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Administration Releases Single-Payer Financing Plan: All savings based on reduced payments to providers

On January 24, the Shumlin administration released its long-awaited financing plan[1] for Green Mountain Care (GMC) – the proposed publicly financed single-payer health care system. The study projects that under GMC Vermont would save $34 million[2] in 2017 in funding the state's $6.0 billion health care system. The report's savings appear to be achieved solely by reducing provider payment rates by $155 million.[3]

The University of Massachusetts Medical School and Wakely Consulting Group were paid $300,000 to provide the cost estimates and to draw up two financing plans for the state. One plan was for the state's single-payer system scheduled for 2017, and the other was for funding the state's new health insurance exchange, which will go into effect in 2014, as required by the federal Affordable Care Act (ACA). The consultants worked directly with members of the administration to develop the report and the plan's cost components.

A federal waiver from the requirements of the ACA is necessary for implementation of the single-payer health care system in 2017. An ACA Section 1332 waiver from the federal Secretary of Department of Health and Human Services would allow Vermont to opt out of specific exchange-related provisions of ACA beginning on Jan. 1, 2017, if it ensures that the state's residents would have access to high quality affordable health insurance by alternative means. The plan indicates that the State of Vermont would receive $267 million in federal funds to support the single-plan as a result of the waiver.

The plan estimates $1.61 billion[4] in new tax revenue would be required to replace the insurance premium portion of the $6.0 billion in total system costs in 2017. And while $1.61 billion may seem like a very large amount, it would have been a much greater sum if the plan did not propose setting provider reimbursement at a low level.

Unexpectedly, the Act 48-mandated financing plan lacked any specific proposals for how the state would generate the $1.61 billion in publicly financed revenue for the new single-payer system. However, it is important to note that the 2017 ACA single-payer waiver from DHHS is not dependent on the enactment by the Vermont Legislature of new taxes in order to move to a single-payer system.

It will be extremely difficult for the legislature to enact broad-based taxes in 2015 sufficient to generate $1.6 billion in new revenue due to the potential impact on the state's economy. Vermont Medical Society (VMS) believes it is entirely plausible that the state's single-payer plan in 2017 will continue to rely on a combination of existing Medicaid revenues and subsidized premiums from beneficiaries to fund the state's single-payer plan. It is clear from the report that a major focus of GMC beginning in 2017 will be the implementation of a state-established uniform reimbursement methodology for the health care services provided to the vast majority of Vermonters who are under 65.

Of great concern to VMS is that the report's $34 million in savings for the 2017 plan appear to be achieved solely by reducing provider payment rates by $155 million.[5] The plan states "[A]nd health care providers will receive the same and adequate rates for all their patients, calculated at 105 percent of Medicare payments."[6] The financing plan further indicates that private insurance reimburses providers at 155 percent of Medicare[7] and that the number of

Continued on Page 3

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H. 522 A Bill Relating to Strengthening Vermont's Response to Opioid Addiction and Methamphetamine Abuse

Last week the House Human Services Committee voted out H. 522, a committee bill relating to "strengthening Vermont's response to opioid addiction and methamphetamine abuse."
(Link to bill: www.leg.state.vt.us/docs/2014/Bills/Intro/H-522.pdf)

VMS is very concerned about misuse of controlled substances and in November, the VMS Education and Research Foundation (VMSERF) released a report addressing *Safe and Effective Treatment of Chronic Pain.* In February, Cyrus Jordan M.D., Director of VMSERF, testified about the report and the challenges involved in treating pain to a joint hearing of the House Human Services Committee and House Judiciary Committee. Dr. Jordan was joined at the hearing by pain specialists who contributed to the report. Both in the report and at the hearing they made a number of recommendations designed to improve treatment for patients in Vermont. To view the entire report, visit VMSFoundation.org and click on the "News" link.

The version of H. 522 voted on by the committee includes some provisions of concern to VMS that are not consistent with the VMS Resolution adopted at the Annual Meeting in October of 2012. *(Link to VMS resolution: www.vtmd.org/sites/default/files/files/2012%20Use%20and%20Improvement%20of%20VPMS.pdf)*

Three areas of concern to VMS are:

1. Requirement to check the VPMS database.

Section 11 (d) of H. 522 requires physicians and other prescribers, or their delegates, to query the Vermont Prescription Monitoring System (VPMS) database in specified circumstances. The Commissioner of Health may promulgate rules requiring prescribers to check the database in other circumstances. The bill requires prescribers to check the VPMS database:

1. The first time a Schedule II, III, or IV controlled substance is prescribed for a patient;
2. At least annually following the initial prescription of a Schedule II, III, IV controlled substance;
3. When starting a patient on long-term opioid therapy of 90 days or more; and
4. Prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance for a patient whose prescription has been lost or stolen. (Note: in addition, physicians will be required to document the writing of replacement prescriptions in their patients' medical records.)

The VMS Council recommends that the legislative mandates in Section 11 (d)[page 15], to check the Vermont Prescription Monitoring System (VPMS) database should be replaced with a requirement that the licensing boards, such as the Vermont Board of Medical Practice (VBMP), in consultation with the Department of Health's Unified System Council, create evidence-based standards concerning when physicians should check the VPMS database. Legislators have informed VMS that an amendment will be offered by the House Human Services Committee on the House floor, that will significantly narrow the requirement to check the VPMS data base, by only requiring prescribers to check the database when opioids are prescribed for chronic pain, initially and annually thereafter.

VMS opposes legislating standards for the practice of medicine. VMS is also concerned that the requirement in this bill to query the VPMS database is not limited to long-term prescriptions for opioids prescribed for the treatment of chronic pain. It covers prescriptions of any Schedule II, III, IV controlled substance for any purpose – acute pain, palliative care, hospice care, or cancer pain, and would cover stimulant prescriptions for children with ADHD, anti-anxiety prescriptions for air travel, post-operative pain, and prescriptions for sleep. "Prescription" is defined as a written order for a regulated drug or controlled substance. The bill does not require physicians who dispense or administer drugs to their patients to check the VPMS database.

2. Use of VPMS data by Department of Health to evaluate prescribing.

VMS recommends that the Department of Health should "push" data from the VPMS database to prescribers and dispensers to inform them when their patients are receiving more controlled substances from multiple prescribers and filling their prescriptions at multiple pharmacies, or receiving more than a therapeutic dose, or when the Department has other indications of possible misuse or diversion of prescription drugs.

3. The VPMS system should include real time data. Requirements to check the VPMS database should be linked to improvements in the functionality of the database.

The bill does not mandate that the prescription data be reported to VPMS in real time. Instead, the bill requires the VPMS advisory committee to report on the feasibility of obtaining real-time information and to evaluate whether increasing the frequency of reporting from every seven days to every 24 hours would yield substantial benefits. VMS encourages the Department of Health to improve the VPMS database, which physicians report is not easy to log into and use and does not work well with electronic medical records. VMS encourages the Department of health to ensure that the data in the VPMS is current and available real-time.

Continued on Page 4

Financing Plan Released

(Cont'd from pg. 1) individuals covered by private insurance will be reduced in 2017 from 343,085 to 39,499.[8] The plan therefore anticipates a 32 percent cut in provider reimbursement in providing care for the 303,585 Vermonters who were formerly covered by private insurance.

As devastating as a $155 million cut in payments would be, VMS believes the plan underestimates the reduction in payments to providers in 2017. The plan indicates the total reduction in payments from private insurance companies would actually be $469 million and that this amount would be offset by an increase in Medicaid payments in 2017 of $314 million -- with a net reduction of $155 million. However, the plan fails to acknowledge the increase in 2013 and 2014 of Medicaid payments to primary care physicians to 100 percent of Medicare that was mandated by the ACA and overstates the savings of any hypothetical increased Medicaid payments in 2017. There is also no guarantee that the legislature would approve such an increase in Medicaid reimbursement.

More importantly, by setting the single-payer reimbursement at 105 percent of Medicare, the single-payer plan would permanently tie its physician and hospital reimbursement to any future increases (or decreases) in Medicare reimbursement. Over the next 20 years, the federal government will continue its efforts to constrain the cost of Medicare in order to ensure its sustainability with the enrollment of the Baby Boomer generation. For example, since 2001, due to Congress' inability to address the Sustainable Growth Rate (SGR), Medicare payments for physician services have only increased by four percent, while the cost of caring for patients as measured by the Medicare Economic Index (MEI) has increased by more than 20 percent.

Correspondence dated Jan. 21, 2013, between the administration and their consultants makes it clear that the single-payer plan's "ongoing savings comes from keeping provider rates at the rate of increase of Medicare rates which is lower than the current growth in health care costs."

The UMass study's estimates are based on the assumption that all Vermont residents would be automatically enrolled in the single-payer plan in 2017. Using the plan's mid-level estimates, 437,500 Vermonters would have GMC as their primary insurance, and provider reimbursement would be at 105 percent of Medicare; 70,000 individuals would continue to receive their insurance from their employers, and provider reimbursement would be at 155 percent of Medicare, and 129,000 seniors would be covered under Medicare, and provider reimbursement would be at 100 percent of Medicare.[9]

Using the plan's estimates, on a population basis, the average reimbursement in Vermont for the entire population would be 109 percent of Medicare. However, due to the higher utilization rates in the Medicare population and the GMC population, the average state-wide reimbursement would be lower. By way of contrast, DVHA currently reimburses federally qualified health centers (FQHCs) on a cost basis at 125 percent of Medicare -- a cost-based reimbursement rate that is 19 percent higher than the 105 percent of Medicare rate established in the financing plan.

Under United Health Foundation's newest edition of the American's Health Rankings, Vermont has been ranked the healthiest state in the union for the sixth year running.[10] Vermont's strengths include its number one position for all health determinants combined, which includes ranking in the top 10 states for a low incidence of infectious disease, a low prevalence of low birth weight infants, a low rate of preventable hospitalizations, a high rate of diabetes treatment, low number of deaths due to all cardiovascular diseases, including heart disease and strokes, a low rate of premature death and ready availability of primary care physicians.

In the recently released 2011 Vermont Health Care Expenditure Analysis, expenditures for health care services provided to Vermonters grew 1.5 percent in 2011. This compares with a growth of 4.7 percent in 2010. Expenditures for physician services in the state grew by a mere 1.1 percent from 2010 to 2011.

The relatively slow growth in health care spending in Vermont and nationally over the last three years provides a starkly different narrative to the one consistently provided over the last several years of ever-escalating health care costs as the justification for the implementation of a single-payer health plan in Vermont.

In February, Vermont was notified by CMS of the award of a $45 million State Innovations Models (SIM) grant from the federal government. This grant will fund efforts over the next four years aimed at supporting implementation of the following three payment models to encourage better coordination of care and improved data transmission: shared savings accountable care payments; bundled payments; and pay-for-performance models.

Continued on Page 4

(Financing Plan Cont'd from pg. 3) VMS wrote a letter of endorsement for the grant and is currently involved in a number of its working groups. It will be critical for VMS and other organizations to emphasize that proposed reimbursement under GMC will undermine the SIM grant's goal to test new models of payment reform that build upon and enhance our existing high-quality health care system. VMS believes setting reimbursement at 105 percent of Medicare and tying that below-cost-of-reimbursement to the future growth in Medicare rates would ensure a rapid erosion of our health care infrastructure and threaten the ability of the state to attract and retain physicians in the future.

In response to these concerns, VMS is working with a number of other organizations in considering funding an independent analysis of the administration's financing plan with a special emphasis on the impact of the plan's payment policy on the sustainability of Vermont's health care system and its ability to attract and retain physicians.

The period of time between today and 2017 will be critical for the future of Vermont's health care system. VMS will strive to keep its members informed of the various health care initiatives as they become available and it will continue its advocacy on behalf of all physicians and their patients.

References: [1]http://hcr.vermont.gov/sites/hcr/files/2013/Health%20Care%20Reform%20Financing%20Plan_typos%26formatting%20corrected_012913.pdf. [2]Ibid. Page x; [3]Ibid. Page 32; [4]Ibid. Page xi; [5]Ibid. Page 33; [6]Ibid. Page viii; [7]Ibid. Page 25; [8]Ibid. Page ix; [9]Ibid. Page 14; [10] http://www.americashealthrankings.org/VT/2012

Prescription Monitoring System

(Cont'd from pg. 2) **Provisions in H. 522 supported by VMS**
There are many provisions in the bill that VMS supports. They include:

- A requirement that prescriptions include the quantity of the drug written in numeric and word form;
- A requirement that individuals picking up prescriptions at the pharmacy show identification;
- A provision authorizing physicians to appoint delegates to check the VPMS database (Note: the rules permit this now.);
- A requirement that prescribers and dispensers register to use the VPMS. Registration for use of the VPMS should be streamlined and incorporated in the re-licensure process;
- Authorization for the DVHA Medical Director and Office of the Chief Medical Examiner to query the VPMS database;
- Authorization for interstate agreements that would enable physicians to check monitoring systems in other states, for example in New Hampshire;
- Authorization for the Department of Health to perform trend analyses on the VPMS data, post information about trends on its website, and send alerts to health care providers and dispensers by email;
- A requirement that licensing authorities, such as the VBMP develop evidence-based standards to guide health care professionals in the appropriate prescription of Schedule II, III, or IV controlled substances;
- Immunity from criminal and civil actions and a treatment training program for health care professionals who prescribe or dispense an opioid antagonist to a patient at risk of overdose or a family member, friend or other person in a position to assist a person at risk of experiencing an opioid-related overdose;
- Establishment of a Unified Pain Management System Advisory Council that will include a primary care physician representing VMS, a primary care clinician representing Bi-State Primary Care Association, a primary care physician representing the American Academy of Family Physicians and a clinician who works in the emergency department of a hospital. The Council will advise the Commissioner of Health concerning rules for the appropriate use of controlled substances in treating chronic non-cancer pain, addiction, and in preventing prescription drug abuse;
- Restoration of the VPMS Advisory Committee which would be charged with identifying ways to improve the effectiveness of the VPMS database and to report on the feasibility of obtaining real-time information from the VPMS;
- A study addressing screening for addiction, intervention and addiction treatment referrals for patients treated in a hospitals and emergency department;
- Creation of a statewide disposal program for unused drugs;
- Immunity for physicians who prescribe opioid antagonists to persons at risk of experiencing an opioid-related overdose and to their families, friends or others in a position to assist a person at risk of experiencing an overdose; and
- Creation of an electronic registry system for the purchase of products containing ephedrine, and similar substances that can be used to manufacture amphetamines.

After H. 522 is debated and voted on by the House, the bill will move to the Senate and will be reviewed by the Senate Health and Welfare Committee and the Senate Judiciary Committee.