EMERGENCY RULE #20-E16

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 COVID-19 outbreak that is the subject of the all-hazard State of Emergency proclaimed by the Governor on March 16, 2020.

I approve the contents of this filing entitled:

RELAXATION OF CREDENTIALING VERIFICATION PRACTICES

/s/ Michael S. Pieciak , on 9/17/2020

(signature) (date)

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

RECEIVED
SEP 17 2020

RECEIVED BY: _____
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:
   RELAXATION OF CREDENTIALING VERIFICATION PRACTICES

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: Ethan McLaughlin

   Agency: Department of Financial Regulation

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

   Telephone: 802 828 - 4859 Fax: 802 828 - 1919

   E-Mail: ethan.mclaughlin@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: 802 828 - 1425 Fax: 802 828 - 1919

   E-Mail: gavin.boyles@vermont.gov

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:

   N/A

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

   N/A

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).

The authority vested in the Commissioner of the Dept. of Financial Regulation by §§ 6 and 8 of 2020 Act 91(as amended by § 13 of 2020 Act 140) and by 18 V.S.A. § 9414 and 8 V.S.A. § 15.

7. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:

Section 6 of 2020 Act 91(as amended by § 13 of 2020 Act 140) states that "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 … 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." Section 8 of 2020 Act 91(as amended by § 13 of 2020 Act 140) states that "[u]ntil 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 … COVID-19 diagnosis, treatment, and prevention…." under 18 V.S.A. § 9414 (a), "the Commissioner [of financial regulation] shall have the power and responsibility to ensure that each managed care organization provides quality health care to its members, in accordance with the provisions of this section." 18 V.S.A. § 9414 (b) states that "[t]he Commissioner shall establish, by rule, specific criteria to be considered under this section." This emergency rule relaxes provider credentialing requirements for health insurance plans, as required by Section 6 of 2020 Act 91(as amended by § 13 of 2020 Act 140), in order to expand health insurance coverage for

COVID-19 diagnosis, treatment and prevention in accordance with Section 8 of 2020 Act 91(as amended by § 13 of 2020 Act 140). The emergency rule also suspends certain specific criteria previously established by the Commissioner, by rule, regarding the credentialing practices of managed care organizations.

8. CONCISE SUMMARY (**150 WORDS OR LESS**):

Responding to the COVID-19 pandemic may require the provision of health care services by physicians or other health care professionals who hold an equivalent license in another State and may require health care providers to work at physical locations where such providers are not credentialed to provide services. This emergency rule temporarily suspends and relaxes certain provider credentialing verification requirements set forth in Section 5.2 of Rule H-2009-0. Suspending these requirements and requiring health insurers to relax their credentialing requirements is intended to expand health insurance coverage for COVID-19 diagnosis, treatment and prevention by facilitating reimbursement through the Medicaid program or commercial insurance during the state and federal emergencies related to COVID-19.

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

Addressing and treating the health needs of Vermonters during the COVID-19 outbreak may require health care services provided in the Vermont by physicians or other health care professionals who hold an equivalent license in another State. It may also require health care providers credentialed within a health care organization to provide services at locations where such providers are not credentialed. The current requirements of Section 5.2 of Rule H-2009-03 and the existing credentialing requirements of health insurers could impede and delay the provision of such health care services by such providers.

10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

Section 6 of 2020 Act 91(as amended by § 13 of 2020 Act 140) requires the Department of Financial Regulation to instruct health insurers to relax credentialing requirements. A coalition of health care provider

representatives, including the Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Bayada Home Health & Hospice, Vermont Health Care Association (long term care facilities), Vermont Care Partners, Bi-State Primary Care Association, the Vermont Medical Society, the Vermont Association of Adult Days, and Dartmouth Hitchcock Health, has communicated to the Governor that relaxing credentialing requirements will help their efforts to fight the COVID-19 pandemic.

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

Managed Care Organizations regulated by the State of Vermont

The Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Bayada Home Health & Hospice, Vermont Health Care Association (long term care facilities), Vermont Care Partners, Bi-State Primary Care Association, the Vermont Medical Society, the Vermont Association of Adult Days, and Dartmouth Hitchcock Health

Physicians or other health care professionals who hold an equivalent license in another State

Physicians or other health care professionals credentialed within a health care organization

Patients and members insured by Managed Care Organizations regulated by the state of Vermont

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

Responding to the COVID-19 pandemic may require the provision of health care services by physicians or other health care professionals who hold an equivalent license in another State and may require health care providers to work at physical locations where such providers are not credentialed to provide services. Facilitating reimbursement for such services by health insurers is expected to significantly decrease the out of pocket costs incurred by Vermont patients. Health Insurers may pay out more money to reimburse providers for the provision of such services.

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):

16. EMERGENCY RULE EFFECTIVE: 09/16/2020

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL
(A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE):
06/30/2021

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).

Managed Care Organization

Credentialing

COVID-19

CORONAVIRUS

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:
   RELAXATION OF CREDENTIALING VERIFICATION PRACTICES
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 **A NEW RULE** .

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

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**

DATE: **September 17, 2020**

RE: **Emergency Rule Titled 'Relaxation of Credentialing Verification Practices' 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:

   RELAXATION OF CREDENTIALING VERIFICATION PRACTICES

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:

   Managed Care Organizations

   Health Insurers

   Health Care Providers

   Insured Patients

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:

None.

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.*

   N/A

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):

   Financial impacts on small business are not anticipated.

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 managed care organizations and health insurers are required to comply with this rule and none of these organizations 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 this rule, the provision of health care services to Vermonters during the COVID-19 outbreak could be impaired or delayed. Material impairments or delays in the provision of health care services during the COVID-19 outbreak could have devastating economic consequences for individual patients and for the economy of the state.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*
   In light of the urgency of responding to the COVID-19 outbreak, the Department of Financial Regulation believes the analysis described herein is sufficient to justify the temporary suspension of the existing rule.

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:

   RELAXATION OF CREDENTIALING VERIFICATION PRACTICES

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.*
   None.

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:
   RELAXATION OF CREDENTIALING VERIFICATION PRACTICES
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:
   In light of the unprecedented urgency of addressing the COVID-19 crisis, the Department of Financial Regulation has not sought extensive public comment on this emergency rule. A coalition of health care provider representatives, including the Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Bayada Home Health & Hospice, Vermont Health Care Association (long term care facilities), Vermont Care Partners, Bi-State Primary Care Association, the Vermont Medical Society, the Vermont Association of Adult Days, and Dartmouth Hitchcock Health, has communicated to the Governor that relaxing credentialing requirements will help their efforts to fight the COVID-19 pandemic. The Department has been in constant communication with industry and the provider community, including multiple calls on responses to the COVID-19 pandemic.
4. PLEASE LIST THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:
   See response to 3, above.
5. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Bayada Home Health & Hospice, Vermont Health Care Association (long term care facilities), Vermont Care Partners, Bi-State Primary Care Association, the Vermont Medical Society, the Vermont Association of Adult Days, and Dartmouth Hitchcock Health

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:

   RELAXATION OF CREDENTIALING VERIFICATION PRACTICES

2. ADOPTING AGENCY:

   Department of Financial Regulation

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

   Department of Finacial Regulation Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations. This rule sets forth the consumer protection and quality requirements that managed care organizations must meet.

4. FORMAL CITATION OF MATERIALS INCORPORATED BY REFERENCE:

   Department of Finacial Regulation Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations. CVR 21-040-010

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

   Electronic form available at: https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=deee40c4-9928-481c-8ab0-66f7248d5585&nodeid=AALAAFAADAAB&nodepath=%2FROOT%2FAAL

%2FAALAAF%2FAALAAFAAD%2FAALAAFAADAAB&level=4&haschildren=&populated=false&title=21+040+010.+RULE+H-2009-03+-+CONSUMER+PROTECTION+AND+QUALITY+REQUIREMENTS+FOR+MANAGED+CARE+ORGANIZATIONS&config=00JAA3YmIxY2M5OC0zYmJjLTQ4ZjMtYjY3Yi02ODZhMTViYWUzMmEKAFBvZENhdGFsb2dfKuGXoJFNHKuKZG9OqaaI&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A5WS0-FPD1-FGRY-B0RF-00008-00&ecomp=c38_kkk&prid=6aadf2b6-6807-4103-9b0b-b32fbbdcc979

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)*:

Effective as of September 16, 2020 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, the requirements of Section 5.2 of Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations, are hereby suspended with respect to physicians or other health care professionals who hold a license in another State and provide health care services to or on behalf of patients in Vermont, either in person or remotely, by means of telemedicine or otherwise, and with respect to other health care professionals who have been issued provisional or temporary Vermont licensure during the COVID-19 State of Emergency.

Run Spell Check

ATTACHMENT TO EMERGENCY RULE FILING
ADDITIONAL RESPONSE REGARDING QUESTION 17

TITLE OF EMERGENCY RULE FILING: Relaxation of Credentialing Verification Practices

ADOPTING AGENCY: Department of Financial Regulation

Additional Response Regarding Question 17:

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL
(*A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE*)

06/30/2021

This emergency rule is promulgated under the authority vested in the Department of Financial Regulation under Section 8 of 2020 Act 91(as amended by § 13 of 2020 Act 140), which grants the Department the authority until July 1, 2021 to adopt certain emergency rules "for the duration of the COVID-19 state of emergency through June 30, 2021." Section 8 of 2020 Act 91(as amended by § 13 of 2020 Act 140) states that such authority is granted "notwithstanding any provision of 3 V.S.A. § 844 to the contrary[,]" such that the 180-day limit on emergency rules specified in 3 V.S.A. § 844(b) does not apply to emergency rules adopted under Section 7 for the duration of the COVID-19 state of emergency through June 30, 2021.

Clean Text

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2020-05-E

RELAXATION OF CREDENTIALING VERIFICATION PRACTICES

Section 1. Purpose

This emergency rule is promulgated pursuant to §§ 6 and 8 of 2020 Act 91(as amended by § 13 of 2020 Act 140), 18 V.S.A. § 9414, 8 V.S.A. § 15 and in response to the State of Emergency declared by the Governor of the State of Vermont on March 16, 2020 regarding the outbreak of COVID-19. The purpose of this emergency rule is to expand health insurance coverage for COVID-19 diagnosis, treatment and prevention by relaxing provider credentialing requirements in order to facilitate the reimbursement through commercial insurance for health care services provided by physicians or other health care professionals who hold an equivalent license in another State or who provide care at physical locations where such health care providers are not credentialed.

Section 2. Definitions.

Terms used in this emergency rule and not defined herein shall have the meanings given to such terms, if any, in Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations.

Section 3. Temporary Suspension of Provider Credentialing Verification Requirements.

Effective as of September 17, 2020 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, the requirements of Section 5.2 of Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations, are hereby suspended with respect to physicians or other health care professionals who hold a license in another State and provide health care services to or on behalf of patients in Vermont, either in person or remotely, by means of telemedicine or otherwise, and with respect to other health care professionals who have been issued provisional or temporary Vermont licensure during the COVID-19 State of Emergency.

Section 4. Relaxation of Provider Credentialing Requirements.

(a) Effective as of September 17, 2020 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, except as otherwise required by applicable federal law or applicable accreditation standards of the National Committee for Quality Assurance, a health insurer shall 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, including, but not limited to relaxing provider credentialing requirements for physicians or other health care professionals who hold a license in another State and

provide health care services to or on behalf of patients in Vermont, either in person or remotely, by means of telemedicine or otherwise, and with respect to other health care professionals who have been issued provisional or temporary Vermont licensure during the COVID-19 State of Emergency.

(b) Effective as of September 17, 2020 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, except as otherwise required by applicable federal law or applicable accreditation standards of the National Committee for Quality Assurance, a health insurer shall not refuse, because of lack of credentials, to pay claims submitted by providers credentialed within a health care organization but not at that health care organization's location where the service was provided or at a location not in that health care organization.

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.

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

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 18 : Health

Chapter 221 : Health Care Administration

Subchapter 001 : Quality, Resource Allocation, And Cost Containment

(Cite as: 18 V.S.A. § 9414)

§ 9414. Quality assurance for managed care

(a) The Commissioner shall have the power and responsibility to ensure that each managed care organization provides quality health care to its members, in accordance with the provisions of this section.

(1) In determining whether a managed care organization meets the requirements of this section, the Commissioner may review and examine, in accordance with subsection (e) of this section, the organization's administrative policies and procedures, quality management and improvement procedures, utilization management, credentialing practices, members' rights and responsibilities, preventive health services, medical records practices, grievance and appeal procedures, member services, financial incentives or disincentives, disenrollment, provider contracting, and systems and data reporting capacities. The Commissioner shall establish, by rule, specific criteria to be considered under this section.

(2) A managed care organization shall, in plain language, disclose to its members:

(A) any provision of its enrollment plan or provider contracts that may restrict referral or treatment options or that may require prior authorization or utilization review or that may limit in any manner the services covered under the members' enrollment plan;

(B) the criteria used for credentialing or selecting health care providers with whom the organization contracts;

(C) the financial inducements offered to any health care provider or health care facility for the reduction or limitation of health care services;

(D) the utilization review procedures of the organization, including the credentials and training of utilization review personnel;

(E) whether the organization's health care providers are contractually prohibited from participating in other managed care organizations or from performing services for persons who are not members of the managed care organization;

(F) upon request, health care providers available to members under the enrollment

plan.

(3) A managed care organization shall not include any provision in a contract with a health care provider that prohibits the health care provider from disclosing to members information about the contract or the members' enrollment plan that may affect their health or any decision regarding health care treatment.

(4) The Commissioner or designee may resolve any consumer or provider complaint arising out of this subsection as though the managed care organization were an insurer licensed pursuant to Title 8. As used in this section, "complaint" means a report of a violation or suspected violation of the standards set forth in this section or adopted by rule pursuant to this section and made by or on behalf of a consumer or provider.

(5) The Commissioner shall prepare an annual report on or before July 1 of each year providing the number of complaints received during the previous calendar year regarding violations or suspected violations of the standards set forth in this section or adopted by rule pursuant to this section. The report shall specify the aggregate number of complaints related to each standard and shall be posted on the Department's website.

(b)(1) A managed care organization shall assure that the health care services provided to members are consistent with prevailing professionally recognized standards of medical practice.

(2) A managed care organization shall participate in the Blueprint for Health established in chapter 13 of this title. If needed to implement the Blueprint, a managed care organization shall establish a chronic care program, which shall include:

(A) appropriate benefit plan design;

(B) informational materials, training, and follow-up necessary to support members and providers; and

(C) payment reform methodologies.

(3) Each managed care organization shall have procedures to assure availability, accessibility, and continuity of care, and ongoing procedures for the identification, evaluation, resolution, and follow-up of potential and actual problems in its health care administration and delivery.

(4) Each managed care organization shall be accredited by a national independent accreditation organization approved by the Commissioner.

(c) Consistent with participation in the Blueprint for Health pursuant to subdivision (b)(2) of this section and the accreditation required by subdivision (b)(4) of this section, the managed care organization shall have an internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The

internal quality assurance program shall be fully described in written form, provided to all managers, providers, and staff and made available to members of the organization. The components of the internal quality assurance program shall include the following:

(1) a peer review committee or comparable designated committee responsible for quality assurance activities;

(2) accountability of the committee to the board of directors or other governing authority of the organization;

(3) participation by an appropriate base of providers and support staff;

(4) supervision by the medical director of the organization;

(5) regularly scheduled meetings; and

(6) minutes or records of the meetings which describe in detail the actions of the committee, including problems discussed, charts reviewed, recommendations made, and any other pertinent information.

(d), (e) [Repealed.]

(f)(1) For the purpose of evaluating a managed care organization's performance under the provisions of this section, the Commissioner may examine and review information protected by the provisions of the patient's privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential.

(2) [Repealed.]

(3) Any information made available under this section shall be furnished in a manner that does not disclose the identity of the protected person. The Commissioner shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner. Information disclosed to the Commissioner under this section shall be confidential and privileged and shall not be subject to subpoena or available for public disclosure, except that the Commissioner is authorized to use such information during the course of any legal or regulatory action under this title against a managed care organization.

(g)(1) In addition to any other remedy or sanction provided by law, after notice and an opportunity to be heard, if the Commissioner determines that a managed care organization has violated or failed to comply with any of the provisions of this section or any rule adopted pursuant to this section, the Commissioner may:

(A) sanction the violation or failure to comply as provided in Title 8, including sanctions provided by or incorporated in 8 V.S.A. §§ 4726, 5108, and 5109, and may use any information obtained during the course of any legal or regulatory action against a managed care organization;

(B) order the managed care organization to cease and desist in further violations;

and

(C) order the managed care organization to remediate the violation, including issuing an order to the managed care organization to terminate its contract with any person or entity which administers claims or the coverage of benefits on behalf of the managed care organization.

(2) A managed care organization that contracts with a person or entity to administer claims or provide coverage of health benefits is fully responsible for the acts and omissions of such person or entity. Such person or entity shall comply with all obligations, under this title and Title 8, of the health insurance plan and the health insurer on behalf of which such person or entity is providing or administering coverage.

(3) A violation of any provision of this section or a rule adopted pursuant to this section shall constitute an unfair act or practice in the business of insurance in violation of 8 V.S.A. § 4723.

(h) Each managed care organization subject to examination, investigation, or review by the Commissioner under this section shall pay the Commissioner the reasonable costs of such examination, investigation, or review conducted or caused to be conducted by the Commissioner, at a rate to be determined by the Commissioner. All examinations conducted under this section shall be pursuant to and in conformity with 8 V.S.A. §§ 3573, 3574, 3575, and 3576, except that the Commissioner may modify or adapt those examination guidelines, principles, and procedures to be more appropriate or useful to the examination of managed care organizations.

(i) [Repealed.] (Added 1993, No. 30, § 19; amended 1995, No. 180 (Adj. Sess.), §§ 21, 38(a), (b); 1999, No. 38, § 22, eff. May 20, 1999; 2007, No. 142 (Adj. Sess.), §§ 2, 3, eff. May 14, 2008; 2007, No. 204 (Adj. Sess.), § 1; 2015, No. 54, § 36; 2015, No. 152 (Adj. Sess.), § 7.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 8 : Banking And Insurance

Chapter 001 : Policy And Administration

(Cite as: 8 V.S.A. § 15)

§ 15. Rules, orders, and administrative interpretations

(a) In addition to other powers conferred by this title and 18 V.S.A. chapter 221, the Commissioner may adopt rules and issue orders as shall be authorized by or necessary to the administration of this title and of 18 V.S.A. chapter 221, and to carry out the purposes of such titles.

(b) The Commissioner may, whether or not requested by any person, issue written advisory interpretations, advisory opinions, non-objection letters, and no action letters under this title and regulations issued under it, including interpretations of the applicability of any provision of this title and regulations issued under it. Such interpretations shall be presumed to be correct unless found to be clearly erroneous by a court of competent jurisdiction. The Commissioner may make public all or a portion of an advisory interpretation.

(c) The Commissioner may waive the requirements of 15 V.S.A. § 795(b) as the Commissioner deems necessary to permit the Department to participate in any national licensing or registration systems with respect to any person or entity subject to the jurisdiction of the Commissioner under this title, Title 9, or 18 V.S.A. chapter 221.

(d) Upon written request by the Office of Child Support and after notice and opportunity for hearing to the licensee as required under any applicable provision of law, the Commissioner may revoke or suspend any license or other authority to conduct a trade or business (including a license to practice a profession) issued to any person under this title, 9 V.S.A. chapter 150, and 18 V.S.A. chapter 221, if the Commissioner finds that the applicant or licensee is subject to a child support order and is not in good standing with respect to that order or is not in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed or as of the date of the commencement of revocation proceedings, as applicable. For purposes of such findings, the written representation to that effect by the Office of Child Support to the Commissioner shall constitute prima facie evidence. The Office of Child Support shall have the right to intervene in any hearing conducted with respect to such license revocation or suspension. Any findings made by the Commissioner based solely upon the written representation with respect to that license revocation or suspension shall be made only for the purposes of that proceeding and shall not be relevant to or introduced in any other proceeding at law, except

for any appeal from that license revocation or suspension. Any license or certificate of authority suspended or revoked under this section shall not be reissued or renewed until the Department receives a certificate issued by the Office of Child Support that the licensee is in good standing with respect to a child support order or is in full compliance with a plan to pay any and all child support payable under a support order. (Added 1999, No. 153 (Adj. Sess.), § 1, eff. Jan. 1, 2001; amended 2009, No. 42, § 33a; 2013, No. 73, § 58, eff. June 5, 2013; 2015, No. 63, § 3, eff. June 17, 2015; 2019, No. 20, § 106.)

VERMONT

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-E16
Title:	Relaxation of Credentialing Verification Practices.
Type:	Emergency
Status:	Adopted
Agency:	Department of Financial Regulation
Legal Authority:	18 V.S.A.§ 9414 and 8 V.S.A. § 15, NOTE: This Emergency rule has specific authority to remain in effect longer than 180 days within Act No. 91 of 2020 §§ 6 and 8 as amended by Act No. 140 of 2020 § 13.

Summary:	Responding to the COVID-19 pandemic may require the provision of health care services by physicians or other health care professionals who hold an equivalent license in another State and may require health care providers to work at physical locations where such providers are not credentialed to provide services. This emergency rule temporarily suspends and relaxes certain provider credentialing verification requirements set forth in Section 5.2 of Rule H-2009-0. Suspending these requirements and requiring health insurers to relax their credentialing requirements is intended to expand health insurance coverage for COVID-19 diagnosis, treatment and prevention by facilitating reimbursement through the Medicaid program or commercial insurance during the state and federal emergencies related to COVID-19.
Persons Affected:	Managed Care Organizations regulated by the State of Vermont; The Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Bayada Home Health & Hospice, Vermont Health Care Association (long term care facilities), Vermont Care Partners, Bi-State Primary Care Association, the Vermont Medical Society, the Vermont Association of Adult Days, and Dartmouth Hitchcock Health Physicians or other health care professionals who hold an equivalent license in another State; Physicians or other health care professionals credentialed within a health care organization; Patients and members insured by Managed Care Organizations regulated by the state of Vermont
Economic Impact:	Responding to the COVID-19 pandemic may require the provision of health care services by physicians or other health care professionals who hold an equivalent license in another State and may require health care providers to work at physical locations where such providers are not credentialed to provide services. Facilitating reimbursement for such services by health insurers is expected to significantly decrease the out of pocket costs incurred by Vermont patients. Health Insurers may pay out more money to reimburse providers for the provision of such services.
Posting date:	Sep 17,2020

Hearing Information

There are not Hearings scheduled for this Rule

Contact Information

Information for Primary Conta

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWE THE RULE.

Level: Primary
Name: Ethan McLaughlin
Agency: Department of Financial Regulation
Address: 89 Main Street
City: Montpelier
State: VT
Zip: 05620-3101
Telephone: 802-828-4859
Fax: 802-828-1919
Email: ethan.mclaughlin@vermont.gov
SEND A COMMENT

Website Address: https://dfr.vermont.gov/about-us/legal-generalcounsel/0d0aproposed

Information for Secondary Cont

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOI REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUI FROM THE PRIMARY CONTACT PERSON.

Level: Secondary
Name: Gavin Boyles
Agency: Department of Financial Regulation
Address: 89 Main Street
City: Montpelier
State: VT
Zip: 05620-3101
Telephone: 802-828-1425
Fax: 802-828-1919
Email: gavin.boyles@vermont.gov
SEND A COMMENT

Keyword Information

Keywords:

Managed Care Organization
Credentialing
COVID-19
CORONAVIRUS

v 1.0.2