

THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

2011 Legislative Wrap-up

2011 LEGISLATIVE SESSION CONCLUDES; HEALTH CARE PLAYS PROMINENT ROLE

On May 6th the Vermont General Assembly wrapped up one of the busiest health-care related legislative sessions in recent memory.

With a newly elected Democratic governor and large Democratic majorities in both the House and Senate, the session which concluded a week early lacked much of the contentiousness seen in recent sessions. The atmosphere of cooperation between the legislative and executive branches of Vermont's government paved the way for a number of health care-related bills that will have a lasting impact on how care is delivered in the state.

This issue of the VMS Legislative Bulletin provides a summary of the sessions major health care legislation, including steps the General Assembly took toward establishing a publicly-financed health care system, tax and reimbursement changes that will affect many physicians, other health care professionals and hospitals.

VERMONT TAKES STEP TOWARD A PUBLICLY-FINANCED HEALTH CARE SYSTEM

The Vermont Legislature took the first step toward a universal publicly-financed health care system when on May 5, by a mainly party-line vote, it passed H.202 -- Governor Shumlin's health care reform bill. The Governor will be signing it into law at the state house on the morning of May 26th. The immediate impact of the bill will be to establish the Green Mountain Care Board to oversee cost containment strategies and the Vermont Health Benefit Exchange to help achieve universal insurance coverage, as required under the federal Accountable Care Act (ACA). In addition, the bill anticipates the possible evolution of the Health Benefit Exchange into Green Mountain Care as the state's publicly financed health care system for all Vermonters. Much of the legislation is devoted to mandating numerous studies that will be the basis of future legislative action over the next several years.

Green Mountain Care Board

The bill creates the Green Mountain Care Board with a chair and four other members to take office on Oct. 1, 2011. The Board's duties will include:

- Develop, implement and evaluate payment reform pilots (the first pilot is scheduled for Jan. 1, 2012 and two more pilot would begin on July 1, 2012);
- Develop payment reform methodologies, which may include global payments, bundled payments, and risk-adjusted capitated payments;
- Review and approve Vermont's Health Information Technology Plan;
- Review and approve the health care workforce development strategic plan;
- Set reasonable rates for health care professionals in order to have a consistent and acceptable reimbursement amounts;
- Review and approve recommendations from BISHCA on insurance rate increases, hospital budgets and CONs;
- Review and approve the benefit package for qualified health benefit plans offered by the health benefit exchange;
- Develop and maintain a method for evaluating system-wide performance and quality;
- Define the Green Mountain Care benefit package; and,
- Recommend a three-year Green Mountain Care budget.

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H. 441 – STATE FISCAL YEAR 2012 BUDGET DOES NOT INCLUDE CATAMOUNT HEALTH PLAN CONVERSION

H.441, the Appropriations bill for state fiscal year 2012, does not include the Governor's proposal to merge Catamount Health into Medicaid. Instead, the bill helps to address the budget shortfall by including a new Catamount compromise that was developed by VMS, VAHHS and BCBSVT and was accepted by the administration and the legislature. Under the compromise, the current Catamount program will continue to be offered by BCBSVT and MVP and the program's reimbursement levels and administrative cost would be reduced as follows:

- Physician reimbursement will be reduced by seven percent from the current level of 118 percent of 2006 Medicare to 110 percent of 2006 Medicare;
- Hospital reimbursement will be reduced by nine percent from the current level of 100 percent of actual cost plus ten percent to 100 percent of the actual cost; and
- BCBSVT's and MVP's administrative costs will be reduced by 15 percent from the current level of seven percent of overall premiums to six percent of overall premium.

It is anticipated that the Catamount program will end on Dec. 31, 2013, and the current enrollees would receive their health insurance from plans offered through the Health Benefit Exchange mandated under the federal Accountable Care Act.

In its advocacy efforts against the Governor's proposal, VMS indicated that expanding enrollment in Medicaid with its below cost physician reimbursement without any limits on enrollee's income would have put physicians' ability to provide care to their patients at risk and it would added to the cost-shift.

Over-the Counter Drugs, Multi-source Prescription Drugs and Specialty Drugs, and Radiology Tier Authorization

Section E.301.1 authorizes Medicaid to create a preferred list for over-the-counter drugs similar to the preferred drug list for prescription drugs. Of potential concern to VMS, it also requires justification for prescribing multi-source prescription drugs. Finally, this section authorizes DVHA to establish lower reimbursements for specialty drugs, high-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

The section also directs DVHA to reduce spending on radiology services by implementing a multiple procedure payment reduction to cases with multiple outpatient radiology imaging services. VMS will work closely with radiologists to ensure that patients receive appropriate imaging services.

H. 436 – TAX BILL INCREASES TAX ON CIGARETTES, HOSPITALS AND MEDICAL CLAIMS

As the session ended, the Vermont House and Senate agreed to a tax package with the Shumlin administration that raises \$27.48 million in new taxes to help fill the state's \$176 million budget gap. The agreed upon increases include \$5.85 million in new provider taxes on hospitals; a 38-cent hike on cigarettes (bringing the total tax per pack to \$2.62) to generate \$4.63 million in revenues, and a new 0.8 percent "claims assessment" on the number of medical claims paid by insurance companies and employers for Vermonters that will generate about \$11 million.

According to the Vermont Association of Hospitals and Healthcare Systems, the final results for hospitals include:

- An increase in the provider tax rate from 5.5 to 5.9 percent on Oct. 1, 2011;
- A base year of 2011 actual experience; and
- An increase in the Medicaid reimbursement rate to hospitals of \$9.0 million.

The tax bill also includes increases in a claims assessment, or tax on medical care claims processed by insurers. A 0.199-percent assessment is already being used to fund health information technology improvements. The new tax is 0.8 percent, which brings the total to 0.999 percent. The tax, which will also be imposed on dental insurance claims in the coming fiscal year, raises \$11.82 million.

The bill as passed does not include a new tax on dentists' net revenues. However, it does include a requirement directing the Secretary of Administration to develop systems to identify and collect data necessary to administer any health-care related tax that is permitted by federal law but that Vermont does not currently levy. VMS will continue to work next year to strongly oppose the creation of any new provider tax on physicians.

H. 201 – PALLIATIVE CARE

Improving palliative care and pain management in Vermont continues to be a high priority for the Vermont General Assembly, in particular, the House Human Services Committee. This year the committee, working with the Palliative Care Task Force, brought out an omnibus bill addressing a number of issues:

- It encourages coverage of concurrent curative and hospice care by private insurers, building on a successful pilot project undertaken by Aetna;
- It requires the Agency of Human Services to move forward on enhanced hospice access benefits including concurrent curative and hospice care and an eligibility expansion to a 12 months life expectancy Medicaid. To accomplish this goal, the agency is required to apply for a demonstration project for dual eligibles by July 1, 2012, and an amendment to its global commitment waiver by July 1, 2013.
- The Department of Disabilities, Aging and Independent Living is required to change its policies to permit patients on hospice to apply for Choices for Care, a program that offers long-term care benefits for patients at home or in nursing facilities such as homemaker services, case management, respite care or home modifications.
- Requires statewide use of the Department of Health's DNR/COLST form; hospitals, nursing homes and residential care facilities may document DNR/COLST orders in facility-specific manner when the patient is in their care, but are required to use the state form when the patient leaves the facility.
- Requires a study on informed consent for DNE/COLST orders with a report back to the legislature by Dec. 1, 2011. The study will make recommendations about who can consent to a DNR/COLST order including family members or persons with known close relationships to the patient; how decisions are to be made based on substitute judgment or best interests of the patient; and how a hospital's internal ethics' protocols may be used to resolve disagreements about the appropriate person to provide consent.
- Inclusion of advance care planning, palliative care, pain management and hospice services in the definition of "Chronic care management" in the Blueprint for Health. Promoting pain and symptom management is also added to the Blueprint's definition of "Chronic Care."

Continuing Medical Education

The most controversial provision in early versions of H. 201 was a provision that mandated physicians to have completed "a minimum of four hours of continuing medical education in the field of palliative care, hospice, end-of-life care, and management of chronic pain." There was an exemption for physicians who did not "engage in direct patient care or provide patient consultations." VMS opposed this provision, and expressed concern that the mandated CME content was not appropriate for all physician specialties and it was not appropriate for the legislature to be determining the content of CME for physicians.

VMS thanks the many members who contacted their legislators during the debate on this issue. It was very important for them to hear from you about this and many legislators spoke to VMS staff about the contacts they had received. Representative George Till, M.D., worked closely with VMS on an amendment to this provision. Drs. Allan Ramsay and Robert Macauley testified on a broad range of issues related to palliative care, including CME. Two other VMS members, Drs. James Viapiano and Carlos Pino, with expertise in pain management also testified to the committee. In the end, the committee proposed an amendment to H. 201 that appropriately delegates responsibility for CME for physicians to the Vermont Board of Medical Practice (VBMP), the licensing board for physicians.

Physicians will be required to take a minimum of ten hours of CME every two years as a condition of license renewal. The VBMP will promulgate rules by August 2012 that establish criteria for CME for physicians. H. 201 includes only broad parameters that the CME should be designed to ensure that the licensee updates their knowledge and skills in his or her own specialty and also keeps abreast of advances in other fields for which patient referrals may be appropriate. In connection with the new CME requirement, the VBMP is also charged with determining how best to evaluate professional competence in recognizing need for timely consultations and referrals for hospice, palliative care and pain management.

Notice of the new CME requirement will be provided to physicians as part of their license renewal application form in the fall of 2012 and physicians the CME requirement will go into effect for licenses expiring after Aug. 31, 2014.

S. 15 - LICENSED MIDWIVES INSURANCE MANDATE AND MATERNAL MORTALITY REVIEW PANEL

S. 15, a bill mandating insurance coverage for services provided by licensed apprentice trained midwives achieved passage. VMS opposed the bill and was able to obtain a number of modifications to the bill in the House, with much work and input from Vermont obstetricians from throughout the state who: testified about the problems with the current regulatory system; suggested workable solutions; reviewed drafts of the bill; proposed amendments; and provided background, position statements and international studies to VMS staff. Drs. Peter Cherouny and Eleanor Capeless from the Maternal Fetal Medicine Department at FAHC worked with VMS throughout the process, testified, and recommended ways to improve the current system. Dr. Roger Young, director of General Obstetrics and Gynecology at the UVM College of Medicine and chair of the Vermont ACOG chapter came to Montpelier twice to testify on the maternal mortality panel and on S. 15. Kristin Werner, CNM and Jennie Lowell, M.D., also testified about the problems their practice experienced backing up licensed midwives. Many other obstetricians spent time on the phone with VMS staff helping it work on this issue.

Insurance Mandate – Network Contract

While the insurance mandate passed, the House version of the bill permitted insurance companies to require midwives to contract with insurers. Typical provisions in insurers' contracts with physicians include: a prohibition on balance billing; a requirement to have malpractice insurance (typically \$1 million/\$3 million); and requirements to conform to uniform HEDIS quality standards and price and quality transparency. VMS believed that it would be beneficial to consumers if there were similar requirements for midwives who are reimbursed by insurers.

Participation in Case Review for Transferred Cases

One significant change achieved by VMS advocacy is that the midwives' case review process for transferred case will include participation by physicians in cases where birth, mother or infant are transferred to hospital. In those transferred cases, a physician, CNM, NP or PA may express concerns confidentially as part of the midwives' peer review process and will be informed of the determination at the completion of the peer review process. If the determination is not satisfactory, the physician or other professional may file a complaint with OPR. This type of peer review is required for every transferred case.

Physicians Informed of Midwives Transport Plans

Midwives are required by law to have a written plan for consultation with physicians and for emergency transfer of women and infants to hospitals. S. 15 requires midwives to provide a copy of their transport plans to any hospital, physician or other health care professional identified in the plan.

Medical Records Information to Accompany Transfers

To address a concern that when pregnant women and infants who elect homebirth are transferred to the hospital, they often arrive without medical records documenting the care they have received from their licensed midwives, S. 15 requires the Office of Professional Regulation to work with midwives to develop a single uniform form that will include medical information needed by the facility or professional receiving the transferred patient. The midwives are currently working to design the form with the Northern New England Perinatal Quality Improvement Network (NNEPQUIN).

Statistical Data and Dept. of Health Report on Homebirth

S. 15 requires licensed midwives and certified nurse midwives to submit data about home births to the Midwives Alliance of North America (MANA). The Department of Health is required to access this database to obtain information relating to the care provided in Vermont by licensed midwives and certified nurse midwives. The commissioner will prepare a report for the legislature addressing the number of home births in Vermont, the number of hospital transports associated with the home births, the treatment of high-risk patients as well as the level of compliance of midwives with laws and rules governing their scope of practice. VMS would have preferred the data about homebirth now being collected by the Office of Professional Regulation to be stored and analyzed by a Vermont health care quality organization. VMS will work with the Department of Health as this provision is implemented.

New Vermont Maternal Mortality Review Panel

While maternal mortality has declined greatly in the last 50 years, recently national maternal mortality rates have begun to increase. Vermont still has a very low rate of maternal mortality – only one or two every 10 years. To ensure that the maternal mortality rate stays low in Vermont, Section 2 of S. 15 creates a confidential Maternal Mortality Review Panel in Vermont similar to the panels in other states, such as New Hampshire. The Department of Health will promulgate rules for the panel and is authorized to delegate the functions of collecting and analyzing data, convening meetings, and organizing the panel to the Northern New England Perinatal Quality Improvement Network (NNEPQUIN). Members of the panel will include obstetricians, a pediatrician, a CNM, a licensed midwife, an obstetric nurse, the medical examiner and the director of the division of maternal and child health in the Department of Health. The Commissioner of Health will submit an annual report to the legislature describing the reviews conducted by the panel, corrective action plans and recommendations for system changes.

H. 420 – OPR BILL – APRN COLLABORATION AGREEMENT

Between late February and early April, representatives of the Vermont Board of Medical Practice (VBMP) and the Vermont Board of Nursing (BoN), met in an attempt to reach a consensus that would address the VBMP's concerns with the BoN's proposal to remove the requirement for a collaborative agreement and permit advance practice registered nurses (APRNs) to become licensed to practice advanced nursing and medicine independently through amended rules, without a change to the enabling statute. Former Representative Stephen Maier facilitated the series of meetings that resulted in a compromise proposal that was presented to the legislature in late April as part of H. 420, the Professional Regulation Bill.

Many VMS members worked closely with staff to make this collaboration happen. Drs. David Coddaira, Howard Schapiro, David Little, Robert Pierattini, Peter Cherouny, Harvey Reich, and Robert Tortolani took the time to meet with legislators or advise VMS staff. VMS President Dr. Paula Duncan met several times with the Dean and leadership and the UVM College of Nursing, who were spearheading the effort to remove the collaborative agreement, and spoke with the Director of the Board of Nursing to get a better understanding of the current regulatory system for APRNs with respect to practice guidelines and quality assurance.

The compromise reached by BoN and VBMP and incorporated in H. 420 addressed a number of issues.

Transition to Practice

H. 420 created a transition to practice period by requiring a formal collaboration agreement for new grads and for APRNs changing specialty or role for example a nurse practitioner changing to a certified nurse midwife. The collaboration agreement can be with a physician (MD or DO) or with an APRN who has at least four years of experience practicing as an APRN. APRNs who are newly graduated are required to have a two-year and 2,400 hour period of collaboration, while APRNs who change roles or population focus are required to have 12 months and 1,600 hours of collaboration. Solo practice is not permitted during the collaborative practice period.

Practice Guidelines

APRNs are required to have individual practice guidelines and to submit the guidelines to the board of nursing for review and approval when they begin practice, renew their license, and change their practice site, clinical role, population focus or specialty. H. 420 also specifies licensure requirements addressing clinical experience, coursework and national certification.

Unprofessional Conduct Standards

The standards for unprofessional conduct for APRNs are upgraded to parallel unprofessional conduct provisions in effect for physicians that address issues that would not be a concern for RNs such as patient abandonment, safe prescribing practices in the internet age and prescribing controlled substances for self or family.

Regulation

VMS had expressed concern about the capacity of a board comprised of a majority of RNs to regulate APRNs, who are essentially practicing medicine. To address this concern H. 420 doubled the number of APRNs on the Board of Nursing from one to two. The bill also formalized the requirement that the Board of Nursing have an APRN Advisory Subcommittee that include a public member and a physician appointed by the VBMP who will serve as a liaison between the two boards, the VBMP and the BoN. Establishing this advisory subcommittee in statute will make it easier for the members of the public and stakeholders to offer input to its deliberations.

VMS has historically supported the requirement for a collaborative agreement with a physician; however, VMS deferred to the decisions reached by the VBMP through the collaborative process with the BoN. VMS is grateful to the members of the boards of nursing and medicine who were willing to engage in that process, and to former representative Steven Maier who facilitated the process. VMS also believes that it would have been extremely difficult to retain the requirement for a collaborative agreement in view of a report issued recently by the Institute of Medicine.



The Vermont Medical Society is the leading voice of physicians in the state and is dedicated to advancing the practice of medicine by advocating on behalf of Vermont's doctors and the patients and communities they care for.

H. 369 – VBMP UPDATED LICENSING LAWS NEW PRACTICE REQUIREMENT

The Department of Health and the Vermont Board of Medical Practice (VBMP) worked this year to introduce a bill that included the first update to the licensing laws for all professionals licensed by the VBMP since the board was transferred to the Department of Health in 2002. VMS worked with the VBMP on the bill and advocated for the bill throughout the legislative process. The bill includes a modern definition of the “practice of medicine” based on a definition developed by the national Federation of State Medical Boards and clarifies the confidentiality of disciplinary matters, and the powers and duties of the board to investigate illegal practice of medicine. It also updates the list of unprofessional conduct provisions to include inappropriate forms of electronic prescribing, disruptive behavior, sexual misconduct that exploits the physician-patient relationship, and prescribing controlled substances for self or family.

Notably, the bill requires the Board to adopt a maintenance-of-licensure rule that will address the requirements for license renewal including the ten hours of CME included in H. 201. Additionally, the bill establishes a practice requirement for the first time. In that regard, the board is required to establish criteria by rule for updating knowledge and skills that will apply to any licensee licensed by VBMP (physician, podiatrist, physician assistant, anesthesiologist assistant or radiologist assistant) who had not practiced for the past three years.

Physician Assistant Updates

The law for physician assistants also was updated to authorize licensing for physicians assistants instead of certification. Currently physician assistants are certified, not licensed. The certification is tied to employment, and if the physician assistant is between jobs, his or her certification lapses. In addition, currently many physician assistants are required to have multiple certifications under the current law; for example if a physician assistant works in the emergency department in two different hospitals, he or she would need two certificates, one for each employer or practice site. Under H. 369 the physician assistant would only need one license, but could only work if he or she was employed by a supervising physician, and would be required to have delegation agreement specifying the physician assistant’s scope of practice with each supervising physician. Medical care must be delegated to the physician assistant by the supervising physician and performed with the supervision of a supervising physician.

The delegation agreement is a detailed description of the duties and scope of practice for the physician assistant that are delegated by a supervising physician and agreed to by the physician and the physician assistant. The bill also clarifies the supervision and scope of practice requirements for the team made up of a supervising physician and a physician assistant. Constant presence of a supervising physician is not required as long as the supervising physician and physician assistant are, or easily can be, in contact with each other via telecommunication.

Other provisions in the physician assistant laws such as the unprofessional conduct standards were updated to be consistent with the standards for physicians and other professionals licensed by VBMP. These provisions were also updated for anesthesiologist assistants, radiologist assistants and podiatrists, with the most notable provision for all professions being the inclusion of the practice requirement that will apply if the professional has not practiced the profession for a period of three years.

S. 96 - ALLOWS FOR PREAUTHORIZATION OF TREATMENT FOR INJURED WORKERS

S.96, an act relating to the state’s worker’s compensation system, provides new rights for physicians to request preauthorization of treatment from insurance carriers. The provision will allow for greater notice that a worker’s compensation carrier will cover the cost of treating an injured worker.

Under the bill, within 14 days of receiving a request for preauthorization for a proposed medical treatment, a workers’ compensation insurer must either: authorize the treatment; deny the treatment; or, order an independent medical examination. If the carrier orders an examination, the insurer shall either authorize or deny the treatment and notify the injured worker of the decision within 45 days of a request for preauthorization.

If the insurer denies the preauthorization of the treatment, the Commissioner of Labor may still issue an order authorizing the treatment if the commissioner finds that the evidence shows that the treatment is reasonable, necessary and related to the work injury.

The bill also includes a section relating to medical records. Under the provision, health care providers examining an injured worker must provide relevant medical records and reports upon receiving a written medical release authorization from the injured worker on a form approved by the department of labor. Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

VERMONT TAKES STEP

(cont'd from pg. 1) **Vermont Health Benefit Exchange**

The bill establishes the Vermont Health Benefit Exchange as a division of Department of Vermont Health Access (DHVA). Beginning on Jan. 1, 2014, the exchange will provide qualified health benefit plans to eligible individuals and small businesses. The commissioner of DHVA is required to make a reasonable effort to maintain contracts with at least two health insurers to provide qualified health benefit plans, in addition to the multi-state plans required by the ACA.

Federal premium credits and cost-sharing subsidies will be available to individuals who enroll in health benefit exchange plans – provided that their income is generally above 133 percent (\$29,861 annually for a family of four) and no more than 400 percent (\$89,808 annually for a family of four) of the Federal Poverty Level (FPL). Dr. Hsiao’s report estimates that under the ACA \$240 million in new federal funds will flow into the exchange in the form of premium subsidies for individuals in 2015 and \$420 million in new federal funds in 2019. It is also anticipated that the individuals currently covered under VHAP would receive their insurance through the exchange beginning Jan. 1, 2014.

The duties and responsibilities of the exchange are drafted to comply with the ACA and these include: offering coverage for health services through qualified health benefit plans; enrolling individuals in a qualified health benefit plan; collecting premium payments made for qualified health benefit plans from employers and individuals on a pretax basis, and, informing enrollees of their eligibility for premiums and subsidies. The section also establishes broad “quality and wellness” standards for qualified plans that include participation in the Blueprint for Health.

Green Mountain Care

The purpose of Green Mountain Care – the bill’s conditional universal publicly-financed health care system – is to provide, as a public good, comprehensive, affordable, high-quality health care coverage for all Vermont residents. The bill authorizes the Agency of Human Services to solicit bids from private insurers for the administration of Green Mountain Care with preference being given to Vermont-based businesses. Individuals would be allowed to maintain coverage they may have other than Green Mountain Care or elect supplemental coverage. The Agency of Human Services is directed to seek permission from CMS to administer the Medicare program in Vermont and to include Medicaid and SCHIP in Green Mountain Care.

The implementation date of Green Mountain Care would be 90 days following the last to occur of the following conditions:

- Enactment of a law by the General Assembly establishing the public financing for Green Mountain Care;
- The Green Mountain Care Board’s approval of an initial benefit package;
- Enactment of an appropriation by the General Assembly for the benefit package; and,
- Receipt of a waiver to allow Green Mountain Care to receive federal individual premium subsidies and small business tax credits provided through the health benefit exchange by the ACA (under current law, the state cannot apply for these waivers until 2017).

Studies

Reforms to the Medical Malpractice System

On Jan. 15, 2012, the Secretary of Administration is required to submit reforms to the medical malpractice system for Vermont. The proposal shall be

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S. 90 – LYME DISEASE

S. 90 was introduced for the purpose of authorizing physicians by law to prescribe, administer or dispense long-term antibiotic therapy after making a diagnosis that a patient has Lyme disease or displays symptoms consistent with a clinical diagnosis of Lyme disease and by documenting the diagnosis and treatment in the patient’s medical records. VMS expressed concern about the legislature legislating clinical practice and the Department of Health expressed concern about overuse of antibiotics from a public health perspective. VMS participated in a meeting with the Commissioner of Health, representatives of the Vermont Lyme Network and legislators to discuss designing an initiative to educate physicians and other health care professionals about Lyme disease. It is likely that the Department of Health will work with the Vermont Medical Society and the UVM College of Medicine to schedule a conference on Lyme Disease.

S. 30 – PENALTIES FOR ASSAULT ON A HEALTH CARE PROVIDER

S. 30 makes the criminal penalties for assaulting a health care worker comparable to the penalties for assaulting a law enforcement officer – imprisonment for not more than one year for the first offense and imprisonment for not more than 10 years for the second and subsequent offenses. Health care workers are defined as employees of a health care facility or a licensed physician who is on the medical staff of a health care facility who is providing direct care to patients or who is part of a team-response to a patient or visitor incident involving real or potential violence. The penalties apply when health care workers are engaged in their official duties of providing patient care.

VERMONT TAKES STEP

(Cont'd from pg. 7) designed to address any findings of defensive medicine and shall include the consideration of a no-fault system and confidential pre-suit mediation.

Integration Plan

The Secretary of Administration is required to make recommendations by Jan. 15, 2012, on how to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees with the Vermont health benefit exchange and Green Mountain Care and whether it is advisable to establish a basic health program for individuals above 133 percent of the federal poverty level (FPL) and at or below 200 percent of FPL, as provided under the ACA.

Aligning the Workers' Compensation System

No later than Jan. 15, 2012, the Commissioner of Labor is required to evaluate the feasibility of integrating or aligning Vermont's workers' compensation system with Green Mountain Care.

Universal Coverage

By Jan. 15, 2012, the Commissioner of DHVA is required to review the requirements for maintaining minimum essential coverage under the ACA and recommend any additional mechanisms to ensure that all Vermonters will obtain health insurance coverage.

Financing Plans

By Jan. 15, 2013, the Secretary of Administration is required to recommend two plans for sustainable financing. One plan will recommend financing for the Vermont health benefit exchange which must be implemented by Jan. 1, 2014, in order to provide coverage to all Vermonters in the absence of a waiver under the ACA. The second plan shall recommend mechanisms to finance Green Mountain Care to achieve a public-private universal health care system.

Health System Planning, Regulation, and Public Health

The Secretary of Administration is required to report by Jan. 15, 2012, on how to unify Vermont's current efforts around health system planning, regulation and public health.

Payment Reform and Regulatory Processes

The Green Mountain Care Board is required to recommend by March 15, 2012, any necessary changes to regulatory processes to align them with the payment reform strategic plan. By Jan. 15, 2012, the commissioner of BISHCA shall review the hospital budget review process and the certificate of need process and recommend modifications needed to enable the participation of the Green Mountain Care board

Health Care Workforce Strategic Plan

The Director of Health Care Reform is required to oversee the development of a health care workforce development

strategic plan to ensure that Vermont has necessary health care workforce to provide care to all Vermonters and provide the plan by Jan. 15, 2013.

Workforce Issues

The Board of Nursing, Board of Medical Practice, and Office of Professional Regulation are required to review licensure issues and make joint recommendations by Jan. 15, 2012, on ways to improve the primary care workforce.

Prior Authorizations

The Green Mountain Care Board is required to consider paying health care providers for completing requests for prior authorization and exempting health care professionals from prior authorization requirements for specific services in Green Mountain Care.

Single Formulary Recommendations

The Commissioner of DVHA is required to report by Jan. 15, 2012, on the feasibility of using a single prescription drug formulary.

**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.