

THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

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VMS PRESIDENT TESTIFIES BEFORE HOUSE HEALTH CARE COMMITTEE

The president of the Vermont Medical Society used his testimony last week before the House Committee on Health Care to emphasize the increasingly difficult practice environment facing primary care physicians in the state.

In his testimony to the committee, Robert Tortolani, M.D, said that the combination of administrative burdens, low reimbursement and increasing overhead were creating a perilous situation for many Vermont physicians and the patients who rely on them.

"We are in a primary care crisis," said Dr. Tortolani. Dr. Tortolani also addressed the growing dearth in medical students choosing to enter primary care fields and encouraged the committee to seek ways to encourage Medical school students to enter primary care, especially in rural areas. He suggested that one way of doing this would be to consider where prospective medical students are coming from, both in terms of where they live and the financial means of their family, when making medical school admission decisions. Dr. Tortolani referenced statistics that show that students from more rural areas with average means are more likely to enter primary care.

Many committee members expressed recognition of, and concern for, the growing primary care problem and signaled a willingness to address it. Committee Chairman Representative Steven Maier said that in his many years on the committee he has heard similar accounts before, but that no specific solutions to date have been presented to the committee, which is something he'd like to see. VMS Executive Vice President Paul Harrington, who accompanied Dr. Tortolani to the hearing, told the committee that VMS would be willing to partner with other stakeholders in the state to put forth recommendations.

During the hearing, VMS also gave each committee member a summary of its advocacy priorities for the year and the results of its latest physicians survey.

GOVERNOR DOUGLAS PROPOSES BUDGET CUTS TO ADDRESS \$150 MILLION SHORTFALL

Governor Douglas in his FY 2011 budget address to the Vermont General Assembly on Tuesday began to outline how his administration proposes to address a projected revenue shortfall of \$150 million in FY 2011. Part of his proposed plan includes \$53 million in spending reductions for spending in human services programs next year. The House Appropriations Committee will begin to work on the budget next week.

While very few details are available at this point, the governor proposed that Medicaid limit emergency visits not resulting in hospital admissions to 12 per patient, per year. Co-insurance for Catamount Health beneficiaries would increase, as would premiums for Dr. Dynasaur and the Vermont Health Access Program. The administration plans to work with private insurers to expand the state's chronic care initiative, the Vermont Blueprint for Health statewide.

VMS is also concerned that the administration's budget is likely to include reductions to programs supporting the physician workforce including educational loan repayment and support for the Area Health Education Center Programs. The Society will closely follow all budget developments, keep members informed and provide input to the legislature and administration as needed.

NEW BILLS OF INTEREST

S.176 – Introduced by Senators Kitchel and Bartlett of Caledonia and Lamoille Districts, this bill proposes to establish a statewide prescription drug formulary.

S. 177 – Introduced by Senators Kitchel and Bartlett of Caledonia and Lamoille Districts, this bill proposes to consolidate the administration of health care into one agency.

S.181 – Introduced by Senator Bartlett of Lamoille District, this bill proposes to contain the costs of hospital services through providing a global payment for inpatient services and strict budgets for hospitals.

H.491 – Introduced by Representative Davis of Washington and others, this bill proposes to create a single-payer health care system in Vermont to promote health, to prevent chronic health conditions, and to contain costs.

H.510 – Introduced by Representative Poirier of Barre City and others, this bill proposes to establish a public health care option called Green Mountain Care with sliding-scale premiums and cost-sharing that would be available to all Vermont residents and would be funded in part by a 10 percent payroll tax on employers. The bill would focus on cost containment by implementing a global hospital budget and reimbursing physicians at the Medicare rate (primary care physicians would receive Medicare plus 10 percent). The bill would require all Vermonters to have health care coverage or pay a penalty. It would require insurers to allow parents to cover adult children up to age 27 and the bill would eliminate pre-existing conditions.

H.512 – Introduced by Representative McFaun of Barre Town, this bill would provide access to, and coverage for, health services provided in hospitals, build on Catamount Health, and offer opportunities for premium relief to all Vermonters. The bill would establish global hospital budgets, require insurers to disclose to BISHCA the rates they negotiate with providers and direct BISHCA to post that information on its website.

If you are interested in the Legislative Committee Meeting schedules and a listing of all bills, please visit the Vermont Legislature's website at <http://www.leg.state.vt.us>. Committee meetings are normally updated daily, and are subject to change without notice.

SENATE AND HOUSE COMMITTEES HOLD JOINT HEARING ON SINGLE PAYER HEALTH CARE

Last week the Senate Health & Welfare Committee and the House Health Care Committee held a joint hearing on health care reform, with a focus on single-payer healthcare. Senator Bernie Sanders kicked the evening off with his comments on health care reform, noting that the Vermont delegation was working to ensure that Vermont is not penalized in national health care reform for being a leader in covering the uninsured. He acknowledged that while he supported single payer, it would not be possible to move forward with a single payer plan nationally this year, and he focused on his efforts to allow states flexibility so that states could take the lead. He also noted the importance of expanding the federally qualified health center (FQHC) system.

Approximately 80 people spoke in the 3-plus hour hearing. The majority of those in attendance strongly supported establishing a single payer plan, but a small minority voiced concerns, such as increased taxes and a possible drag on the economy. Sue Deppe, MD, spoke on behalf of the Vermont Psychiatric Association Executive Committee in support of single payer, citing the lower overhead costs and elimination of rationing based on inability to pay that would come with

a change to a single-payer system. Deb Richter, a primary care physician and single payer advocate also commented on administrative waste. She held up a long list of insurance companies in a single computer sheet and single payer supporters working with her unfurled the list across the House floor. Bruce Talbot, MD, a retired physician, observed that, based on his 51 years of experience in military and private systems, the public system is better. VMS Council Member Stuart Williams, MD, also spoke in support of single payer. He observed that having a total health care budget would improve efficiency by removing insurers as middlemen. An ob-gyn spoke about helping set up the White River free clinic in 1982, which at the time was expected to be unnecessary in a few years. A family practice physician spoke about insurance CEO compensation and the need to limit medical loss ratios for insurers.

The two committees have begun to review a number of health care reform bills and plan to meet jointly for several weeks. VMS will testify on the various bills and will keep members informed of their progress.

DRAFT APRN RULES TO REMOVE COLLABORATIVE REQUIREMENT

Since early 2008, the Board of Nursing has been working on drafting rules that essentially would allow APRNs to practice independently. VMS has expressed its concerns about the rules orally and in writing on various drafts of the rules. At the January 2010 Board of Nursing meeting, the board approved a draft and scheduled a formal public hearing for February 12, 2010.

The latest version of the draft rules removes the requirement for a written collaborative agreement not only for nurse practitioners, but also for certified nurse midwives, certified registered nurse anesthetists and clinical nurse specialists in psychiatric and mental health nursing. VMS believes that before elimination of the collaborative agreement is considered for these nursing specialties, a multi-disciplinary task force including physicians and APRNs who practice these specialties should conduct a study reviewing the current status of the written agreement, any evidence of the need for change, and evidence of the impact of making a change to the requirement specific to these additional specialties. The written collaboration requirement ensures that a system is in place for collaboration between the two professions when more complex care is required.

The draft rule requires APRNs to complete a graduate nursing degree that includes a clinical component of at least 500 hours. At the UVM College of Medicine, students receive more than 5000 hours of clinical education, about 10 times as much as the minimum number of hours required for APRNs.

The draft rule also requires new APRN graduates and APRNs who change roles (eg. NP to CRNA) or population focuses (pediatric to geriatric) to work in a setting with a

preceptor who is either a physician or an APRN before they may practice independently. Unlike physicians who practice under supervision during their residency years, on-site supervision is not required for the APRN limited-license preceptorship period. New graduates must complete a minimum of 1000 hours of clinical practice with a preceptor in their specialty area of certification, or approximately 26 weeks based on 37.5-hour week.

A requirement that practice guidelines for APRNs be mutually acceptable to the medical and nursing professions has been removed in the draft rules. This requirement helped to ensure that patients receive the same standard of medical care whether they see an APRN or a physician. Most patients assume that they will receive the same level of care of care.

Additionally, the draft rule does not include any transparency requirement that would require APRNs to identify their professional license or their level of education to their patients. Finally, VMS is concerned that APRNs will be regulated by a licensing board comprised of one APRN, five RNs, two LPNs, one LNA, and two public members. This board does not afford APRNs an opportunity for regulation by a group of peers.

VMS will continue to raise concerns about the rules, and welcomes thoughts and comments from members. For copies of the VMS resolution, the draft rules and VMS comments to date, please see the Education section of the VMS website.

A public hearing on the draft rule will be held on Feb. 12, 2010, at 9 a.m. at the National Life Building in Montpelier. Please let VMS know if you are able to attend the hearing.

TIGER TEAMS ESTABLISHED TO IDENTIFY BUDGET SAVINGS; REPORT RECOMMENDS OUTCOMES BUDGETING

To respond to the massive revenue shortfalls in Vermont – a projected deficit of \$150,000,000 for SFY 2010 – the administration established “tiger teams” of state employees and contractors to identify cost savings and reductions in their departments. The term originated within the military to describe a team whose purpose is to penetrate security of “friendly” installations, and thus test their security measures.

The Medicaid Tiger Team included leaders from the Office of Vermont Health Access (OVHA) and HP (formerly EDS, the contractor that pays Medicaid claims). The recommendations of the team included:

- Benchmarking Vermont’s benefit allowances to peer states: New Hampshire, Massachusetts, Rhode Island, Wisconsin, and Washington;
- Maximizing access to private insurance;
- Expanding the utilization of Vermont’s premium based system; and,
- Strengthening the relationship between the Medicaid Provider Fraud and Abuse Unit (MFRAU) and OVHA’s Program Integrity Unit.

The report noted that Vermont was ranked as the healthiest state according to the United Health Foundation and the Commonwealth Fund. Additionally, Vermont was ranked No. 1 by United Cerebral Palsy in their 2009 analysis for the manner in which it serves individuals with intellectual and developmental disabilities.

The benchmarks comparing Vermont to peer states identified the following potential savings in the Medicaid program:

- \$385,000 – limiting emergency room visits to 12 per year (New Hampshire)
- \$3 million – limiting x-rays to 15 per year (New Hampshire)
- \$593,000 – limiting physician visits to 18 visits per year (New Hampshire)

Some or all of the tiger team recommendations may be included in the administration’s 2011 budget.

Challenges for Change Report – Outcome Budgeting

Another budget reduction strategy was developed by a joint legislative government accountability committee, a bi-partisan, bi-cameral group of legislators working with the administration. The group hired a consultant from Minnesota, Public Strategies Group (PSG), which prepared a report generally recommending that the legislature change the budgeting process to focus on results or outcomes instead

of payment for units of service. The report recommended that the outcomes in the area of human services include redesign the human service and health care delivery system into a client centric integrated system that improves outcomes while remaining affordable.

The report found that a 5-percent reduction in SFY 2011 and 10-percent reduction in SFY 2012 could be obtained by redesigning functions and avoiding duplication and overlap between programs and services. The report also found that by purchasing results instead of units of services, the state could save an additional 5 percent in 2011 and 10 percent in 2012.

The Human Services outcomes are being considered by the House Human Services Committee. Legislative leadership established the very ambitious timeline of having the bill on the governor’s desk by Feb. 1, 2010, and the draft bill gives state agencies only 30 days after the bill is signed to begin implementation of the outcome strategies that will be identified by the legislature.

In total the report identified \$38 million in state general fund savings for 2011, about \$24 million of that from the Agency of Human Services. To balance the FY 2011 budget, the administration’s budget will need to include an additional \$112 million in cuts.

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