The Legislative Bulletin

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House Health Care Committee Expands S. 88

Late last week on a 9-2 vote the House Health Care Committee reported favorably a strike all amendment to S.88 – an act relating to health care financing and universal access to health care in Vermont.

As reported in the previous legislative bulletin, as it passed the Senate S.88 directed the legislative health care reform commission to contract with a consultant to develop at least three design options for comprehensive healthcare reform in Vermont. Under the bill, one of the options must be for a single-payer plan decoupled from employment. All of the options would be presented to the general assembly by February of 2011

The House Health Care Committee's amendment modifies the Senate bill by adding more specificity to the other two plans required to be developed by the health care commission and consultant. The second study would design a public benefit option administered by state government that would compete with private insurers and the third option would be based on Vermont's current health care reform initiatives such as Catamount and the Blueprint for Health and new opportunities available to Vermont under the federal health care reform law.

The Senate version also established BISHCA-regulated hospital budget targets of 4 percent for rates and 4.5 percent for net patient revenues over the next two years. The House changed the hospital budget targets by eliminating the 4 percent ceiling for rates and replacing it with a broad directive that hospital rates increases must be minimized. The House also changed the hospital net patient revenue figures to 4.5 percent in fiscal year 2011 and a new lower figure of 4 percent in fiscal year 2012.

The committee added multiple provisions to the Senate passed study that expand many of Vermont's current health care reform initiatives.

The first section added by the house directs the various branches of state government to take such actions as are necessary to enforce the provisions of the recently enacted federal healthcare reform bill – the Patient Protection and Affordable Care Act of 2010.

The next major section makes numerous amendments to the Blueprint. The first major change shifts responsibility for the Blueprint from the Department of Health to a renamed Department of Vermont Health Access. The logic behind the change appears to be an effort to consolidate many of Vermont's health-care reform efforts at the Department of Vermont Health Access. In its testimony, VMS raised concerns that such a change might diminish the Blueprint's strong linkage with the public health programs housed within the Department of Health.

The section also includes several provisions related to chronic care management and the medical home and community health teams that are far more detailed and prescriptive than the current enabling legislation. In opposition to the provisions, VMS cited the importance of allowing the physician-led medical homes greater flexibility in designing community health teams in a manner that reflects the unique infrastructure and needs of the various communities around the state.

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(cont'd from pg. 1) VMS supported the bill's proposal to make the blueprint for health statewide – subject to the full participation of Medicaid, Medicare and the state's three commercial insurance companies, including their self-insured plans.

In an effort to achieve full connectivity to the state's health information exchange network by Vermont's hospitals, the bill establishes a certification process for hospitals that will be linked to the annual hospital budget review process. Representatives of the Vermont Association of Hospitals and Health Systems testified against such a highly regulatory process and cited the current voluntary participation by the state's hospitals in this exchange network.

The final version of this section deleted a provision VMS objected to that would have linked a physician's ability to receive Medicaid funds to adopting certified EHRs and being engaged in meaningful use with their participation in the state's Blueprint. VMS pointed out that most physicians would pursue EHR incentive funding under the Medicare program and pediatricians following the Medicaid track would be unfairly discriminated against.

One of the most significant provisions in the legislation deals with the development of pilot Accountable Care Organizations or as the bill describes them, Community Health Systems. Under this provision, pilot Community Health Systems would be developed in order to address the total costs of the delivery system and improve health outcomes. These systems would be organized around primary care professionals and align with the Blueprint's strategic plan and the statewide health information technology plan. The bill contemplates health insurers, Medicaid, Medicare and all of the payers reimbursing this new entity for integrated patient care through a single system of coordinated payments in a global budget.

The section's strategic plan would have the first community health system operational on Jan. 1, 2011 with at least two others operational beginning on July 1, 2011. In its testimony, VMS cited the enormous amount of work that would have to be undertaken in order to achieve the level of clinical and administration integration between physicians, hospitals, FQHCs, and other health professionals and health care facilities in order to work under a single prospective global budget. The bill reflects VMS's suggestion for the development of a thorough testing of pilots within willing communities to review the concept and ensure it achieves its contemplated benefits.

Aware of Massachusetts' health care reform experience with expanding access and the resulting lack of access to primary care, the committee's amendment also creates a committee to

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Law Delays 21.3-Percent Medicare Reduction Through End of May

Last Thursday night President Obama signed into law H.R. 4851, the Continuing Extension Act of 2010, reinstating Medicare physician payments to where they were on March 31, and again postponing the 21.3-percent cut that was supposed to take effect in 2010. This most recent extension of 2009 payment rates will continue through the end of May, and will be applied retroactively to all physician services provided to Medicare patients in April. The legislation passed the Senate by a bipartisan vote of 59-38, and subsequently passed the House by a bipartisan vote of 289-112.

The bill also contains a provision that would allow certain hospital-based doctors to be eligible for health care information technology "meaningful use" incentives under the American Recovery and Reinvestment Act (ARRA) and extends eligibility for a 65-percent subsidy for health coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The hold on processing April claims that the Centers for Medicare & Medicaid Services (CMS) had placed to avoid implementing the payment cut technically expired on Wednesday, April 14, 2010. However, since Congress acted promptly, it is unlikely that many claims were actually processed at the lower payment rates. The American Medical Association (AMA) was informed by CMS that any claims paid that reflected the 21.3-percent cut will be reprocessed automatically without any action required from physicians.

Physician organizations and CMS agree that a permanent solution is needed. In an April 16 statement, the AMA said, "Congress must now turn toward solving this problem once and for all through repeal of the broken payment formula that will hurt seniors, military families and the physicians who care for them. It is impossible for physicians to care for all seniors when Medicare payments fall so far below the cost of providing care." In its statement CMS agreed that the physician payment formula is broken and stated that the agency will continue to work with Congress to find a long-term solution.

VMS will continue to work closely with the AMA, other physician organizations and our Congressional delegation to pass a permanent fix to the Medicare sustainable growth rate formula.

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(cont'd from pg. 2) determine what additional primary care capacity will be needed if Vermont achieves universal access, and creates a detailed and targeted five-year strategic plan to ensure an adequate primary care workforce. The committee will have 17 members, including representatives of VMS, the UVM College of Medicine's Office of Primary Care and Area Health Education Centers (AHEC) program, Blueprint, and Bi-State Primary Care Association.

The committee is charged with reviewing the current capacity of the primary care workforce in Vermont, including geographic access to services and unmet primary health care needs. The committee will also study the resources needed to ensure that the primary care workforce and delivery system are adequate to provide care when all Vermonters have access to coverage, and will determine how state government, universities and others will assist in developing the resources needed in primary care.

The Department of Health, in collaboration with AHEC will report to the legislative commission on health care reform, the House Health Care Committee and the Senate Health and Welfare Committee on its findings, strategic plan and recommendations for legislative action.

Adjustments to the Pharmaceutical Marketing Disclosure Law

The House Health Care Committee worked closely with VMS on S. 88 to make a number of helpful amendments to last year's pharmaceutical marketing disclosure and gift ban bill.

In order to end the practice of Vermont physicians being banned from partaking in conference meals while attending bona fide educational meetings, the bill allows the sponsor of an event to apply part of the funding to provide meals and other food for all conference participants. In addition, the bill exempts from the gift ban the provision of refreshments at a booth at conferences or seminars. These two amendments track similar revisions in the Massachusetts regulation and were strongly advocated for by VMS. The bill also allows hospital foundations that are organized as a nonprofit entity separate from the hospital to accept funds from pharmaceutical companies in order to conduct CME courses.

With respect to free samples, the bill requires each manufacturer to disclose to the office of the attorney general all free samples of prescribed products provided to health care providers and identify for each sample the product, recipient, number of units, and dosage. However, the manufacturer does not have to report the value of the free sample. The release of any information relating to free samples for research purposes would have the names and license number of the recipients redacted and be subject to confidentiality protections.

Since the Patient Protection and Affordable Care Act of 2010 – the new federal healthcare reform bill – contains a provision requiring manufacturers to report similar information to the U.S. Department of Health and Human Services, the VMS did not oppose this provision. In addition, the new provision only becomes operational if the federal government does not provide the Office of the Attorney General research information in a form that can be analyzed.

Finally, the House Health Care Committee's amendment to S. 88 mandates insurers to cover dental anesthesia for dental procedures for children who are unable to receive dental treatment in an outpatient setting. It also mandates coverage for approved therapies for tobacco cessation approved by the FDA. At least one insurer in Vermont already covers these services.

If S. 88 as amended is passed by the full house, it would go to a conference committee comprised of three representatives from each the house and senate. For the full text of S.88 as amended by the House Health Care Committee, please see the House Calendar of April 16th at *www.leg.state.vt.us.*

Input Sought for VMS's Annual Physician Survey

VMS is once again preparing its annual physician survey and would like to receive input from members on what questions the survey should ask.

Each year VMS conducts the survey in order to ensure that the organization's work reflects the concerns and priorities of the state's physicians. The results will help shape the organization's direction for the next year by serving as a guide for the VMS Priority Planning Retreat to be held on June 19th.

Questions from last year's survey, which can be viewed by visiting *http://www.vtmd.org/2009vmsphysiciansurvey.htm*, pertained to three key topics: physicians' satisfaction with their practice health and determinants, national health care reform and Vermont's health care priorities.

To suggest a question, contact Stephanie Winters at swinters@vtmd.org or (802) 223-7898.

2010 Annual Meeting

Saturday, November 6, 2010

Equinox Hotel
Manchester, Vermont

!!! SAVE THE DATE !!!

Mark Your Calendar, Spend the Weekend and Bring the Whole Family!

Make your reservations today! Call 1-877-854-7625.
(Make sure you tell them you are with the VMS)