H.815

Introduced by Representative Berbeco of Winooski

Referred to Committee on

Date:

Subject: Health; health insurance; Medicaid; mental health professionals; Department of Financial Regulation; Department of Vermont Health Access

Statement of purpose of bill as introduced: This bill proposes to limit the extent to which health insurers may reduce reimbursement rates for mental health services. It would also require health insurers and Vermont Medicaid to provide notice and stakeholder engagement opportunities prior to implementing any change to reimbursement methodology, billing policy, coding alignment, supervised billing requirements, or service authorization requirements affecting mental health, substance use disorder, or intellectual or developmental disability services.

An act relating to health insurance and Medicaid reimbursement for certain health care services

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

Sec. 1. 8 V.S.A. § 4072 is amended to read:

§ 4072. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

* * *

(c) A health insurance plan shall provide coverage for treatment of a mental condition and shall:

(1) not establish any rate, term, or condition that places a greater burden on a covered individual for access to treatment for a mental condition than for access to treatment for other health conditions, including no greater co-payment for primary mental health care or services than the co-payment applicable to care or services provided by a primary care provider under a covered individual's health insurance plan and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under a covered individual's health insurance plan;

(2) not exclude from its network or list of authorized providers any licensed mental health or substance use disorder treatment provider located within the geographic coverage area of the health insurance plan if the provider is willing to meet the terms and conditions for participation established by the health insurer;

(3) not reduce the reimbursement rate for more than one mental health code for the same mental health professional license type in any contract year below the reimbursement rate provided for that code and license type in the previous contract year;

(4) make any deductible or out-of-pocket limits required under a health insurance plan comprehensive for coverage of both mental and physical health conditions; and

~~(4)~~(5) if the health insurance plan provides prescription drug coverage, ensure that at least one medication in each therapeutic class approved by the U.S. Food and Drug Administration for the treatment of substance use disorder, including for opioid use disorder, methadone, buprenorphine, and naltrexone, is available on the lowest cost-sharing tier of the plan's prescription drug formulary.

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Sec. 2. 18 V.S.A. § 9418h is added to read:

§ 9418h. MODIFICATIONS TO REIMBURSEMENT AND CODING POLICIES FOR CERTAIN SERVICES AND PROVIDERS

(a) Notwithstanding any provision of this subchapter to the contrary, a health plan shall not implement any change to reimbursement methodology, billing policy, coding alignment, supervised billing requirements, or service

authorization requirements affecting mental health, substance use disorder, or intellectual or developmental disability services without first:

(1) publicly identifying whether the change is required by federal or State law and, if so, citing the specific federal or State statute, regulation, or rule that requires the change;

(2) publicly identifying which elements of the change, if any, are discretionary policy choices;

(3) publishing the proposed policy language and billing guidance on its website, and sending written notice directly to providers, including independent mental health providers, designated and specialized service agencies, relevant advocacy organizations, and representatives of individuals and families of individuals who receive services that will be affected by the change, and the Department of Financial Regulation, at least 90 days prior to implementation;

(4) conducting at least one public stakeholder meeting and soliciting public comments; and

(5) publishing on its website a written response describing the ways in which stakeholder input and public comments were considered and incorporated.

(b) Prior to implementing any reimbursement or coding policy change described in subsection (a) of this section, the health plan shall:

(1) conduct and publicly release a fiscal impact analysis;

(2) conduct and publicly release an assessment of the impact on access to care and on the provider workforce, demonstrating that the change will not reduce service availability; and

(3) consult with affected providers, the Office of the Health Care Advocate, Disability Rights Vermont, and representatives of individuals and families of individuals who receive services that will be affected by the change.

(c)(1) For 12 months following implementation of a reimbursement or coding policy change described in subsection (a) of this section, the health plan shall monitor and shall post on its website and report to the Department of Financial Regulation quarterly on access indicators, including:

(A) provider network participation and withdrawal;

(B) wait times for services; and

(C) service denial rates and service reductions.

(2) If monitoring demonstrates a reduction in access, the health plan shall take corrective action to restore the access levels that were in effect prior to the policy change.

(d)(1) The Department of Financial Regulation shall provide written notice to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare at least 60 days prior to

implementation of any policy or reimbursement change affecting mental health, substance use disorder, or intellectual or developmental disability services that does one more of the following:

(A) reduces or is reasonably expected to reduce provider reimbursement;

(B) increases uncompensated administrative or supervision requirements; or

(C) is reasonably expected to increase wait times, reduce provider participation, or reduce availability of services, regardless of whether the change is described as coding alignment, billing clarification, compliance update, policy modernization, or otherwise.

(2) The notice shall include the fiscal analysis, access impact assessment, and stakeholder engagement documentation required by this section.

Sec. 3. 33 V.S.A. § 1905b is added to read:

§ 1905b. MODIFICATIONS TO REIMBURSEMENT AND CODING POLICIES FOR CERTAIN SERVICES AND PROVIDERS

(a) Notwithstanding any provision of this subchapter to the contrary, the Department of Vermont Health Access shall not implement any change to Medicaid reimbursement methodology, billing policy, coding alignment, supervised billing requirements, or service authorization requirements

affecting mental health, substance use disorder, or intellectual or developmental disability services without first:

(1) publicly identifying whether the change is required by federal or State law and, if so, citing the specific federal or State statute, regulation, or rule that requires the change;

(2) publicly identifying which elements of the change, if any, are discretionary policy choices;

(3) publishing the proposed policy language and billing guidance on the Department's website and sending written notice directly to providers, including independent mental health providers, designated and specialized service agencies, relevant advocacy organizations, and representatives of individuals and families of individuals who receive services that will be affected by the change at least 90 days prior to implementation;

(4) conducting at least one public stakeholder meeting and soliciting public comments; and

(5) publishing on the Department's website a written response describing the ways in which stakeholder input and public comments were considered and incorporated.

(b) Prior to implementing any Medicaid reimbursement or coding policy change described in subsection (a) of this section, the Department of Vermont Health Access shall:

(1) conduct and publicly release a fiscal impact analysis;

(2) conduct and publicly release an assessment of the impact on access to care and on the provider workforce, demonstrating that the change will not reduce service availability; and

(3) consult with affected providers, the Office of the Health Care Advocate, Disability Rights Vermont, and representatives of individuals and families of individuals who receive services that will be affected by the change.

(c)(1) For 12 months following implementation of a reimbursement or coding policy change described in subsection (a) of this section, the Department of Vermont Health Access shall post quarterly reports on its website showing updated access indicators, including:

(A) provider network participation and withdrawal;

(B) wait times for services; and

(C) service denial rates and service reductions.

(2) If monitoring demonstrates a reduction in access, the Department shall take corrective action to restore the access levels that were in effect prior to the policy change.

(d)(1) The Department of Vermont Health Access shall provide written notice to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare at least 60 days prior to

implementation of any Medicaid policy or reimbursement change affecting mental health, substance use disorder, or intellectual or developmental disability services that does one more of the following:

(A) reduces or is reasonably expected to reduce provider reimbursement;

(B) increases uncompensated administrative or supervision requirements; or

(C) is reasonably expected to increase wait times, reduce provider participation, or reduce availability of services, regardless of whether the change is described as coding alignment, billing clarification, compliance update, policy modernization, or otherwise.

(2) The notice shall include the fiscal analysis, access impact assessment, and stakeholder engagement documentation required by this section.

Sec. 4. EFFECTIVE DATES

(a) Sec. 1 (8 V.S.A. § 4072; mental health reimbursement rates) shall take effect on January 1, 2027.

(b) The remaining sections shall take effect on passage.