The Legislative Bulletin

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2009 Legislative Wrap-up

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A Summary of Health Care Related Legislation passed by the Vermont General Assembly

H. 441 - 2010-2011 Appropriations: Despite a severe budget shortfall and rapidly declining revenue forecasts, the Vermont General Assembly was unwilling to go along with a four-percent cut in physician Medicaid reimbursement rates proposed by Gov. James Douglas, instead passing legislation limiting the cut to two percent. ***(Pg. 2)***

S. 129 – Practice Variation: BISHCA will be required to contract with VPQHC to identify treatments or procedures for which the utilization rates varies significantly among geographic regions within Vermont and to recommend solutions to contain health care costs by appropriately reducing variation. ***(Pg. 2)***

H. 444 – 2009 Health Care Reform Omnibus: The health care reform omnibus bill passed by the General Assembly contained numerous provisions favorable to physicians, including reducing the time for both health insurers and workers' compensation carriers to pay claims, establishing contract standards for health plan contracts with physicians, regulating rental networks. ***(Pg. 3)***

H. 435 – Pain and Palliative Care: A mandate that all physicians licensed by the Vermont Board of Medical Practice complete a minimum of four hours of palliative CME every two years was not included in the final version of H. 435. ***(Pg. 5)***

S. 48 – Marketing of Prescribed Products: A final VMS-supported compromise deleting the public disclosure of free drug samples allowed for the passage of S. 48, which revises the current pharmaceutical disclosure law by banning many gifts outright and mandating full disclosure of allowable expenditures to physicians, health care organizations, state-funded academic institutions, and non-profit groups. ***(Pg. 6)***

H. 24 – Colorectal Cancer Screening Insurance Mandate: With the passage of H. 24, health insurers in Vermont will now be required to cover colorectal cancer screenings. The screenings must be in accordance with American Cancer Society guidelines and patients cannot be charged co-payments of more than $100. ***(Pg. 7)***

S. 7 – Tobacco Use in the Workplace: The General Assembly passed legislation (S. 7) that further restricts the use of lighted tobacco products in most workplaces. The intent of the bill was to close some loopholes in the existing Smoking in Public Places Law (Clean Indoor Air Act). ***(Pg. 7)***

S. 26 – Disclosure of Patient Information to Medical Examiner: Under a bill spurred by the Department of Health and supported by VMS, health care providers will now be required to provide the medical records of deceased patients to the state's chief medical examiner when requested. ***(Pg. 7)***

View the full text of any of these bills at:
http://www.leg.state.vt.us/database/status/status.cfm
Type in the corresponding bill number and click on the "As passed both House and Senate" version.

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H.441 - Legislature Halves Administration's Proposed Cuts in Physician Medicaid Reimbursement for Non-Evaluation and Management Procedures

Despite a severe budget shortfall and rapidly declining revenue forecasts, the Vermont General Assembly was unwilling to go along with a four-percent cut in physician Medicaid reimbursement rates proposed by Gov. James Douglas, instead passing legislation limiting the cut to two percent.

Affecting all services except for evaluation and management codes 99201 through 99499, the cut will reduce physician reimbursements by approximately $800,000, but only save the state around $250,000 as the federal government pays for 70 percent of Medicaid reimbursements. In total, the reimbursement cuts to health care practitioners and social service programs is expected to be approximately $8 million while the state expects to save only $2.7 million.

Other programs and services affected by this two-percent reduction include alcohol and drug abuse prevention programs, family services grants, residential care for adults with disabilities and children, home and community-based care for seniors, services to the blind and visually impaired, and services for individuals with traumatic brain injuries.

Another budget cut of particular interest to health care providers was a $870,000-reduction in funding to the loan repayment program for physicians, dentists, nurses, and nurse educators. This is a significant reduction from last year's budget, which included a total of $1.4 million for loan repayment.

Additional cuts proposed by the administration but turned back by the legislature include 20 percent ($2.3 million) on most procedures for the state's 16,000 Medicare/Medicaid eligible patients and 50 percent ($2.6 million) in primary care and case management fees.

However, all of the original cuts proposed by the administration could once again be back on the table if the Governor calls legislators back to Montpelier for a special session by vetoing the budget, or by convincing legislators to rework the budget by simply threatening a veto. In the days following the passage of the legislature's budget the Governor had publicly voiced his disapproval of the budget and intimated that he wanted to continue looking for ways to cut spending and reduce new revenues that the legislature's budget called for.

As of press time, Gov. Douglas had not publicly announced whether or not he would sign the budget, but as long as negotiations continue between the administration and the legislature there is a risk that health care reimbursement could be negatively impacted.

S.129 - BISHCA and VPQHC to Look Into Practice Variations

Under S.129, the Commissioner of the Banking, Insurance, Securities and Health Care Administration (BISHCA) is required to contract with VPQHC to identify treatments or procedures for which the utilization rates varies significantly among geographic regions within Vermont and to recommend solutions to contain health care costs by appropriately reducing variation, including by promoting the use of equally or more effective, lower-cost treatments and therapies. Much of the impetus behind the legislation was based on the research of Dr. Elliott Fisher and Dr. Jack Weinberg as found in the Dartmouth Atlas project.

In his testimony on S. 129, VMS President John Brumsted, M.D., pointed out that Vermont consistently ranks as one of the lowest cost and most efficient health care systems in the country. He also indicated the major reason for examining practice variation should be to improve the quality of health care and that it should not be used solely as a mechanism to reduce health care costs.

By Jan. 15, 2010, BISHCA is required to report to legislative committees on their analysis and to consult with VMS, the Vermont Association of Hospitals and Health Systems, Inc. (VAHHS), and others, to recommend: a process to ensure appropriate utilization in treatments or procedures across Vermont; modifications to existing regulatory processes; solutions to reduce inappropriate low or high utilization; and, incentives for hospitals and health care professionals to change inappropriately low or high utilization.

BISHCA is also required to prepare a health plan administrative costs report that provides the legislature with administrative costs comparisons between private insurers and self-insured health plans, while the secretary of administration is required to present a plan for a shared decision-making demonstration project to be integrated with the Blueprint for Health

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S.129 - Practice Variations

(cont'd from pg. 2) The legislation also includes a section directing the Commission on Health Care Reform to convene a workgroup to support the development of an application for anticipation in a national ACO state learning collaborative. Under the bill, an ACO is defined as an entity that enables healthcare providers to be accountable for the overall cost and quality of care for the population they serve and to share in savings created by improving quality and slowing spending growth. The new section assumes that ACOs will likely be a part of President Obama's national health care reform legislation.

Finally, the bill includes a number of certificate of need (CON) provisions that have been agreed to by BISHCA and VAHHS. These include: technical provisions on calculating expenditures for jurisdictional determinations; clarification of when a CON would expire; a new definition of non-material change; and, a requirement that all new ambulatory surgical centers go through the CON process.

H.444 - Omnibus Bill Improves Workers' Compensation and Health Insurers' Payment Procedures and Contract Standards

The health care reform omnibus bill (H. 444) passed by the General Assembly contained numerous provisions favorable to physicians, including reducing the time for both health insurers and workers' compensation carriers to pay claims, establishing contract standards for health plan contracts with physicians, regulating rental networks, and making modest adjustments to Vermont's access to health care initiatives.

The bill also maximizes Vermont's potential to compete successfully for federal stimulus funding for primary and preventive care, electronic health record systems for doctors and hospitals and a health information network to allow for the exchange of electronic information among providers and patients.

Workers' Compensation
H. 444 addresses the timely payment of workers' compensation medical bills by including provisions drafted by a VMS-led workgroup that highlighted the difficulties physicians face in receiving timely payment for workers compensation claims. It also clarifies that a physician is able to bring a complaint against an insurance carrier to the Department of Labor.

The bill adds to Title 21 new timely payment requirements of medical bills under a workers' compensation claim. Under current law, these provisions are in Title 18 along with the provisions for timely payment of traditional medical bills. H. 444 reduces the amount of time an insurance carrier has to either pay the bill, or provide written notification to the injured employee, healthcare provider and Commissioner Department of Labor that the bill is contested, from 45 to 30 days, following receipt of a medical bill.

If the employer or insurance company denied the medical bill based on insufficient information to determine liability for payment, the bill requires the insurance carrier to pay or deny payment within 30 days after receiving additional information. The bill establishes a 12-percent annual interest rate for unpaid medical bills.

The bill stipulates that a medical bill must be submitted in legible form with every field or data element relevant to the treatment completed and treatment coding that conforms to the criteria of the National Correct Coding Initiative. The bill also allows the Commission of Labor to assess penalties against the employer or insurance carrier that fails to comply with provisions of sections and permits the Commissioner to refer to the BISHCA Commissioner if the insurance carrier neglects or fails to pay medical bills is required.

H. 444 adds to Title 21 protections against recoupment of payments to physicians by workers' compensation carriers and also prohibitions against down coding by these companies.

Contract Standards
Another VMS-led workgroup's findings impacted H. 444 as the bill took significant steps toward administrative simplification, improved transparency and greater balance in the relationship between health insurers and physicians by addressing:

- Timely Payment – The bill reduces the time for payment of clean claims, both paper claims and electronic claims to 30 days from the 45 days permitted by existing law. Effective date: July 1, 2010.

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H.444 - Health Care Reform Omnibus Bill

(cont'd from pg. 3)

- Access to Fee Schedules – H. 444 requires plans to provide physicians with the fee schedule amounts, on request, for any codes they actually bill or codes that physicians in the same specialty typically bill. Plans may provide this information on a CD-ROM, electronically or in hard copy if a hard copy is specifically requested. Health care practitioners are required to maintain the confidentiality of fee schedule information they receive from a health plan, which also will be available to practitioners who are considering whether to contract with a plan. Effective date: plans required to provide fee schedule on request beginning July 1, 2009.

- Access to Claim Editing Information – The bill requires plans to disclose the claim editing software they use and the additional percentages they pay for modifiers, such as modifiers for multiple procedures, assistant surgeons, office visits on same day as surgery, or bilateral procedures (effective date: July 1, 2010). The bill also requires interested parties to study and make recommendations about the most appropriate way to ensure that health care practitioners can obtain information about the edit standards that are applied to the services they provide by health plans. Effective date: July 1, 2011.

- Contract and Amendment Standards – The bill creates standards for contracts addressing contract amendments, disclosure of products covered by the contract, term of the contract, termination notice period, and mechanisms for resolving grievances. H. 444 also requires a summary disclosure form or executive summary of the contract to be included with contract and amendments as contracts are often more than 20 pages long. The summary will include key terms and the pages where they can be found as well as health plan contact information a practitioner can use to obtain additional information. Beginning July 1, 2009, summary provided on request within 60 days of request. Summary included in contracts entered or renewed on or after July 1, 2009. No latter than July 1, 2014 for all other existing contracts.

- Most Favored Nation Clauses – The bill prohibits the use of "most favored nation" clauses in health care contracts, which are often used by health plans to prevent practitioners from granting better discounts to other health plans. Effective date: July 1, 2009.

- Rental Networks (Silent PPOs) – The bill ensures oversight and accountability of rental networks by requiring them to register with BISHCA if they are not already licensed or registered. The bill also creates transparency requirements for rental networks and requires all parties to a rental network contract to comply with all of the terms of the underlying contract with the physician. As well, the health care practitioner must agree to this type of rental transaction in the underlying contract and a contracting entity or health plan engaging in this practice must:
  - o Create a list – posted on its Web site and updated at least every 90 days – of third parties with access to the network and discounts;
  - o Require the third party to identify the source of the contract discount on each remittance advice or explanation of payment form; and
  - o Notify the third party of termination of the underlying contract and require the third party to cease claiming the discount or other contract rights after termination.

The bill prohibits "downstream rental" which occurs when an entity which itself obtained access to the network through a rental arrangement in turn rents the network to other entities. As contracts get farther and farther away from the original contract with the physician, many have found it becomes increasingly difficult to obtain prior authorization or correct payment problems. To date, Vermont is the only state that has banned such downstream rentals. Effective date: Jan. 1, 2010.

- Enforcement – The bill clarifies the authority of BISHCA to enforce the timely payment and contract standards provisions enacted last year and this year. BISHCA may examine and investigate health plans and other contracting entities, order them to cease and remediate violations and may impose administrative penalties of up to $1,000 for each violation or up to $10,000 for each willful violation. At the option of either party, binding arbitration may also enforce the law. Effective date: July 1, 2009.

Other provisions in the bill include:

- Legalizing a practice now supported by the Center for Disease Control (CDC) national standards whereby health care providers may treat the partners of patients with chlamydia without examining the partners; and

- Mandating coverage of oral cancer drugs, if coverage of oral drugs is no more expensive than intravenously administered or injected cancer drugs.

H.435 - Palliative Care and Pain Management Bill Approved Without Mandatory CMEs

A mandate that all physicians licensed by the Vermont Board of Medical Practice (VBMP) complete a minimum of four hours of continuing medical education on palliative care every two years as a condition of license renewal was not included in the final version of H. 435.

Throughout the process legislators and advocates voiced their concerns that Vermont is one of only a handful of states with no CME requirement for physicians or nurses as part of their license renewal processes. But in the final analysis the legislature decided that more information was needed before creating a CME mandate. As passed, the bill directs VBMP and the Vermont Board of Nursing (BON) to review the CME issue and report back to the legislature by Jan. 15, 2010. The report must include "recommendations for improving the knowledge and practice of health care professionals in Vermont with respect to palliative care and pain management." The VBMP and BON are specifically directed to consider:

- Continuing medical education requirements;
- Use of live interactive training programs;
- Implementation of training programs as a condition of hospital credentialing;
- Appropriate frequency and intensity of training for health care practitioners in different fields of practice;
- Enhancing informed patient choice through use of the patient's bill of rights;
- Identifying barriers to effective communication and proposing solutions to overcome them;
- Integration of palliative care and hospice referrals into health care providers' practices; and,
- Methods for informing the public of the training that health care providers have received in palliative care and pain management.

The CME issue was first raised during the summer study committee on pain management and palliative care and in response, VMS convened a group of physicians – including Wendy Davis, MD, Commissioner of Health, David Clauss, MD, chair of VBMP, Jeffrey Klein, MD, associate dean for CME at the UVM College of Medicine, and VMS President John Brumsted, MD – to look into the issue.

The group submitted a joint letter to the study committee outlining a two-track approach to ensuring competency of practicing physicians in Vermont and ensuring knowledge about pain management and palliative care. The first track would identify knowledge deficits in pain and palliative care and create interdisciplinary CME curriculum options in a variety of delivery formats to address those deficits. The second track would make recommendations regarding the establishment of new standards to ensure the sustained competency of practicing physicians reflecting the best emerging national standards for evaluation of competence and maintenance of certification, taking into account work already underway at the national level by the Federation of State Medical Boards and the American Board of Medical Specialties.

VMS is pleased that the Committee did not mandate CME and believes that the VBMP report will fit with the collaborative process outlined above.

Provisions that were included in the final bill include:

- A patients' bill of rights for palliative care and pain management that specifies the right of patients to be informed of evidence-based options for care, request or reject treatments to relieve pain, and the right of children with serious or life-limiting conditions to receive palliative care while continuing to receive curative treatment;
- An update to the Vermont informed-consent law clarifying that patients are entitled to answers to specific questions about foreseeable risks and benefits of their treatment;
- A requirement that the Office of Vermont Health Access apply to the Centers for Medicare and Medicaid Services for a Medicaid waiver to allow Vermont to provide concurrent palliative care and curative care for children who have life-limiting conditions;
- Inclusion of advance care planning, palliative care and pain management to the definition of "chronic condition" for purposes of addressing these issues through the Blueprint for Health;
- Inclusion of the word "pain" in the scope of practice sections of the licensing laws of a number of health care practitioners;
- A report on the number of Vermonters who die in various settings including hospital emergency rooms, other hospital settings, at home, in a nursing home, in a hospice facility, and if they received hospice care within the last 30 days of life; and,
- A taskforce to be led by the Vermont Ethics Network that would coordinate palliative care and pain management initiatives in Vermont, help Vermonters gain access to services and propose solutions to address gaps in services.

S.48 - Pharmaceutical Disclosure Law Revised, Many Gifts Banned Outright

A final VMS-supported compromise deleting the public disclosure of free drug samples, allowed for the passage of S. 48. The legislation revises the current pharmaceutical disclosure law, bans many gifts outright and mandates full disclosure of allowable expenditures to physicians, health care organizations, state-funded academic institutions, and non-profit groups. The legislation is one further step in Vermont's efforts to control the cost of pharmaceuticals by regulating the marketing activities of drug companies and it is consistent with VMS's recently adopted resolution on Grants and Gifts to Physicians.

During a statehouse press conference in support of the bill, VMS President John Brumsted, M.D., said "patients need to have confidence in the prescribing decisions of their doctors. Greater transparency around relationships with pharmaceutical companies allows for that confidence and protects the doctor/patient relationship."

According to an April 2009 report of Vermont Attorney General William H. Sorrell, in fiscal year 2008 pharmaceutical manufacturers reported spending more than $2.9 million in Vermont on fees, travel expenses, and other direct payments to Vermont physicians, hospitals, universities, and others for the purpose of marketing their products. Of Vermont's 4,573 licensed health care professionals, 2,280 were recipients. Of the above amount, approximately $2.1 million in payments went to physicians. The top 100 individual recipients received nearly $1.8 million in fiscal year 2008.

Under the bill a new distinction is created between "allowable expenditures" that may or may not be reported to the Office of the Attorney General (OAG) and "gifts," most of which would be banned. By October 1st of each year, every pharmaceutical, medical device and biological product manufacturer would be required to disclose to the OAG the value, nature, purpose, and recipient of any allowable expenditures (with the exception of royalties and licensing fees). The disclosures would be made in a form established by the OAG and would be publicly available and searchable by prescribers on the OAG's Web site. By April 1st of each year, the OAG would report on the allowable expenditures and gifts disclosed during the past year to the Governor and the General Assembly.

The bill states that it is unlawful for any pharmaceutical manufacturer to give a gift to a health care professional. However, it does exempt from the ban and the reporting requirements the following items: samples of a prescription drug provided to a health care professional for free distribution to patients; peer-reviewed academic, scientific or other clinical articles or journals; scholarships for medical students, residents or fellows to attend an educational seminar of a national professional organization; and, rebates and discounts for prescription drugs. The attorney general may impose a civil penalty of no more than $10,000 per violation on any manufacturer.

"Allowable expenditures" means: payment to the sponsor of a significant educational seminar; honoraria and payment of the expenses of a health care professional who serves on the faculty at an educational seminar; compensation for a bona fide clinical trial or research project; reimbursement for expenses necessary for technical training on the use of a medical device; royalties and licensing fees; and, other benefits provided by a manufacturer of prescribed products at fair market value. As noted above, all allowable expenditures would be publicly available on the OAG's website, with the exception of royalties and licensing fees. The legislature rejected an amendment supported by VMS that would have permitted modest meals that serve a genuine educational function.

The House of Representatives added a requirement to the bill that free drug samples provided to prescribers be reported by manufacturers and the information be searchable on OAG website. VMS and others raised concerns that the reporting requirement might discourage physicians from accepting free samples for their patients, as well as highlight the location of physician offices with drug supplies. The final version of the bill dropped the reporting of free samples and instead directs the OAG to study the issue and report back to the legislature with its recommendations on Dec. 15, 2009.

The bill also creates a therapeutic equivalent drug work group to explore increasing the usage of generic drugs by allowing pharmacists to substitute a therapeutically equivalent generic drug from a specified list when a physician prescribes a more expensive brand-name drug in the same class. The work group shall consist of two physicians appointed by VMS, two pharmacists appointed by the Vermont Pharmacy Association and three representatives of the drug utilization review board.

The work group shall transmit the list of therapeutically equivalent generic drugs to the Board of Medical Practice and the Board of Pharmacy for review and comment. The boards shall review the list of therapeutically equivalent generic drugs jointly and provide comments. By Jan. 15, 2010, the work group shall provide a report to the legislature on the list generated, the comments provided by the boards of medical practice and of pharmacy, patient advocacy organizations, and any other information the work group deems relevant to the consideration of draft legislation.

H.24 - Bill Requiring Insurance Coverage of Colorectal Cancer Screening Passes

With the passage of H. 24, health insurers in Vermont will now be required to cover colorectal cancer screenings. The screenings must be in accordance with American Cancer Society guidelines and patients cannot be charged co-payments of more than $100.

For an insured age 50 or older, coverage would be required to include one fecal occult blood test per year and either a flexible sigmoidoscopy every five years or colonoscopy every 10 years. For an insured who is at high risk for colorectal cancer, insurers would be required to cover screening examinations and lab tests recommended by the patient's treating physician.

Insurers would be required to cover the full cost of the screening. Co-payments would be limited to the level of the co-payments for primary care services under the insured's plan, but could not exceed $100. Screening would not be subject to the insured's deductible or coinsurance requirements.

S.7 - Lighted Tobacco in the Workplace Loopholes Closed, Tobacco Program Funding Cut

Smoke Free Workplace
The General Assembly passed legislation (S. 7) that further restricts the use of lighted tobacco products in most workplaces. The intent of the bill was to close some loopholes in the existing Smoking in Public Places Law (Clean Indoor Air Act), that allowed indoor smoking areas in some workplaces.

An amendment to the bill exempted the Veterans Home in Bennington from this legislation.

Tobacco Program Funding
House and Senate budget conferees finalized a budget that cuts a roughly $1.9 million from the tobacco program budget. The legislation also removed the various line items under the Department of Health's portion of the program and allows the department and the Tobacco Evaluation and Review Board to allocate funds as they see fit. However, the earmark for pregnant smokers did remain.

S.26 - Patient Information Now Required to be Shared with Medical Examiners Upon Examiners' Request

Under a bill spurred by the Department of Health and supported by VMS, health care providers will now be required to provide the medical records of deceased patients to the state's chief medical examiner when requested by examiners.

The legislation was originally introduced as a separate bill authorizing physicians to disclose information about their patients to the chief medical examiner, but was ultimately included in S. 26, a bill relating to profits from crime. The bill's language was changed from "allowing" physicians to disclose information to "requiring" them to do so in order to meet HIPPA requirements.

FTC Offers ID Theft Prevention Steps To Ease Compliance for Low-Risk Firms

The Federal Trade Commission May 13 released an online template to guide businesses that are required under new rules to prevent identity theft incidents, despite having a low risk of experiencing such problems. Under the rules, financial institutions and "creditors"must develop prevention programs that identify relevant patterns, practices, and specific activities that are "red flags"for possible identity theft. The FTC has been accused of interpreting the creditor category too broadly, applying it to health care providers and other organizations that may have a low risk of identity theft. The commission's new template is designed to ease compliance for such entities. Both financial institutions and creditors were initially given until Nov. 1 to comply with the rules. However, the FTC extended the deadline for creditors twice because of industry concerns. The first time, it was moved to May 1 . On the eve of that deadline, it was delayed once again until Aug. 1 .

The FTC's new red flags template for businesses that have a low risk of identity theft is available at:
http://www.ftc.gov/bcp/edu/microsites/redflagsrule/get-started.shtm

Thank you to all of our members and partners for the input, testimony and calls you made this legislative session to help improve the quality of health care in the state of Vermont.

The VMS staff are grateful and appreciative for all that you do!

To view the full text of any of the bills discussed in this issue go to:
http://www.leg.state.vt.us/database/status/status.cfm
Type in the bill number and click on the "As passed both House and Senate" version.

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