VERMONT
GREEN MOUNTAIN CARE BOARD

GMCB Legislative Update

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July 15, 2020

Signed by Governor

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- Act 91 (H.742) – An act relating to Vermont's response to COVID-19
  - Signed by Governor on March 30, 2020

- Act 136 (H.965) – An act relating to health care- and human services-related appropriations from the Coronavirus Relief Fund
  - Signed by Governor on July 2, 2020

- Act 140 (H.960) – An act relating to miscellaneous health care provisions
  - Signed by Governor on July 6, 2020

Act 91 Overview

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Act 91 (H.742) provides administrative and provider flexibility, including:

- Increases flexibility for AHS to address COVID-19;
- Allows GMCB to waive or permit variance from laws, guidance, and standards related to hospital budgets, CON, health insurance rate review, and ACO budget review for up to 6 months after emergency;
- Directs DFR to consider adopting emergency rules to expand health insurance coverage and to waive or limit cost-sharing requirements, and expand patient access to and provider reimbursement for health care services delivered through telehealth, audio-only, and other telecommunication services;
- Offers changes to prescription drug coverage requirements;
- Increases health care professional licensing flexibility;
- Expands telehealth insurance coverage.

Act 91 Implementation

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GMCB Implementation of Sec. 5 of Act 91 (H.742)

Notwithstanding any provision of 18 V.S.A. chapter 220 or 221, 8 V.S.A. § 4062, 33 V.S.A. chapter 18, subchapter 1, or the Green Mountain Care Board's administrative rules, guidance, or standards to the contrary, during a declared state of emergency in Vermont as a result of COVID-19 and for a period of six months following the termination of the state of emergency, the Green Mountain Care Board may waive or permit variances from State laws, guidance, and standards with respect to the following regulatory activities, to the extent permitted under federal law, as necessary to prioritize and maximize direct patient care, safeguard the stability of health care providers, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic: (1) hospital budget review; (2) certificates of need; (3) health insurance rate review; and (4) accountable care organization certification and budget review.

Act 136 Overview

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Act 136 (H.965) contains $326.2 million allocated to health care and human services:

- $275 million in grants for eligible health care providers (hospitals, independent doctors, mental health providers, dentists, rural health clinics, FQHCs, pharmacies and medical labs).
- Remaining funds are for childcare, food assistance, and other services.

Act 140 Overview

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Act 140 (H.960) addresses mental health, hospital budget review, expansion of VPharm coverage, and the review and modification of prior authorization requirements.

Act 140: Data Collection

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Sec. 1. 18 V.S.A. § 9375 is amended to direct the GMCB to "collect and review data from each community mental health and developmental disability agency designated by the Commission of Mental Health or of Disabilities, Aging, and Independent Living, which may include; scope of service, volume, utilization, discharges, payer mix, quality, coordination with other aspects of the health care system, and financial condition, including solvency. The Board shall:

- Have processes appropriate to the designated and specialized service agencies' scale and their role in Vermont's health care system, and
- Consider ways in which psychiatric hospitals can be integrated into systemwide payment and delivery system reform.

Act 140: Brattleboro Retreat

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Sec. 3. HOSPITAL BUDGET REVIEW; TRANSITIONAL PROVISIONS

- Any hospital whose budget newly comes under GMCB review as a result of the amendments to 18 V.S.A. § 9451 made by Sec. 2, the Board may increase the scope of the budget review process for the hospital gradually, provided the Board conducts a full review of the hospital's proposed budget no later than the budget for FY 2024.
- In developing its process for transitioning to a full review, the Board shall collaborate with the hospital and AHS to prevent duplication of efforts and reporting requirements. The Board and AHS shall determine which documents submitted by the hospital to the AHS are appropriate to share with the Board. In determining whether and to what extent to exercise discretion, the Board shall consider;
  1) existing fiscal oversight of hospital by AHS; and
  2) fiscal pressures on the hospital as a result of COVID-19.

Act 140: Prior Authorization

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Sec. 8. 18 V.S.A. § 9418b amended

(h)(1) A health plan shall annually review the list of medical procedures and medical tests for which it requires prior authorization at least annually and shall eliminate the prior authorization requirement for those procedures and tests for which a requirement is no longer justified or for which requests are routinely approved with frequency as to demonstrate the prior auth does not promote health care quality or reduce spending to a degree sufficient to justify the admin costs to the plan.

(2) Attest to the DFR and GMCB annually on or before September 15 that is has completed the review and appropriate elimination of prior auth requirements as required by subdivision (1).

Act 140: Prior Authorization and EHR

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Sec. 9. PRIOR AUTHORIZAION; ELECTRONIC HEALTH RECORDS; REPORT

- DFR, in consultation with health insurers and health care provider associations, shall report opportunities to increase the use of real-time decision support tools embedded in EHRs to complete prior authorization requests for imaging and pharmacy services, including options that minimize cost for health care providers and insurers.
- Due on or before January 15, 2022 to the GMCB and the House Committee on Health Care, the Senate Committees on Health & Welfare and on Finance,

Act 140: Prior Authorization and APM

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Sec. 10. PRIOR AUTHORIZATION; ALL-PAYER ACO MODEL; REPORT

- The GMCB, in consultation with DVHA, certified ACOs, 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 incentive to increase scale, and 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 health care committees.

Act 140: Prior Authorization & Gold Carding

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Sec. 11. PRIOR AUTHORIZATION; GOLD CARDING; PILOT PROGRAM; REPORTS

- On or before January 15, 2022 each health insurer with more than 1,000 covered lives in Vermont for major medical 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. The insurer shall make available electronically, including on a publicly available website, details about its prior authorization exemption or streamlining program, including criteria outlined in Sec. 11.
- On or before January 15, 2023, each insurer required to implement a pilot program shall report to the House Committee on Health Care, the Senate Committees on Health & Welfare and on Finance, and the GMCB:
    1) results of the pilot, including analysis of cost and savings;
    2) prospects for the health insurer continuing or expanding the program;
    3) feedback the insurer received about the program from the health care provider community; and
    4) an assessment of the admin costs to the insurer of administering and implementing prior auth requirements.

Act 140: Prior Authorization & Provider Exemptions

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Sec. 12. PRIOR AUTHORIZATION; PROVIDER EXEMPTIONS; REPORT

On or before September 30, 2021, DVHA shall provide findings and recommendations to the GMCB, the House Committee on Health Care, the Senate Committees on Health & Welfare and on Finance regarding clinical prior authorization requirements in the Vermont Medicaid program, including:

1) A description and evaluation of 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;

Act 140: Prior Authorization & Provider Exemptions (cont.)

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2) 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;

3) 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;

4) which State and federal approvals would be needed in order to make proposed changes to the Medicaid prior authorization requirements; and

5) the potential for aligning prior authorization requirements across payers.

Act 140 Extensions Relating to Act 91

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H.960 extends several provisions in Act 91 beyond to March 31, 2020. Including the following:

- Deems out-of-state licensed health care professional licensed in Vermont;
- Waives certain telehealth requirements during state of emergency;
- Allows retired health care professional to practice under specific requirements.

H.960 also allows DFR emergency rules, rulemaking and extensions through June 30, 2021.

Pending House Bills

H.607 – an act relating to increasing the supply of primary care providers in Vermont

- The Director of Health Care Reform shall maintain a current health care workforce development strategic plan, with the help of an advisory group to continue efforts to ensure that Vermont has the health care workforce necessary to provide care to all Vermont residents. A draft of the plan must be submitted for review and approval to the GMCB by December 1, 2020, and the Board shall review and approve the plan within 30 days following receipt. On or before January 15, 2021, the Director will provide the workforce strategic plan to the legislature.
- DVHA in collaboration with the Office of Primary Care and the Area Health Education Centers at UVM College of Medicine to establish rural primary care physician scholarship program.
- Appropriates money to VDH to additional scholarships for nursing students through the Health Care Educational Loan Repayment Fund

Passed in House; referred to Senate Health & Welfare

Pending House Bills

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H.795 – An act relating to increasing hospital price transparency

- On or before February 1, 2021, the GMCB shall report its progress to the House Committee on Health Care and the Senate Committees on Health & Welfare and Finance in developing and implementing a public, interactive, web-based price transparency dashboard for use by health care consumers, including the results of the Board's efforts to validate VHCURES data through comparison with hospital discharge data and with information from the health insurers.
- The GMCB shall develop and maintain a public dashboard that allows consumers to compare health care prices for certain services across the State. The dashboard shall be accessible on the statewide comparative hospital quality report published by the Commissioner of Health.
- The Board shall update the information at least annually.
- On or before February 1, 2022, the GMCB shall provide a demonstration of the dashboard to the House Committee on Health Care and the Senate Committees on Health & Welfare and Finance.

Passed in House; bill committed to Committee on Health & Welfare

Pending Senate Bills

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S.202 – An act relating to limiting the co-payment amount for chiropractic services in certain health insurance plans

- Limit co-pay amount for chiropractic services in silver- and bronze-level qualified and reflective health benefit plans to no more than 125% of the amount of the co-pay applicable to care and services provided by a primary care provider under the same plan.

S.245 – An act relating to eliminating cost-sharing requirements for primary care

- No cost sharing for preventative and primary care services

S.290 – An act relating to health care reform implementation

- Create additional reporting, certification, and budget requirements for ACOs; direct hospitals to report certain rate increases to the GMCB; and impose new requirements on contracting between health plans and providers. The Board's membership must include a health care professional, require the Board to begin exercising its rate-setting authority and to establish site-neutral reimbursement amounts, and direct the Board to review and approve contract between health plans and providers.
- The bill would also impose limits on health insurance rate increase attributable to administrative expenses and require AHS to report on 2-year ACO budget and reporting cycles and on the likely effects of attributing or not attributing state employees and public-school employees to an ACO.

Pending Senate Bills

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S.296 – An act relating to limiting out-of-pocket expenses for prescription insulin prices

- Limit beneficiary's total out-of-pocket responsibility for prescription insulin medication to not more than $100.00 per 30-day supply. *Passed in Senate; referred to the House Committee on Health Care.*

S.309 – An act relating to limitations on health care contract provisions and surprise medical bills

- Prohibit certain provisions in contract between health insurers and health care providers and limit out-of-network providers at in-network facilities.

Total Appropriation (in millions)

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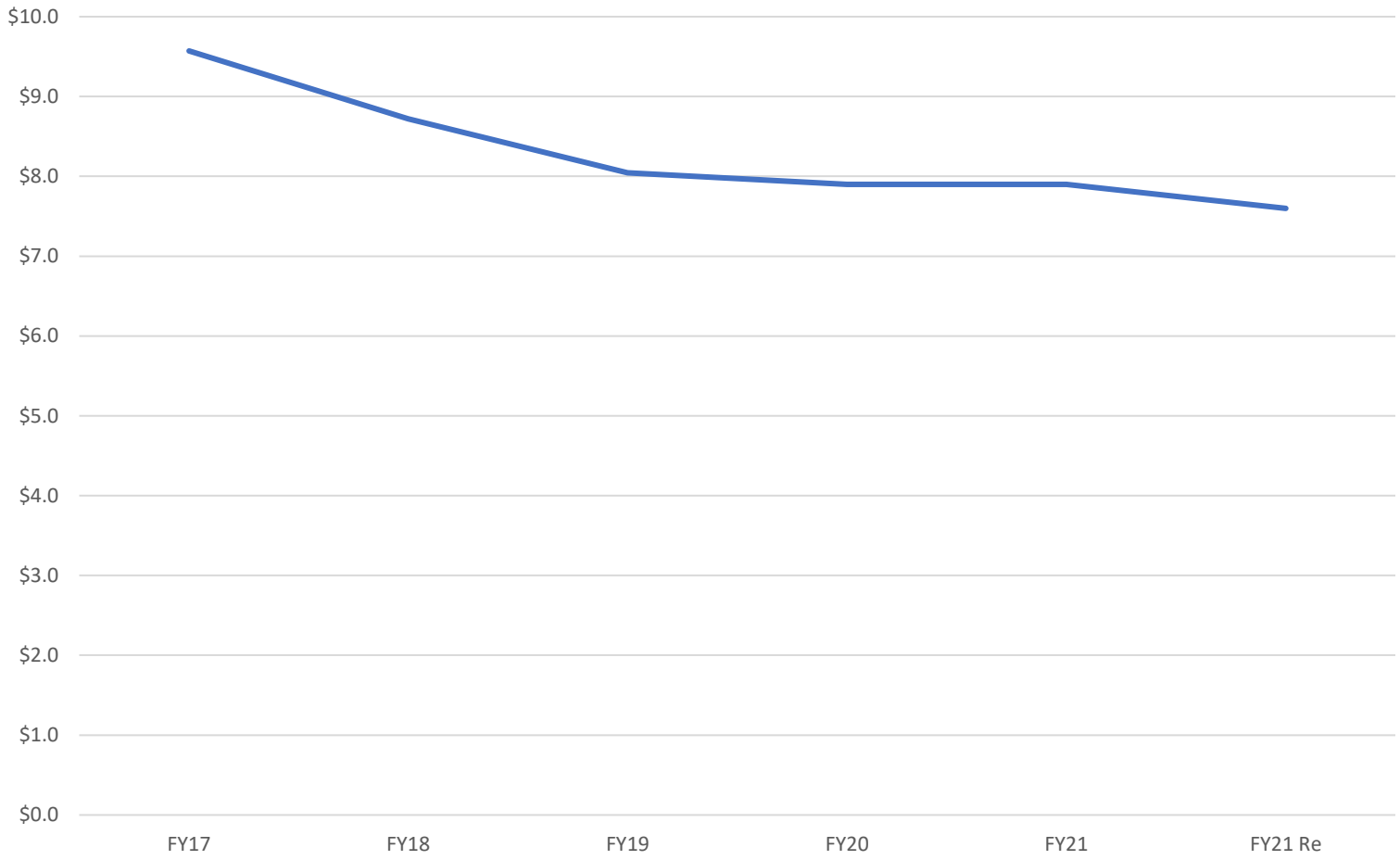

Appropriation by Fund (in millions)

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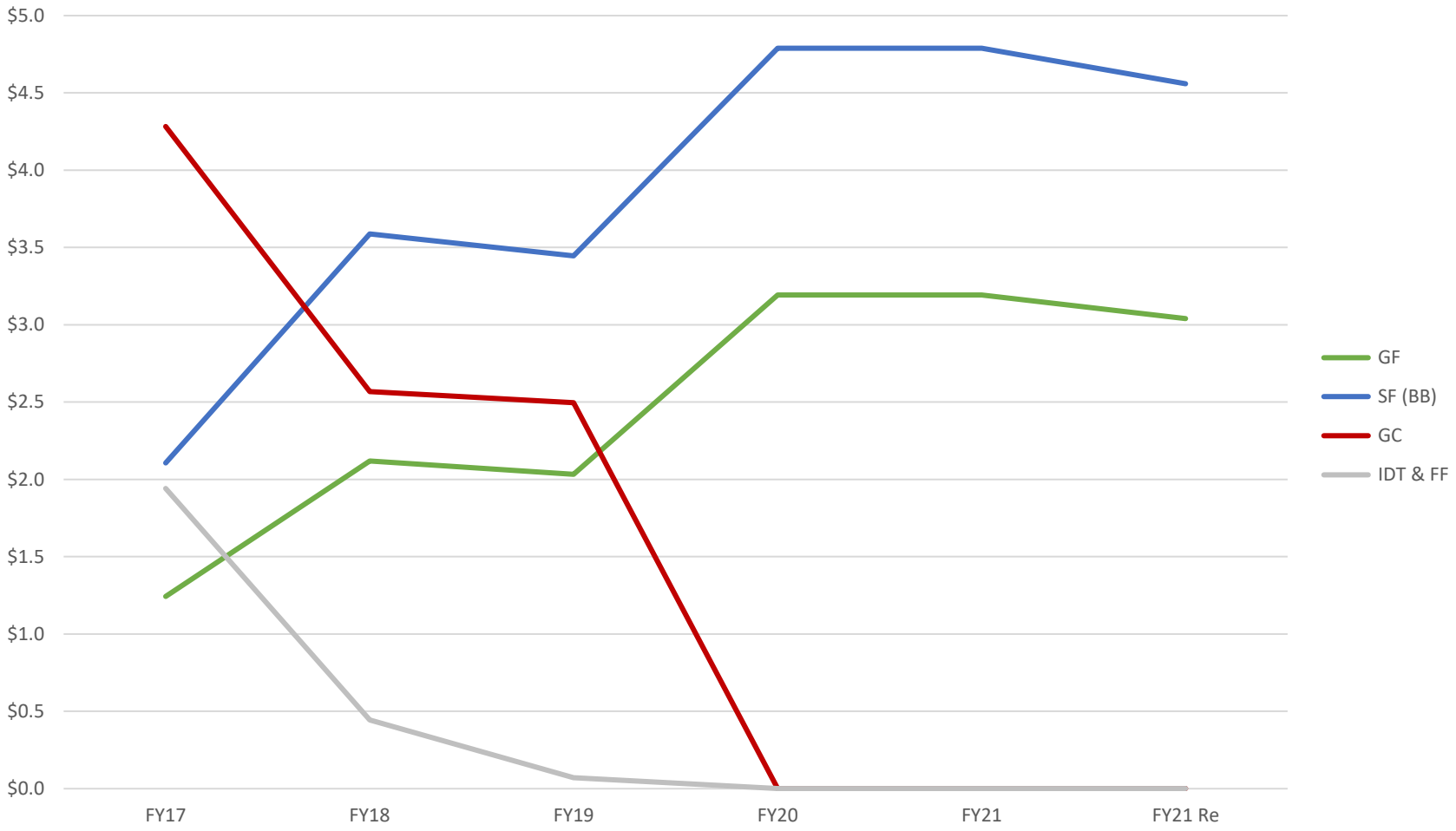

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Questions?