H.206

An act relating to miscellaneous changes affecting the duties of the Department of Vermont Health Access

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

Sec. 1. 33 V.S.A. § 1992 is amended to read:

§ 1992. MEDICAID COVERAGE FOR ADULT DENTAL SERVICES

(a) Vermont Medicaid shall provide coverage for medically necessary dental services provided by a dentist, dental therapist, or dental hygienist working within the scope of the provider's license as follows:

(1) Preventive services, including prophylaxis and fluoride treatment, with no co-payment. These services shall not be counted toward the annual maximum benefit amount set forth in subdivision (2) of this subsection.

(2)(A) Diagnostic, restorative, and endodontic procedures, to a maximum of $1,000.00 per calendar year, provided that the Department of Vermont Health Access may approve expenditures in excess of that amount when exceptional medical circumstances so require. Exceptional medical circumstances include emergency dental services, as defined by the Department by rule.

(B) The following individuals shall not be subject to the annual maximum benefit amount set forth in this subdivision (2):

(i) individuals served through the Community Rehabilitation and Treatment and Developmental Disability Services programs pursuant to Vermont's Global Commitment to Health Section 1115 demonstration; and

(ii) Medicaid beneficiaries who are pregnant or in the postpartum eligibility period, as defined by the Department by rule.

(3) Other dental services as determined by the Department by rule.

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Sec. 2. 33 V.S.A. chapter 19, subchapter 1 is amended to read:

Subchapter 1. Medicaid

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§ 1908. MEDICAID; PAYER OF LAST RESORT; RELEASE OF INFORMATION

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(d) On and after July 1, 2016, an insurer shall:

(1) ~~accept~~ Accept the Agency's right of recovery and the assignment of rights and shall not charge the Agency or any of its authorized agents fees for the processing of claims or eligibility requests. Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information that will enable the Agency to determine the existence of third-party coverage for Medicaid recipients, the period during which Medicaid recipients may have been covered by the insurer, and the nature of the

coverage provided, including information such as the name, address, and identifying number of the plan.

(2) If the insurer requires prior authorization for an item or service, accept the Agency's authorization that the item or service is covered under the Medicaid state plan or waiver as if such authorization were the insurer's prior authorization.

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§ 1909. DIRECT PAYMENTS TO AGENCY; DISCHARGE OF INSURER'S OBLIGATION

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(c)(1) An insurer that receives notice that the Agency has made payments to the provider shall pay benefits or send notice of denial directly to the Agency. Receipt of an Agency claim form by an insurer constitutes notice that payment of the claim was made by the Agency to the provider and that form supersedes any contract requirements of the insurer relating to the form of submission.

(2) An insurer shall respond to any request made by the Agency regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of such health care item or service.

(3) An insurer shall not:

(A) deny a claim submitted by the Agency solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if the claim is submitted by the Agency within the three-year period beginning on the date on which the item or service was furnished and any action by the Agency to enforce its rights with respect to a claim is commenced within six years ~~of~~ following the Agency's submission of the claim~~.~~; or

(B) deny a claim submitted by the Agency on the basis of failing to obtain a prior authorization for the item or service for which the claim is being submitted, if the Agency has transmitted authorization that the item or service is covered by the Medicaid state plan or waiver under subdivision 1908(d)(2) of this title.

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Sec. 3. 18 V.S.A. § 4284 is amended to read:

§ 4284. PROTECTION AND DISCLOSURE OF INFORMATION

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(b)(1) The Department shall provide only the following persons with access to query the VPMS:

(A) a health care provider, dispenser, or delegate who is registered with the VPMS and certifies that the requested information is for the purpose

of providing medical or pharmaceutical treatment to a bona fide current patient;

(B) personnel or contractors, as necessary for establishing and maintaining the VPMS;

(C) the Medical Director of the Department of Vermont Health Access and the Director's designee, for the purposes of Medicaid quality assurance, utilization, and federal monitoring requirements with respect to Medicaid recipients for whom a Medicaid claim for a Schedule II, III, or IV controlled substance has been submitted;

(D) a medical examiner or delegate from the Office of the Chief Medical Examiner, for the purpose of conducting an investigation or inquiry into the cause, manner, and circumstances of an individual's death; and

(E) a health care provider or medical examiner licensed to practice in another state, to the extent necessary to provide appropriate medical care to a Vermont resident or to investigate the death of a Vermont resident.

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Sec. 4. FEDERALLY QUALIFIED HEALTH CENTERS; ALTERNATIVE PAYMENT METHODOLOGY; REPORT

The Department of Vermont Health Access shall collaborate with representatives of Vermont's federally qualified health centers (FQHCs) to develop a mutually agreeable alternative payment methodology for Medicaid

payments to the FQHCs that is at least equal to the amount that would be paid under the prospective payment system established under the Benefits Improvement and Protection Act of 2000. On or before October 1, 2023, the Department shall provide a final report on the development of the methodology to the Joint Fiscal Committee, the House Committee on Health Care, and the Senate Committee on Health and Welfare.

Sec. 5. BLUEPRINT FOR HEALTH; PAYMENTS TO PATIENT-CENTERED MEDICAL HOMES; REPORT

On or before January 15, 2024, the Director of Health Care Reform in the Agency of Human Services shall recommend to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare, on Appropriations, and on Finance the amounts by which health insurers and Vermont Medicaid should increase the amount of the per-person, per-month payments they make to Blueprint for Health patient-centered medical homes in furtherance of the goal of providing the additional resources necessary for delivery of comprehensive primary care services to Vermonters and in order to sustain access to primary care services in Vermont. The Agency shall provide an estimate of the State funding that would be needed to support the increase for Medicaid, both with and without federal financial participation. The Agency shall also evaluate and report on potential mechanisms for ensuring that all payers are contributing equitably to the

Blueprint on behalf of their covered lives in Vermont, including a consideration of supporting Blueprint initiatives through the health care claims tax established in 32 V.S.A. chapter 243.

Sec. 6. REPEAL OF PROSPECTIVE REPEAL OF 18 V.S.A. § 9473(g)

2021 Acts and Resolves No. 74, Sec. E.227.2 (prospective repeal; pharmacy benefit managers; 340B entities), as amended by 2022 Acts and Resolves No. 131, Sec. 7, is repealed.

Sec. 7. 18 V.S.A. § 2251 is amended to read:

§ 2251. LIEN ESTABLISHED

(a) ~~A~~ Except as otherwise provided in this section, a hospital in Vermont, as defined in section 1801 of this title, furnishing medical or other service, including charges of private duty nurses, to a patient injured by reason of an accident not covered by the Workers' Compensation Act, 21 V.S.A. ~~§ 601 et seq.~~ chapter 9, ~~shall have~~ may file a lien upon any recovery for damages to be received by the patient, or by ~~his or her~~ the patient's heirs or personal representatives in the case of ~~his or her~~ the patient's death, whether by judgment or by settlement or compromise after the date of the services. ~~This lien shall not attach to one-third of the recovery or $500.00, whichever shall be the lesser, and in addition the lien shall be subordinate to an attorney's lien.~~

(b)(1) Notwithstanding subsection (a) of this section, a hospital shall not have a lien under this chapter if the patient has health insurance, including

coverage under Medicare, Medicaid, or a health plan issued by a health insurer, as defined in section 9402 of this title, and the patient, or the patient's heirs or personal representatives in the case of the patient's death, provides the hospital with proof of health insurance not later than 90 days after the patient's discharge from or death at the hospital.

(2) Notwithstanding subdivision (1) of this subsection, a hospital may file a lien pursuant to subsection (a) of this section for any amount owed to the hospital for the patient's deductible or coinsurance, or both, under the health insurance plan for the medical or other services furnished by the hospital by filing notice of a lien at least 120 days after the hospital billed the patient's health insurance plan for the amount owed to the hospital for services furnished to the patient.

(3) The patient's health insurance plan shall not deny payment for services furnished by the hospital to the patient on the basis that some or all of the patient's medical costs may be covered by a property and casualty insurance plan, unless such denial is required or expressly permitted by State or federal law.

(c)(1) A hospital that recovers under this chapter shall be responsible for a pro rata share of the legal and administrative expenses incurred in obtaining the judgment, settlement, or compromise.

(2) In no event shall the hospital lien exceed one-third of the net judgment, settlement, or compromise received by the injured patient.

Sec. 8. 2022 Acts and Resolves No. 167, Sec. 2a is added to read:

Sec. 2a. GREEN MOUNTAIN CARE BOARD; HOSPITAL SYSTEM TRANSFORMATION; PILOT PROJECTS; REPORT

(a) The Agency of Human Services shall engage in transformation planning with up to four hospitals, or other number of hospitals if possible with alternate funds, to reduce inefficiencies, lower costs, improve population health outcomes, reduce health inequities, and increase access to essential services while maintaining sufficient capacity for emergency management. The transformation planning shall be informed by the data analysis and community engagement required in Sec. 2 of this act. The Secretary of Human Services or designee and the Chair and staff of the Green Mountain Care Board shall consult with each other on the engagements in this section and the data analysis and community engagement required in Sec. 2 of this act to ensure the work is aligned.

(b) On or before February 15, 2024, the Agency of Human Services shall update the Senate Committee on Health and Welfare and the House Committee on Health Care on the progress of this work.

Sec. 9. EFFECTIVE DATES

This act shall take effect on July 1, 2023, except that Sec. 7 (hospital liens) shall take effect on January 1, 2024.