing regulated professional activities and practices as may be necessary to protect the public health, safety, and welfare. If the Director or Commissioner finds that a professional practice, act, offering, therapy, or procedure by persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated is exploitative, deceptive, or detrimental to the public health, safety, or welfare, or a combination of these, the Director or Commissioner may issue an order to cease and desist from the applicable activity, which, after reasonable efforts to publicize or serve the order on the affected persons, shall be binding upon all persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated, and a violation of the order shall subject the person or persons to professional discipline, may be a basis for injunction by the Superior Court, and shall be deemed a violation of 3 V.S.A. § 127.

* * * Quarantine and Isolation for COVID-19 as Exception to Seclusion * * *

Sec. 22. ISOLATION OR QUARANTINE FOR COVID-19 NOT SECLUSION

(a) Notwithstanding any provision of statute or rule to the contrary, it shall not be considered the emergency involuntary procedure of seclusion for a voluntary patient, or for an involuntary patient in the care and custody of the Commissioner of Mental Health, to be placed in quarantine if the patient has been exposed to COVID-19 or in isolation if the patient has tested positive for COVID-19.

(b) Notwithstanding any provision of statute or rule to the contrary, it shall not be considered seclusion, as defined in the Department for Children and Families' Licensing Regulations for Residential Treatment Programs in Vermont, for a child in a residential treatment facility to be placed in quarantine if the child has been exposed to COVID-19 or in isolation if the child has tested positive for COVID-19.

* * * Telehealth * * *

Sec. 23. TELEHEALTH EXPANSION; LEGISLATIVE INTENT

It is the intent of the General Assembly to increase Vermonters' access to health care services through an expansion of telehealth services without increasing social isolation or supplanting the role of local, community-based health care providers throughout rural Vermont.

Sec. 24. 8 V.S.A. § 4100k is amended to read:

§ 4100k. COVERAGE OF HEALTH CARE SERVICES DELIVERED THROUGH TELEMEDICINE AND BY STORE-AND-FORWARD MEANS

(a)(1) All health insurance plans in this State shall provide coverage for health care services and dental services delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation.

(2)(A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or through telemedicine.

(B) The provisions of subdivision (A) of this subdivision (2) shall not apply to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor to provide health care or dental services.

(b) A health insurance plan may charge a deductible, co-payment, or coinsurance for a health care service or dental service provided through telemedicine ~~so~~ as long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(c) A health insurance plan may limit coverage to health care providers in the plan's network. A health insurance plan shall not impose limitations on the number of telemedicine consultations a covered person may receive that exceed limitations otherwise placed on in-person covered services.

(d) Nothing in this section shall be construed to prohibit a health insurance plan from providing coverage for only those services that are medically necessary and are clinically appropriate for delivery through telemedicine, subject to the terms and conditions of the covered person's policy.

(e) ~~A health insurance plan may reimburse for teleophthalmology or teledermatology provided by store and forward means and may require the distant site health care provider to document the reason the services are being provided by store and forward means.~~

(1) A health insurance plan shall reimburse for health care services and dental services delivered by store-and-forward means.

(2) A health insurance plan shall not impose more than one cost-sharing requirement on a patient for receipt of health care services or dental services delivered by store-and-forward means. If the services would require cost-sharing under the terms of the patient's health insurance plan, the plan may impose the cost-sharing requirement on the services of the originating site health care provider or of the distant site health care provider, but not both.

(f) A health insurer shall not construe a patient's receipt of services delivered through telemedicine or by store-and-forward means as limiting in

any way the patient's ability to receive additional covered in-person services from the same or a different health care provider for diagnosis or treatment of the same condition.

(g) Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

~~(g)~~(h) In order to facilitate the use of telemedicine in treating substance use disorder, when the originating site is a health care facility, health insurers and the Department of Vermont Health Access shall ensure that the health care provider at the distant site and the health care facility at the originating site are both reimbursed for the services rendered, unless the health care providers at both the distant and originating sites are employed by the same entity.

~~(h)~~(i) As used in this subchapter:

* * *

(2) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402~~, as well as~~; a stand-alone dental plan or policy or other dental insurance plan offered by a dental insurer; and Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

* * *

(4) "Health care provider" means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services, including dental services, in this State to an individual during that individual's medical care, treatment, or confinement.

* * *

(6) "Store and forward" means an asynchronous transmission of medical information, such as one or more video clips, audio clips, still images, x-rays, magnetic resonance imaging scans, electrocardiograms, electroencephalograms, or laboratory results, sent over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191 to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty ~~and by which~~. In store and forward, the health care provider at the distant site reviews the medical information without the patient present in real time and communicates a care plan or treatment recommendation back to the patient or referring provider, or both.

(7) "Telemedicine" means the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of

1996, ~~Public Law~~ Pub. L. No. 104-191. ~~Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.~~

Sec. 25. 18 V.S.A. § 9361 is amended to read:

§ 9361. HEALTH CARE PROVIDERS DELIVERING HEALTH CARE SERVICES THROUGH TELEMEDICINE OR BY ~~STORE AND FORWARD~~ STORE-AND-FORWARD MEANS

* * *

(c)(1) A health care provider delivering health care services or dental services through telemedicine shall obtain and document a patient's oral or written informed consent for the use of telemedicine technology prior to delivering services to the patient.

(A) The informed consent for telemedicine services shall be provided in accordance with Vermont and national policies and guidelines on the appropriate use of telemedicine within the provider's profession and shall include, in language that patients can easily understand:

(i) an explanation of the opportunities and limitations of delivering health care services or dental services through telemedicine;

(ii) informing the patient of the presence of any other individual who will be participating in or observing the patient's consultation with the provider at the distant site and obtaining the patient's permission for the participation or observation; and

(iii) assurance that all services the health care provider delivers to the patient through telemedicine will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

* * *

(e) ~~A patient receiving teleophthalmology or teledermatology by store and forward means shall be informed of the right to receive a consultation with the distant site health care provider and shall receive a consultation with the distant site health care provider upon request. If requested, the consultation with the distant site health care provider may occur either at the time of the initial consultation or within a reasonable period of time following the patient's notification of the results of the initial consultation. Receiving teledermatology or teleophthalmology by store and forward means.~~

(1) A patient receiving health care services or dental services by store-and-forward means shall be informed of the patient's right to refuse to receive services in this manner and to request services in an alternative format, such as through real-time telemedicine services or an in-person visit.

(2) Receipt of services by store-and-forward means shall not preclude a patient from receiving ~~real time~~ real-time telemedicine ~~or face-to-face~~ services or an in-person visit with the distant site health care provider at a future date.

(3) Originating site health care providers involved in the ~~store and forward~~ store-and-forward process shall obtain informed consent from the patient as described in subsection (c) of this section.

Sec. 26. WAIVER OF CERTAIN TELEHEALTH REQUIREMENTS DURING STATE OF EMERGENCY

Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, during a declared state of emergency in Vermont as a result of COVID-19, the following provisions related to the delivery of health care services through telemedicine or by store-and-forward means shall not be required, to the extent their waiver is permitted by federal law:

(1) delivering health care services, including dental services, using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 8 V.S.A. § 4100k(i), as amended by this act, if it is not practicable to use such a connection under the circumstances;

(2) representing to a patient that the health care services, including dental services, will be delivered using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 18 V.S.A. § 9361(c), if it is not practicable to use such a connection under the circumstances; and

(3) obtaining and documenting a patient's oral or written informed consent for the use of telemedicine or store-and-forward technology prior to

delivering services to the patient in accordance with 18 V.S.A. § 9361(c), if obtaining or documenting such consent, or both, is not practicable under the circumstances.

Sec. 27. TELEMEDICINE REIMBURSEMENT; SUNSET

8 V.S.A. § 4100k(a)(2) (telemedicine reimbursement) is repealed on January 1, 2026.

* * * Child Care Programs; Extraordinary Financial Relief * * *

Sec. 28. SUPPLEMENTAL CHILD CARE GRANTS; TEMPORARY SUSPENSION OF CAP

Notwithstanding the provision in 33 V.S.A. § 3505(a) that enables the Commissioner for Children and Families to reserve not more than one-half of one percent of the Child Care Financial Assistance Program (CCFAP) appropriation for extraordinary financial relief to assist child care programs that are at risk of closing due to financial hardship, the Commissioner may direct a greater percentage of the fiscal year 2020 CCFAP appropriation for this purpose while the state of emergency related to COVID-19 is in effect.

* * * Unemployment Insurance * * *

Sec. 29. 21 V.S.A. § 1314a is amended to read:

§ 1314a. QUARTERLY WAGE REPORTING; MISCLASSIFICATION; PENALTIES

(a)(1) ~~Effective with the calendar quarter ending September 30, 1986 and all subsequent calendar quarters, each~~ Each employing unit ~~which~~ that is an

employer ~~as defined in subdivision 1301(5) of this chapter, having~~ that has individuals in employment as defined in subdivision 1301(6) of this chapter~~,~~ shall file with the Commissioner on forms ~~to be~~ supplied by the Commissioner ~~to each such employer~~ a detailed wage report ~~containing~~ for each calendar quarter that contains each individual worker's name, Social Security number, gross wages paid during each ~~such~~ calendar quarter, and any other information the Commissioner deems ~~reasonably~~ necessary in the administration of this chapter.

(2) ~~Effective with the calendar quarter ending March 31, 2001, and all subsequent calendar quarters, in~~ In addition to other information required by this section, the wage reports required by this subsection shall include for each worker paid by the hour~~,~~ the worker's gender~~,~~ and the worker's hourly wage. ~~The wage reports may be filed electronically.~~

* * *

(c) An employing unit~~, as defined in subdivision 1301(4) of this chapter which~~ that is not an employer~~, as defined in subdivision 1301(5),~~ shall, upon request of the Commissioner, ~~file~~ submit reports on forms furnished by the Commissioner ~~reports respecting~~ regarding employment, wages, hours of employment, ~~and~~ unemployment, and related matters ~~as~~ that the Commissioner deems ~~reasonably~~ necessary in the administration of this chapter.

(d) Reports required by subsection (c) of this section shall be ~~returned so as to be received by~~ submitted to the Commissioner not later than 10 calendar

days after the date ~~of the mailing of~~ the Commissioner's request <u>was mailed</u> to the employing unit.

(e) On ~~the~~ request of the Commissioner, any employing unit or employer shall report, within 10 days of the mailing or personal delivery of the request, separation information ~~with respect to~~ <u>for</u> a claimant, any disqualifying income the claimant may have received<u>,</u> and any other information that the Commissioner may ~~reasonably~~ require to determine ~~a~~ <u>the</u> claimant's eligibility for unemployment compensation. The Commissioner shall make ~~such~~ a request ~~whenever~~ <u>when:</u>

<u>(1)</u> the claimant's eligibility is dependent ~~either~~ upon<u>:</u>

<u>(A)</u> wages paid during an incomplete calendar quarter in which the claimant was separated<u>;</u> or

<u>(B)</u> ~~upon~~ the last completed quarter~~,~~<u>;</u> and

<u>(2)</u> ~~when to do so would~~ <u>obtaining the information will</u> result in more timely benefit payments.

(f)(1) Any employing unit or employer that fails to:

(A) File ~~any~~ <u>a</u> report required by this section shall be subject to ~~a~~ <u>an administrative</u> penalty of $100.00 for each report not received by the prescribed due dates.

(B) Properly classify an individual regarding the status of employment ~~is~~ <u>shall be</u> subject to ~~a~~ <u>an administrative</u> penalty of not more than $5,000.00 for each improperly classified employee. In addition, an employer

found to have violated this section is prohibited from contracting, directly or indirectly, with the State or any of its subdivisions for up to three years following the date the employer was found to have failed to properly classify, as determined by the Commissioner in consultation with the Commissioner of Buildings and General Services or the Secretary of Transportation, as appropriate. Either the Secretary or the Commissioner, as appropriate, shall be consulted in any appeal relating to prohibiting the employer from contracting with the State or its subdivisions.

(2)(A) Penalties under this subsection shall be collected in the same manner ~~provided for the collection of~~ as contributions ~~in~~ under section 1329 of this title and shall be paid into the Contingent Fund ~~provided~~ established in section 1365 of this title.

(B) If the employing unit demonstrates that its failure was due to a reasonable cause, the Commissioner may waive or reduce the penalty.

(g)(1) Notwithstanding any other provisions of this section, the Commissioner may where practicable require ~~of~~ any employing unit ~~that~~ to file the reports required ~~to be filed~~ pursuant to subsections (a) through (d) of this section ~~be filed~~, or any departmental registration required prior to submitting the reports required by this section, in an electronic media form.

(2) The Commissioner may waive the requirement that an employing unit submit a report in an electronic media form if the employing unit attests that it is unable to file the required report in that form.

* * * Unemployment Insurance Related to COVID-19 Outbreak * * *

Sec. 30. 21 V.S.A. § 1325 is amended to read:

§ 1325. EMPLOYERS' EXPERIENCE-RATING RECORDS; DISCLOSURE TO SUCCESSOR ENTITY

(a)(1) The Commissioner shall maintain an experience-rating record for each employer. Benefits paid shall be charged against the experience-rating record of each subject employer who provided base-period wages to the eligible individual. Each subject employer's experience-rating charge shall bear the same ratio to total benefits paid as the total base-period wages paid by that employer bear to the total base-period wages paid to the individual by all base-period employers. The experience-rating record of an individual subject base-period employer shall not be charged for benefits paid to an individual under any of the following conditions:

* * *

(G) The individual voluntarily separated from that employer as provided by subdivision 1344(a)(2)(A) of this chapter for one of the following reasons:

(i) to self-isolate or quarantine at the recommendation of a health care provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the individual has been diagnosed with COVID-19;

(II) the individual is experiencing the symptoms of COVID-19;

(III) the individual has been exposed to COVID-19; or

(IV) the individual belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(ii) because of an unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment;

(iii) to care for or assist a family member of the individual who is self-isolating or quarantining at the recommendation of a health care provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the family member has been diagnosed with COVID-19;

(II) the family member is experiencing the symptoms of COVID-19;

(III) the family member has been exposed to COVID-19; or

(IV) the family member belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(iv) to care for or assist a family member who has left employment because of an unreasonable risk that they could be exposed to or become infected with COVID-19 at their place of employment; or

(v) to care for a child under 18 years of age because the child's school or child care has been closed or the child care provider is unavailable due to a public health emergency related to COVID-19.

(H) As used in this subdivision (a)(1):

(i) "Family member" means an individual's parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child. As used in this subdivision (a)(1)(H)(i), "spouse" includes a domestic partner or civil union partner.

(ii) "An unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment" shall include the individual's place of employment being out of compliance with the Guidance on Preparing Workplaces for COVID-19 issued by the U.S. Occupational Safety and Health Administration (OSHA) or any similar guidance issued by OSHA, the U.S. Centers for Disease Control, or the Vermont Department of Health and any other conditions or factors that the Commissioner determines to create an unreasonable risk.

(2) If an individual's unemployment is directly caused by a major disaster declared by the President of the United States pursuant to 42 U.S.C. § 5122 and the individual would have been eligible for federal disaster

unemployment assistance benefits but for the receipt of regular benefits, an employer shall be relieved of charges for benefits paid to the individual with respect to any week of unemployment occurring due to the natural disaster up to a maximum amount of four weeks.

(3)(A) Subject to the provisions of subdivision (B) of this subdivision (a)(3), an employer shall be relieved of charges for benefits paid to an individual for a period of up to eight weeks with respect to benefits paid because:

(i) the employer temporarily ceased operation, either partially or completely, at the individual's place of employment in response to a request from a public health authority with jurisdiction that the employer cease operations because of COVID-19, in response to an emergency order or directive issued by the Governor or the President related to COVID-19, or because the employer voluntarily ceased operations due to the actual exposure of workers at that place of employment to COVID-19;

(ii) the individual becomes unemployed as a direct result of a state of emergency declared by the Governor or the President in relation to COVID-19 or an order or directive issued by the Governor or President in relation to COVID-19; or

(iii) the individual has been recommended or requested by a medical professional or a public health authority with jurisdiction to be isolated

or quarantined as a result of COVID-19, regardless of whether the individual has been diagnosed with COVID-19.

(B) An employer shall only be eligible for relief of charges for benefits paid under the provisions of this subdivision (a)(3) if the employer rehires or offers to rehire the individual within a reasonable period of time after the employer resumes operations at the individual's place of employment, as determined by the Commissioner, or upon the completion of the individual's period of isolation or quarantine.

(C) The Commissioner may extend the period for which an employer shall be relieved of charges for benefits paid to employees pursuant to subdivision (A)(i) of this subdivision (a)(3) by an amount that the Commissioner determines to be appropriate in light of the terms of any applicable request from a local health official or the Commissioner of Health or any applicable emergency order or directive issued by the Governor or the President and any other relevant conditions or factors.

* * *

Sec. 31. 21 V.S.A. § 1344 is amended to read:

§ 1344. DISQUALIFICATIONS

(a) An individual shall be disqualified for benefits:

* * *

(2) For any week benefits are claimed, except as provided in subdivision (a)(3) of this section, until he or she has presented evidence to the satisfaction

of the Commissioner that he or she has performed services in employment for a bona fide employer and has had earnings in excess of six times his or her weekly benefit amount if the Commissioner finds that such individual is unemployed because:

(A) He or she has left the employ of his or her last employing unit voluntarily without good cause attributable to such employing unit. An individual shall not suffer more than one disqualification by reason of such separation. However, an individual shall not be disqualified for benefits if:

(i) the individual left such employment to accompany a spouse who:

~~(i)~~(I) is on active duty with the U.S. Armed Forces and is required to relocate due to permanent change of station orders, activation orders, or unit deployment orders, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit; or

~~(ii)~~(II) holds a commission in the U.S. Foreign Service and is assigned overseas, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit~~.~~;

(ii) the individual has left employment to self-isolate or quarantine at the recommendation of a health care provider or pursuant to a specific

recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the individual has been diagnosed with COVID-19;

(II) the individual is experiencing the symptoms of COVID-19;

(III) the individual has been exposed to COVID-19; or

(IV) the individual belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(iii) the individual has left employment because of an unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment;

(iv) the individual has left employment to care for or assist a family member of the individual who is self-isolating or quarantining at the recommendation of a health care provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:

(I) the family member has been diagnosed with COVID-19;

(II) the family member is experiencing the symptoms of COVID-19;

(III) the family member has been exposed to COVID-19; or

(IV) the family member belongs to a specific class or group of persons that have been identified as being at high-risk if exposed to or infected with COVID-19;

(v) the individual has left employment to care for or assist a family member who has left employment because of an unreasonable risk that they could be exposed to or become infected with COVID-19 at their place of employment; or

(vi) the individual left employment to care for a child under 18 years of age because the child's school or child care has been closed or the child care provider is unavailable due to a public health emergency related to COVID-19.

* * *

(G) As used in this subdivision (a)(2):

(i) "Family member" means an individual's parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child. As used in this subdivision (a)(2)(G)(i), "spouse" includes a domestic partner or civil union partner.

(ii) "An unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment" shall include the individual's place of employment being out of compliance with the Guidance on Preparing Workplaces for COVID-19 issued by the U.S. Occupational Safety and Health Administration (OSHA) or any similar

guidance issued by OSHA, the U.S. Centers for Disease Control, or the Vermont Department of Health and any other conditions or factors that the Commissioner determines to create an unreasonable risk.

(H)(i) Except as otherwise provided pursuant to subdivision (2) of this subdivision (a)(2)(H), an unemployed individual who is eligible for benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection shall be ineligible for benefits under those subdivisions if the individual becomes eligible for benefits provided pursuant to:

(I) enacted federal legislation that amends or establishes a federal program providing benefits for unemployed individuals that are similar to the benefits provided pursuant to subdivisions (2)(A)(ii)–(vi); or

(II) a national emergency declared by the President that results in the provision of benefits pursuant to Disaster Unemployment Assistance, Emergency Unemployment Compensation, Extended Unemployment Compensation, or any similar type program.

(ii) An individual who is receiving benefits pursuant to a federal program as set forth in subdivision (i) of this subdivision (a)(2)(H) shall not receive benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection except when and to the extent that the benefits provided by the applicable federal program are different from or are not in lieu of the benefits that are available pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection, in which

case the benefits provided under subdivisions (2)(A)(ii)–(vi) of this subsection shall continue.

(iii) Nothing in this subdivision (a)(2)(H) shall be construed to prevent an individual from receiving benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection if the individual's employer refuses or fails to pay the individual for leave under the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.

* * *

(5) For any week with respect to which the individual is receiving or has received remuneration in the form of:

* * *

(F) Sick pay or pay received pursuant to the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.

* * *

* * * Repeal of COVID-19 Related Unemployment Insurance Provisions * * *

Sec. 32. REPEAL

21 V.S.A. § 1325(a)(1)(G), (H), and (a)(3) are repealed.

Sec. 33. 21 V.S.A. § 1344 is amended to read:

§ 1344. DISQUALIFICATIONS

(a) An individual shall be disqualified for benefits:

* * *

(2) For any week benefits are claimed, except as provided in subdivision (a)(3) of this section, until he or she has presented evidence to the satisfaction of the Commissioner that he or she has performed services in employment for a bona fide employer and has had earnings in excess of six times his or her weekly benefit amount if the Commissioner finds that such individual is unemployed because:

(A) He or she has left the employ of his or her last employing unit voluntarily without good cause attributable to such employing unit. An individual shall not suffer more than one disqualification by reason of such separation. However, an individual shall not be disqualified for benefits if~~:~~

~~(i)~~ the individual left such employment to accompany a spouse who:

~~(I)~~(i) is on active duty with the U.S. Armed Forces and is required to relocate due to permanent change of station orders, activation orders, or unit deployment orders, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit; or

~~(II)~~(ii) holds a commission in the U.S. Foreign Service and is assigned overseas, and when such relocation would make it impractical or impossible, as determined by the Commissioner, for the individual to continue working for such employing unit~~;~~.

~~(ii) the individual has left employment to self-isolate or quarantine at the recommendation of a healthcare provider, or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President for one of the following reasons:~~

~~(I) the individual has been diagnosed with COVID-19;~~

~~(II) the individual is experiencing the symptoms of COVID-19;~~

~~(III) the individual has been exposed to COVID-19; or~~

~~(IV) the individual belongs to a specific class or group of persons that have been identified as being at high risk if exposed to or infected with COVID-19;~~

~~(iii) the individual has left employment because of an unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment;~~

~~(iv) the individual has left employment to care for or assist a family member of the individual who is self-isolating or quarantining at the recommendation of a healthcare provider or pursuant to a specific recommendation, directive, or order issued by a public health authority with jurisdiction, the Governor, or the President, for one of the following reasons:~~

~~(I) the family member has been diagnosed with COVID-19;~~

~~(II) the family member is experiencing the symptoms of COVID-19;~~

~~(III) the family member has been exposed to COVID-19; or~~

~~(IV) the family member belongs to a specific class or group of persons that have been identified as being at high risk if exposed to or infected with COVID-19;~~

~~(v) the individual has left employment to care for or assist a family member who has left employment because of an unreasonable risk that they could be exposed to or become infected with COVID-19 at their place of employment; or~~

~~(vi) the individual left such employment to care for a child under 18 years of age because the child's school or child care has been closed or the child care provider is unavailable due to a public health emergency related to COVID-19.~~

~~(H)(i) Except as otherwise provided pursuant to subdivision (2) of this subdivision (a)(2)(H), an unemployed individual who is eligible for benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection shall be ineligible for benefits under those subdivisions if the individual becomes eligible for benefits provided pursuant to:~~

~~(I) enacted federal legislation that amends or establishes a federal program providing benefits for unemployed individuals that are similar to the benefits provided pursuant to subdivisions (2)(A)(ii)–(vi); or~~

~~(II) a national emergency declared by the President that results in the provision of benefits pursuant to Disaster Unemployment Assistance,~~

~~Emergency Unemployment Compensation, Extended Unemployment Compensation, or any similar type program.~~

~~(ii) An individual who is receiving benefits pursuant to a federal program as set forth in subdivision (i) of this subdivision (a)(2)(H) shall not receive benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection except when and to the extent that the benefits provided by the applicable federal program are different from or are not in lieu of the benefits that are available pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection, in which case the benefits provided under subdivisions (2)(A)(ii)–(vi) of this subsection shall continue.~~

~~(iii) Nothing in this subdivision (a)(2)(H) shall be construed to prevent an individual from receiving benefits pursuant to subdivisions (2)(A)(ii)–(vi) of this subsection if the individual's employer refuses or fails to pay the individual for leave under the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act.~~

* * *

~~(G) As used in this subdivision (a)(2):~~

~~(i) "Family member" means an individual's parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child. As used in this subdivision (a)(2)(G)(i), "spouse" includes a domestic partner or civil union partner.~~

~~(ii) "An unreasonable risk that the individual could be exposed to or become infected with COVID-19 at the individual's place of employment" shall include the individual's place of employment being out of compliance with the Guidance on Preparing Workplaces for COVID-19 issued by the U.S. Occupational Safety and Health Administration (OSHA) or any similar guidance issued by OSHA, the U.S. Centers for Disease Control, or the Vermont Department of Health and any other conditions or factors that the Commissioner determines to create an unreasonable risk.~~

* * *

(5) For any week in which the individual is receiving or has received remuneration in the form of:

* * *

~~(F) Sick pay or pay received pursuant to the federal Emergency Family and Medical Leave Expansion Act or the federal Emergency Paid Sick Leave Act~~.

* * *

Sec. 34. 21 V.S.A. § 1346 is amended to read:

§ 1346. CLAIMS FOR BENEFITS; RULES; NOTICE

* * *

(c)(1) An employer shall post notice of how an unemployed individual can seek unemployment benefits in a form provided by the Commissioner in a place conspicuous to individuals performing services for the employer. The

notice shall also advise individuals of their rights under the Domestic and Sexual Violence Survivor's Transitional Employment Program, established pursuant to chapter 16A of this title. The Commissioner shall provide a copy of the notice to an employer upon request without cost to the employer.

(2) An employer shall provide an individual with notification of the availability of unemployment compensation at the time of the individual's separation from employment. The notification may be based on model notification language provided by the U.S. Secretary of Labor.

* * * Motor Vehicles * * *

Sec. 35. PHOTOGRAPHS FOR RENEWALS

(a) Notwithstanding any provision of 23 V.S.A. § 115(g), 610(c), or 617(e) to the contrary, a licensee shall be permitted to renew a driver's license, learner's permit, privilege to operate, or non-driver identification card with a photograph obtained not more than 16 years earlier that is compliant with the federal REAL ID Act, 6 C.F.R. part 37.

(b) Notwithstanding 1 V.S.A. § 214, subsection (a) of this section shall take effect retroactively on March 20, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

Sec. 36. EXTENSIONS

(a) Notwithstanding any provision of 23 V.S.A. § 312, 457, 458, 3702, or 3703 to the contrary, all International Registration Plan trip permits and

temporary authorizations, temporary registration certificates, and temporary number plates shall be valid for 90 days from the date of issuance.

(b) Notwithstanding any provision of Title 23 of the Vermont Statutes Annotated or rules adopted pursuant to Title 23 to the contrary, the Commissioner of Motor Vehicles may extend any existing permits issued by the Department of Motor Vehicles, excluding International Registration Plan trip permits, for an additional 90 days.

(c) Notwithstanding any provision of 23 V.S.A. § 115, 302, 304a, 305, 601, or 617 to the contrary, the Commissioner shall extend all of the following for an additional 90 days after expiration: driver's licenses; learner's permits; privileges to operate; non-driver identification cards; registrations; and registration plates or placards for an individual with a disability.

(d) Notwithstanding 1 V.S.A. § 214, subsections (a) and (b) of this section shall take effect retroactively on March 20, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

(e) Notwithstanding 1 V.S.A. § 214, subsection (c) of this section shall take effect retroactively on March 17, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

Sec. 37. USE OF EIGHT-LIGHT SYSTEM ON SCHOOL BUSES

(a) Notwithstanding any provision of 23 V.S.A. § 1283(a)(4) to the contrary, the driver of a Type I or a Type II school bus may keep the alternately flashing red signal lamps of an eight-light system lighted when making deliveries of food to school aged children.

(b) Notwithstanding 1 V.S.A. § 214, subsection (a) of this section shall take effect retroactively on March 20, 2020 and continue in effect until the termination of the state of emergency declared by the Governor as a result of COVID-19.

* * * Effective Dates * * *

Sec. 38. EFFECTIVE DATES

This act shall take effect on passage, except that:

(1) In Sec. 24, 8 V.S.A. § 4100k(e) (coverage of health care services delivered by store-and-forward means) shall take effect on January 1, 2021.

(2) Sec. 29 shall take effect on July 1, 2020.

(3) Secs. 32 and 33 shall take effect on March 31, 2021.

Date Governor signed bill: March 30, 2020

No. 140. An act relating to miscellaneous health care provisions.

(H.960)

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.~~

Collect and review data from each community mental health and developmental disability agency designated by the Commissioner of Mental Health or of Disabilities, Aging, and Independent Living pursuant to chapter 207 of this title, which may include data regarding a designated or specialized

service agency's scope of services, volume, utilization, payer mix, quality, coordination with other aspects of the health care system, and financial condition, including solvency. The Board's processes shall be appropriate to the designated and specialized service agencies' scale and their role in Vermont's health care system, and the Board shall consider ways in which the designated and specialized service agencies can be integrated fully into systemwide payment and delivery system reform.

* * *

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 Disabilities, Aging, and Independent Living or designee;

(G) the Commissioner of Financial Regulation or designee;

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

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

(J) the Secretary of Education or designee;

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

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

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

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

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

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

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

(R) the Health Care Advocate established pursuant to 18 V.S.A. § 9602;

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

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

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

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

(W) 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 Health shall serve as vice chair.

(3) The Council shall meet every other month between 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 six meetings annually. 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 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.

(d)(1) On or before October 1, 2020, as part of the reporting requirements of the Sustainability Report between the Agency of Human Services and the Brattleboro Retreat , the Agency and the Brattleboro Retreat shall submit an interim report to the Joint Fiscal Committee, and to the Chairs of the Senate Committee on Health and Welfare and the House Committee on Health Care describing the steps that the Brattleboro Retreat is taking to improve communication and relations with its employees.

(2) On or before February 1, 2021, as part of the reporting requirements of the Sustainability Report between the Agency of Human Services and the Brattleboro Retreat, the Agency and the Brattleboro Retreat shall submit a final report to the Senate Committee on Health and Welfare and to the House Committee on Health Care describing the steps that the Brattleboro Retreat is taking to improve communication and relations with its employees, the Brattleboro Retreat's assessment of the effectiveness of those efforts, and how

the Brattleboro Retreat plans to manage future communications and relations with its employees.

* * * 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) When Vermont next seeks changes to its Global Commitment to Health Section 1115 Medicaid demonstration waiver, the Agency of Human Services shall request approval from the Centers for Medicare and Medicaid Services to include 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.

* * * Extending Certain Act 91 Provisions Beyond State of Emergency * * *

Sec. 13. 2020 Acts and Resolves No. 91 is amended to read:

* * * Supporting Health Care and Human Service Provider Sustainability* * *

Sec. 1. AGENCY OF HUMAN SERVICES; HEALTH CARE AND HUMAN SERVICE PROVIDER SUSTAINABILITY

~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, the Agency of Human Services shall consider ~~waiving or~~ modifying existing rules~~,~~ or adopting emergency rules~~,~~ to protect access to health care services, long-term services and supports, and other human services under the Agency's jurisdiction. In ~~waiving,~~ modifying~~,~~ or adopting rules, the Agency shall consider the importance of the financial viability of providers that rely on funding from the State, federal government, or Medicaid, or a combination of these, for a major portion of their revenue.

* * *

* * * Protections for Employees of Health Care Facilities and Human Service Providers * * *

Sec. 3. PROTECTIONS FOR EMPLOYEES OF HEALTH CARE FACILITIES AND HUMAN SERVICE PROVIDERS

In order to protect employees of a health care facility or human service provider who are not licensed health care professionals from the risks associated with COVID-19, through March 31, 2021, all health care facilities and human service providers in Vermont, including hospitals, federally qualified health centers, rural health clinics, residential treatment programs, homeless shelters, home- and community-based service providers, and long-term care facilities, shall follow guidance from the Vermont Department of Health regarding measures to address employee safety, to the extent feasible.

* * * Compliance Flexibility * * *

Sec. 4. HEALTH CARE AND HUMAN SERVICE PROVIDER REGULATION; WAIVER OR VARIANCE PERMITTED

Notwithstanding any provision of the Agency of Human Services' administrative rules or standards to the contrary, ~~during a declared state of emergency in Vermont as a result of COVID-19~~ through March 31, 2021, the Secretary of Human Services may waive or permit variances from the following State rules and standards governing providers of health care services and human services as necessary to prioritize and maximize direct patient care, support children and families who receive benefits and services through the

Department for Children and Families, and allow for continuation of operations with a reduced workforce and with flexible staffing arrangements that are responsive to evolving needs, to the extent such waivers or variances are permitted under federal law:

(1) Hospital Licensing Rule;

(2) Hospital Reporting Rule;

(3) Nursing Home Licensing and Operating Rule;

(4) Home Health Agency Designation and Operation Regulations;

(5) Residential Care Home Licensing Regulations;

(6) Assisted Living Residence Licensing Regulations;

(7) Home for the Terminally Ill Licensing Regulations;

(8) Standards for Adult Day Services;

(9) Therapeutic Community Residences Licensing Regulations;

(10) Choices for Care High/Highest Manual;

(11) Designated and Specialized Service Agency designation and provider rules;

(12) Child Care Licensing Regulations;

(13) Public Assistance Program Regulations;

(14) Foster Care and Residential Program Regulations; and

(15) other rules and standards for which the Agency of Human Services is the adopting authority under 3 V.S.A. chapter 25.

* * *

Sec. 6. MEDICAID AND HEALTH INSURERS; PROVIDER ENROLLMENT AND CREDENTIALING

(a) ~~During~~ Until the last to terminate of a declared state of emergency in Vermont as a result of COVID-19, a declared federal public health emergency as a result of COVID-19, and a declared national emergency as a result of COVID-19, and to the extent permitted under federal law, the Department of Vermont Health Access shall relax provider enrollment requirements for the Medicaid program, and the Department of Financial Regulation shall direct health insurers to relax provider credentialing requirements for health insurance plans, in order to allow for individual health care providers to deliver and be reimbursed for services provided across health care settings as needed to respond to Vermonters' evolving health care needs.

(b) In the event that another state of emergency is declared in Vermont as a result of COVID-19 after the termination of the State and federal emergencies, the Departments shall again cause the provider enrollment and credentialing requirements to be relaxed as set forth in subsection (a) of this section.

* * *

* * * Access to Health Care Services and Human Services * * *

Sec. 8. ACCESS TO HEALTH CARE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

It is the intent of the General Assembly to increase Vermonters' access to medically necessary health care services during and after a declared state of

emergency in Vermont as a result of COVID-19. ~~During such a declared state of emergency, the~~ Until July 1, 2021, and notwithstanding any provision of 3 V.S.A. § 844 to the contrary, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address the following ~~for the duration of the state of emergency~~ through June 30, 2021:

(1) expanding health insurance coverage for, and waiving or limiting cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention;

(2) modifying or suspending health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expanding patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Sec. 9. PRESCRIPTION DRUGS; MAINTENANCE MEDICATIONS; EARLY REFILLS

(a) As used in this section, "health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in

18 V.S.A. § 9402. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(b) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through June 30, 2021, all health insurance plans and Vermont Medicaid shall allow their members to refill prescriptions for chronic maintenance medications early to enable the members to maintain a 30-day supply of each prescribed maintenance medication at home.

(c) As used in this section, "maintenance medication" means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

Sec. 10. PHARMACISTS; CLINICAL PHARMACY; EXTENSION OF PRESCRIPTION FOR MAINTENANCE MEDICATION

(a) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through June 30, 2021, a pharmacist may extend a previous prescription for a maintenance medication for which the patient has no refills remaining or for which the authorization for refills has recently expired if it is not feasible to obtain a new prescription or refill authorization from the prescriber.

(b) A pharmacist who extends a prescription for a maintenance medication pursuant to this section shall take all reasonable measures to notify the prescriber of the prescription extension in a timely manner.

(c) As used in this section, "maintenance medication" means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

Sec. 11. PHARMACISTS; CLINICAL PHARMACY; THERAPEUTIC SUBSTITUTION DUE TO LACK OF AVAILABILITY

(a) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, a pharmacist may, with the informed consent of the patient, substitute an available drug or insulin product for an unavailable prescribed drug or insulin product in the same therapeutic class if the available drug or insulin product would, in the clinical judgment of the pharmacist, have substantially equivalent therapeutic effect even though it is not a therapeutic equivalent.

(b) As soon as reasonably possible after substituting a drug or insulin product pursuant to subsection (a) of this section, the pharmacist shall notify the prescribing clinician of the drug or insulin product, dose, and quantity actually dispensed to the patient.

Sec. 12. BUPRENORPHINE; PRESCRIPTION RENEWALS

~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, to the extent permitted under federal law, a health care professional authorized to prescribe buprenorphine for treatment of

substance use disorder may authorize renewal of a patient's existing buprenorphine prescription without requiring an office visit.

Sec. 13. 24-HOUR FACILITIES AND PROGRAMS; BED-HOLD DAYS

~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, to the extent permitted under federal law, the Agency of Human Services may reimburse Medicaid-funded long-term care facilities and other programs providing 24-hour per day services for their bed-hold days.

* * * Regulation of Professions * * *

* * *

Sec. 17. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; OUT-OF-STATE HEALTH CARE PROFESSIONALS

(a) Notwithstanding any provision of Vermont's professional licensure statutes or rules to the contrary, ~~during a declared state of emergency in Vermont as a result of COVID-19~~ through March 31, 2021, a health care professional, including a mental health professional, who holds a valid license, certificate, or registration to provide health care services in any other U.S. jurisdiction shall be deemed to be licensed, certified, or registered to provide health care services, including mental health services, to a patient located in Vermont using telehealth or as part of the staff of a licensed facility, provided the health care professional:

(1) is licensed, certified, or registered in good standing in the other U.S. jurisdiction or jurisdictions in which the health care professional holds a license, certificate, or registration;

(2) is not subject to any professional disciplinary proceedings in any other U.S. jurisdiction; and

(3) is not affirmatively barred from practice in Vermont for reasons of fraud or abuse, patient care, or public safety.

(b) A health care professional who plans to provide health care services in Vermont as part of the staff of a licensed facility shall submit or have submitted on the individual's behalf the individual's name, contact information, and the location or locations at which the individual will be practicing to:

(1) the Board of Medical Practice for medical doctors, physician assistants, and podiatrists; or

(2) the Office of Professional Regulation for all other health care professions.

(c) A health care professional who delivers health care services in Vermont pursuant to subsection (a) of this section shall be subject to the imputed jurisdiction of the Board of Medical Practice or the Office of Professional Regulation, as applicable based on the health care professional's profession, in accordance with Sec. 19 of this act.

(d) This section shall remain in effect ~~until the termination of the declared state of emergency in Vermont as a result of COVID-19 and~~ through March 31, 2021, provided the health care professional remains licensed, certified, or registered in good standing.

Sec. 18. RETIRED HEALTH CARE PROFESSIONALS; BOARD OF MEDICAL PRACTICE; OFFICE OF PROFESSIONAL REGULATION

(a)(1) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, a former health care professional, including a mental health professional, who retired not more than three years earlier with the individual's Vermont license, certificate, or registration in good standing may provide health care services, including mental health services, to a patient located in Vermont using telehealth or as part of the staff of a licensed facility after submitting, or having submitted on the individual's behalf, to the Board of Medical Practice or Office of Professional Regulation, as applicable, the individual's name, contact information, and the location or locations at which the individual will be practicing.

(2) A former health care professional who returns to the Vermont health care workforce pursuant to this subsection shall be subject to the regulatory jurisdiction of the Board of Medical Practice or the Office of Professional Regulation, as applicable.

(b) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, the Board of Medical Practice and the Office of Professional Regulation may permit former health care professionals, including mental health professionals, who retired more than three but less than 10 years earlier with their Vermont license, certificate, or registration in good standing to return to the health care workforce on a temporary basis to provide health care services, including mental health services, to patients in Vermont. The Board of Medical Practice and Office of Professional Regulation may issue temporary licenses to these individuals at no charge and may impose limitations on the scope of practice of returning health care professionals as the Board or Office deems appropriate.

Sec. 19. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; IMPUTED JURISDICTION

A practitioner of a profession or professional activity regulated by Title 26 of the Vermont Statutes Annotated who provides regulated professional services to a patient in the State of Vermont without holding a Vermont license, as may be authorized ~~in~~ during or after a declared state of emergency, is deemed to consent to, and shall be subject to, the regulatory and disciplinary jurisdiction of the Vermont regulatory agency or body having jurisdiction over the regulated profession or professional activity.

Sec. 20. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY AUTHORITY TO ACT FOR REGULATORY BOARDS

(a)(1) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, if the Director of Professional Regulation finds that a regulatory body attached to the Office of Professional Regulation by 3 V.S.A. § 122 cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Director may exercise the full powers and authorities of that regulatory body, including disciplinary authority.

(2) ~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, if the Executive Director of the Board of Medical Practice finds that the Board cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Executive Director may exercise the full powers and authorities of the Board, including disciplinary authority.

(b) The signature of the Director of the Office of Professional Regulation or of the Executive Director of the Board of Medical Practice shall have the same force and effect as a voted act of their respective boards.

(c)(1) A record of the actions of the Director of the Office of Professional Regulation taken pursuant to the authority granted by this section shall be

published conspicuously on the website of the regulatory body on whose behalf the Director took the action.

(2) A record of the actions of the Executive Director of the Board of Medical Practice taken pursuant to the authority granted by this section shall be published conspicuously on the website of the Board of Medical Practice.

Sec. 21. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY REGULATORY ORDERS

~~During a declared state of emergency in Vermont as a result of COVID-19~~ Through March 31, 2021, the Director of Professional Regulation and the Commissioner of Health may issue such orders governing regulated professional activities and practices as may be necessary to protect the public health, safety, and welfare. If the Director or Commissioner finds that a professional practice, act, offering, therapy, or procedure by persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated is exploitative, deceptive, or detrimental to the public health, safety, or welfare, or a combination of these, the Director or Commissioner may issue an order to cease and desist from the applicable activity, which, after reasonable efforts to publicize or serve the order on the affected persons, shall be binding upon all persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated, and a violation of the order shall subject the person or persons to

professional discipline, may be a basis for injunction by the Superior Court, and shall be deemed a violation of 3 V.S.A. § 127.

* * *

* * * Telehealth * * *

* * *

Sec. 26. WAIVER OF CERTAIN TELEHEALTH REQUIREMENTS ~~DURING STATE OF EMERGENCY~~ FOR A LIMITED TIME

Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, ~~during a declared state of emergency in Vermont as a result of COVID-19~~ through March 31, 2021, the following provisions related to the delivery of health care services through telemedicine or by store-and-forward means shall not be required, to the extent their waiver is permitted by federal law:

(1) delivering health care services, including dental services, using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 8 V.S.A. § 4100k(i), as amended by this act, if it is not practicable to use such a connection under the circumstances;

(2) representing to a patient that the health care services, including dental services, will be delivered using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of

1996, Pub. L. No. 104-191 in accordance with 18 V.S.A. § 9361(c), if it is not practicable to use such a connection under the circumstances; and

(3) obtaining and documenting a patient's oral or written informed consent for the use of telemedicine or store-and-forward technology prior to delivering services to the patient in accordance with 18 V.S.A. § 9361(c), if obtaining or documenting such consent, or both, is not practicable under the circumstances.

* * *

* * * Effective Dates * * *

Sec. 38. EFFECTIVE DATES

This act shall take effect on passage, except that:

(1) In Sec. 24, 8 V.S.A. § 4100k(e) (coverage of health care services delivered by store-and-forward means) shall take effect on ~~January 1, 2021~~ May 1, 2020 for commercial health insurance and on July 1, 2020 for Vermont Medicaid.

* * *

Sec. 14. OFFICE OF PROFESSIONAL REGULATION; TEMPORARY LICENSURE

Notwithstanding any provision of 3 V.S.A. § 129(a)(10) to the contrary, through March 31, 2021, a board or profession attached to the Office of Professional Regulation may issue a temporary license to an individual who is

a graduate of an approved education program if the licensing examination required for the individual's profession is not reasonably available.

Sec. 15. BOARD OF MEDICAL PRACTICE; TEMPORARY PROVISIONS; PHYSICIANS, PHYSICIAN ASSISTANTS, AND PODIATRISTS

(a) Notwithstanding any provision of 26 V.S.A. § 1353(11) to the contrary, the Board of Medical Practice or its Executive Director may issue a temporary license through March 31, 2021 to an individual who is licensed to practice as a physician, physician assistant, or podiatrist in another jurisdiction, whose license is in good standing, and who is not subject to disciplinary proceedings in any other jurisdiction. The temporary license shall authorize the holder to practice in Vermont until a date not later than April 1, 2021, provided the licensee remains in good standing.

(b) Through March 31, 2021, the Board of Medical Practice or its Executive Director may waive supervision and scope of practice requirements for physician assistants, including the requirement for documentation of the relationship between a physician assistant and a physician pursuant to 26 V.S.A. § 1735a. The Board or Executive Director may impose limitations or conditions when granting a waiver under this subsection.

* * * Delivery of Health Care Services by Telehealth and Telephone * * *

Sec. 16. COVERAGE FOR HEALTH CARE SERVICES DELIVERED BY TELEPHONE; WORKING GROUP

(a) The Department of Financial Regulation shall 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. The working group shall include representatives of the Department of Vermont Health Access, health insurers, the Vermont Medical Society, Bi-State Primary Care Association, the VNAs of Vermont, the Vermont Association of Hospitals and Health Systems, the Office of the Health Care Advocate, and other interested stakeholders.

(b) On or before December 1, 2020, the Department of Financial Regulation shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance the working group's recommendations for ongoing coverage of health care services delivered by telephone.

Sec. 17. TELEHEALTH; CONNECTIVITY; FUNDING OPPORTUNITIES

(a) The Vermont Program for Quality in Health Care, Inc., shall consult with its Statewide Telehealth Workgroup, the Department of Public Service, and organizations representing health care providers and health care consumers to identify:

(1) areas of the State that do not have access to broadband service and that are also medically underserved or have high concentrations of high-risk or vulnerable patients, or both, and where equitable access to telehealth services would result in improved patient outcomes or reduced health care costs, or both; and

(2) opportunities to use federal funds and funds from other sources to increase Vermonters' access to clinically appropriate telehealth services, including opportunities to maximize access to federal grants through strategic planning, coordination, and resource and information sharing.

(b) Based on the information obtained pursuant to subsection (a) of this section, the Vermont Program for Quality in Health Care, Inc., and the Department of Public Service, with input from organizations representing health care providers and health care consumers, shall support health care providers' efforts to pursue available funding opportunities in order to increase Vermonters' access to clinically appropriate telehealth services via information dissemination and technical assistance to the extent feasible under the current billback funding mechanism under 18 V.S.A. § 9416(c).

(c) In coordinating and administering the efforts described in this section, the Vermont Program for Quality in Health Care, Inc. shall use federal funds to the greatest extent possible.

* * * Effective Dates * * *

Sec. 18. 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;

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

(4) notwithstanding 1 V.S.A. § 214, in Sec. 14 (2020 Acts and Resolves No. 91), the amendment to Sec. 38 (effective date for store and forward) shall take effect on passage and shall apply retroactively to March 30, 2020.

Date Governor signed bill: July 6, 2020

No. 159. An act relating to hospital price transparency, hospital sustainability planning, provider sustainability and reimbursements, and regulators' access to information.

(H.795)

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

Sec. 1. GREEN MOUNTAIN CARE BOARD; PRICE TRANSPARENCY DASHBOARD; PRIVATE PAY PRICING; REPORT

On or before February 1, 2021, the Green Mountain Care Board shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding its progress in developing and implementing a public, interactive, Internet-based price transparency dashboard for use by health care consumers, including the results of the Board's efforts to validate VHCURES data through comparison with hospital discharge data and with information from the health insurers and the status of the Board's work with the various payers to incorporate location information into VHCURES data. The Board shall also include in the report any information ascertained from the validation process regarding payments for services by patients without health insurance coverage, as well as the information the hospitals track relating to self-pay patients and the means by which hospitals may provide information to the Board in the future regarding actual amounts paid for services by patients without health insurance coverage.

Sec. 2. 18 V.S.A. § 9411 is added to read:

§ 9411. INTERACTIVE PRICE TRANSPARENCY DASHBOARD

(a) The Green Mountain Care Board shall develop and maintain a public, interactive, Internet-based price transparency dashboard that allows consumers to compare health care prices for certain health care services across the State. Using data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) established pursuant to section 9410 of this title, the dashboard shall provide the range of actual allowed amounts for selected health care services, showing both the amount paid by the health insurer or other payer and the amount of the member's responsibility, and shall allow the consumer to sort the information by geographic location, by health care provider, by payer type, and by the specific health care procedure or health care service. The Board shall provide a link on the dashboard to the statewide comparative hospital quality report published by the Commissioner of Health pursuant to section 9405b of this title.

(b) The Board shall update the information in the interactive price transparency dashboard at least annually.

Sec. 3. INTERACTIVE PRICE TRANSPARENCY DASHBOARD; DEMONSTRATION; RECOMMENDATIONS; REPORT

(a) On or before February 1, 2022, the Green Mountain Care Board shall provide a demonstration of the interactive price transparency dashboard

developed pursuant to 18 V.S.A. § 9411 to the House Committees on Health Care and the Senate Committees on Health and Welfare and on Finance.

(b) In addition to the demonstration required by subsection (a) of this section, on or before February 1, 2022, the Green Mountain Care Board shall provide recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding ways in which the price transparency dashboard may be expanded to provide information on health care quality, on actual amounts charged to patients without health insurance coverage after the application of any relevant charity care policies or other discounts, and on other claims and payment data not currently collected by VHCURES.

Sec. 4. HOSPITAL SUSTAINABILITY PLANNING; REPORTS

(a)(1) The Green Mountain Care Board shall consider ways to increase the financial sustainability of Vermont hospitals in order to achieve population-based health improvements while maintaining community access to services. In conducting this work, the Board shall consult with the Director of Health Care Reform in the Agency of Human Services, Vermont hospitals, the Vermont Association of Hospitals and Health Systems, certified accountable care organizations, the Office of the Health Care Advocate, and other interested stakeholders.

(2) All materials submitted to the Board pursuant to this section shall be provided to the Office of the Health Care Advocate, which shall not further disclose any confidential information.

(b) On or before November 15, 2020, the Board shall inform the Health Reform Oversight Committee about its consideration to date of ways to increase hospital financial sustainability as set forth in subdivision (a)(1) of this section.

(c) On or before April 1, 2021, the Board shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance an update on its progress in considering and developing recommendations for increasing hospital financial sustainability as set forth in subdivision (a)(1) of this section.

(d)(1) On or before September 1, 2021, the Board shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance its final recommendations for increasing the financial sustainability of Vermont hospitals in order to achieve population-based health improvements while maintaining community access to services.

(2) In the event that the COVID-19 pandemic makes it impracticable for the Board to submit its recommendations by the date specified in subdivision (1) of this subsection, the Board shall provide an update on its progress by September 1, 2021 and shall make best efforts to submit its final recommendations in a timely manner but not later than November 15, 2021.

Sec. 5. PROVIDER SUSTAINABILITY AND REIMBURSEMENTS; REPORTS

(a) The Green Mountain Care Board, in collaboration with the Department of Financial Regulation, the Department of Vermont Health Access, and the Director of Health Care Reform in the Agency of Human Services, shall identify processes for improving provider sustainability and increasing equity in reimbursement amounts among providers. In evaluating potential processes, the Board's considerations shall include:

(1) care settings;

(2) value-based payment methodologies, such as capitation;

(3) Medicare payment methodologies;

(4) public and private reimbursement amounts; and

(5) variations in payer mix among different types of providers.

(b) On or before November 15, 2020, the Board shall provide an update to the Health Reform Oversight Committee regarding its progress in identifying processes for improving provider sustainability and increasing equity in reimbursement amounts among providers.

(c) On or before March 15, 2021, the Board shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance the options that the Board has identified as demonstrating the greatest potential for improving provider sustainability and increasing equity in

reimbursement amounts among providers and shall identify areas that would require further study prior to implementation.

Sec. 6. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

* * *

(b)(1) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of the proposed rate. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, and any other information required by the Board. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

* * *

(3)(A) Upon request, in conjunction with a rate filing required by subsection (a) of this section, an insurer shall provide to the Board detailed information about the insurer's payments to specific providers, which may

include fee schedules, payment methodologies, and other payment information specified by the Board.

(B) Confidential business information and trade secrets received from an insurer pursuant to subdivision (A) of this subdivision (3) shall be exempt from public inspection and copying under 1 V.S.A. § 317(c)(9) and shall be kept confidential, except that the Board may disclose or release information publicly in summary or aggregate form if doing so would not disclose confidential business information or trade secrets.

(C) Notwithstanding 1 V.S.A. chapter 5, subchapter 2 (Vermont Open Meeting Law), the Board may examine and discuss confidential information outside a public hearing or meeting.

* * *

Sec. 7. [Deleted.]

Sec. 8. [Deleted.]

Sec. 9. 18 V.S.A. § 9457 is amended to read:

§ 9457. INFORMATION AVAILABLE TO THE PUBLIC

(a) ~~All information~~ Information required to be filed under this subchapter shall be made available to the public upon request~~, provided that~~ in accordance with 1 V.S.A. chapter 5, subchapter 3 (Public Records Act), except that information that directly or indirectly identifies individual patients or health care practitioners shall ~~not be directly or indirectly identifiable~~ be kept confidential.

(b) Notwithstanding 1 V.S.A. chapter 5, subchapter 2 (Vermont Open Meeting Law) or any provision of this subchapter to the contrary, the Board may examine and discuss confidential information outside a public hearing or meeting.

Sec. 10. 2020 Acts and Resolves No. 91, Sec. 8, as amended by 2020 Acts and Resolves No. 140, Sec. 13, is further amended to read:

Sec. 8. ACCESS TO HEALTH CARE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

It is the intent of the General Assembly to increase Vermonters' access to medically necessary health care services during and after a declared state of emergency in Vermont as a result of COVID-19. Until July 1, 2021, and notwithstanding any provision of 3 V.S.A. § 844 to the contrary, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address the following through June 30, 2021:

(1) expanding health insurance coverage for, and waiving or limiting cost-sharing requirements directly related to, ~~COVID-19~~ the diagnosis of COVID-19, including tests for influenza, pneumonia, and other respiratory viruses performed in connection with making a COVID-19 diagnosis~~,~~; the treatment~~,~~ of COVID-19 when it is the primary or a secondary diagnosis; and the prevention of COVID-19;

(2) modifying or suspending health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(3) expanding patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services.

Sec. 11. 2020 Acts and Resolves No. 140, Sec. 4 is amended to read:

Sec. 4. MENTAL HEALTH INTEGRATION COUNCIL; REPORT

* * *

(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 Health shall serve as vice chair.

(3) The Council shall meet every other month between ~~October 1, 2020~~ January 15, 2021 and January 1, 2023.

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

* * *

Sec. 12. EFFECTIVE DATES

(a) Sec. 2 (18 V.S.A. § 9411) shall take effect on November 1, 2020, with the interactive price transparency dashboard becoming available for use by the public as soon as it is operational, but in no event later than February 15, 2022.

(b) Secs. 6 (8 V.S.A. § 4062) and 9 (18 V.S.A. § 9457) shall take effect on November 1, 2020.

(c) The remaining sections shall take effect on passage.

Date Governor signed bill: October 5, 2020

Proposed Rules Postings
A Service of the Office of the Secretary of State

Search Rules

Deadline For Public Comment

Deadline: Unavailable.

The deadline for public comment is unavailable for this rule. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	20-E22
Title:	Access to Health Care Services During the COVID-19 Pandemic.
Type:	Emergency
Status:	Adopted
Agency:	Department of Financial Regulation
Legal Authority:	Acts No. 91, 140,and 159 of 2020.
Summary:	The emergency rule: (1) requires health insurers to provide coverage for clinically appropriate health care services delivered remotely through telehealth or audio-only telephone through telehealth or audio-only telephone on the same basis as in-person consultations; (2) requires health insurers to provide coverage of COVID-19 diagnosis, testing, and treatment without member cost-sharing; and (3) suspends prescription drug deductible requirements for medications that may be considered preventative care for the purposes of 26 U.S.C. § 223(c)(2)(C).
Persons Affected:	The emergency rule primarily affects health insurers, pharmacy benefit managers, and members of health insurance plans.
Economic Impact:	The Department anticipates that the emergency rule will provide substantial financial relief to Vermonters. Although the Department expects insurers to absorb substantial costs as a result of the emergency rule, these costs constitute a small fraction of the net income generated by insurers from April to June 2020, when claims were lower than expected due to the pandemic.
Posting date:	Oct 22,2020

Hearing Information

There are not Hearings scheduled for this Rule

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

Level: Primary
Name: Sebastian Arduengo
Agency: Department of Financial Regulation
Address: 89 Main Street
City: Montpelier
State: VT
Zip: 05620-3101
Telephone: 802-828-4846
Fax: 802-828-5593
Email: sebastian.arduengo@vermont.gov
SEND A COMMENT

Website Address: https://dfr.vermont.gov/about-us/legal-generalcounsel/0d0aproposed-rules-and-public-comment
VIEW WEBSITE

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON.

Level: Secondary
Name: Gavin Boyles
Agency: Department of Financial Regulation
Address: 89 Main Street
City: Montpelier
State: VT
Zip: 05620
Telephone: 802-272-2338
Fax: 802-828-1919
Email: gavin.boyles@vermont.gov
SEND A COMMENT

Keyword Information

Keywords:

Health Insurance
Telehealth
Audio-only Telephone
COVID-19
Testing
Treatment
Prescription Deductibles

Back

Accessbility Policy | Privacy Policy
A Vermont Government Website Copyright 2020 State of Vermont

v 1.0.2