

# THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

2014 Legislative Wrap-Up

## Contact Us

P.O. Box 1457  
Montpelier, Vermont 05601

Toll-Free: 800-640-8767  
Fax: 802-223-1201

Online at: [www.vtmd.org](http://www.vtmd.org)

## Working for Vermont Physicians at the State House

**Paul Harrington**  
Executive Vice President  
[pharrington@vtmd.org](mailto:pharrington@vtmd.org)

**Madelaine Mongan**  
Deputy Exec. Vice Pres.  
[mmongan@vtmd.org](mailto:mmongan@vtmd.org)

**Stephanie Winters**  
Operations Director  
[swinters@vtmd.org](mailto:swinters@vtmd.org)

The 2014 legislative session was perhaps more notable for health care reform legislation that wasn't addressed by the General Assembly, than what actually was.

Two issues served as the major health care themes during the session: oversight of the Vermont Health Connect online insurance marketplace, and anticipation of Governor Peter Shumlin's health care financing details.

However, the General Assembly did pass a number of health care-related bills, including:

- A 1.6 percent increase in the Medicaid reimbursement rate (pg 1);
- Revisions to Vermont Board of Medical Practice investigative procedures (pg 2);
- Amendments to the gifts ban (pg 9);
- Improvements to timeliness of treatment for acutely ill psychiatric patients (pg 3); and,
- Prohibiting the use of handheld portable devices while driving and smoking in vehicles while minors are present (page 4).

For more information on these and other public policies, please consult the following pages in this issue of the VMS Legislative Bulletin.

To read the full text of the various bills, please go to: [leg.state.vt.us/database/status/status.cfm](http://leg.state.vt.us/database/status/status.cfm).

## H. 885 / SFY 2015 BUDGET

### Conference committee lands on 1.6 percent Medicaid reimbursement increase

The conference committee agreed on a 1.6 percent Medicaid reimbursement increase that will be funded in part by an assessment on employers whose employees receive Medicaid benefits. The 1.6 percent reimbursement increase will cost about \$2 million and will begin on Jan. 1, 2015. In its budget proposal, the Shumlin Administration included a 2 percent Medicaid cost of living increase for physicians and other health care professionals. The House-passed budget included a 3/4 percent increase, while the Senate-passed version included the full 2 percent. VMS has advocated for annual inclusion of a cost of living increase for physicians for many years and strongly supported including the 2-percent increase in the FY 2015 budget.

The Medicaid reimbursement rate is particularly important for VMS since the Affordable Care Act (ACA) increased income eligibility for Medicaid to 133 percent of the federal poverty level. This has resulted in approximately 67,000 additional Vermonters becoming eligible for Medicaid. While many of these new Medicaid beneficiaries were formerly covered by VHAP, which reimburses at the same rates as Medicaid, some were covered by Catamount which reimbursed at approximately 10 percent more than Medicare, and still others were covered by employer sponsored insurance or were uninsured. As of the end of May, about 27,000 Vermonters were covered in the individual insurance market by Vermont Health Connect (VHC), the health care exchange. The VHC exchange plans operated by BCBSVT and MVP reimburse physicians at commercial insurance rates.

VMS continues to be concerned about whether health care reform will be adequately financed at a level sufficient to recruit and retain a high quality health care workforce. The budget also included language that acknowledges the importance of increasing the Medicaid rates for primary care to the Medicare level. The current enhanced payments to primary care authorized by the Affordable Care Act (ACA) will expire on Dec. 31, 2014, unless Congress takes action to extend the payments.

Link to VMS resolution: <http://www.vtmd.org/sites/all/themes/vms/documents/policies/2009/2009%20Preserving%20Patient%20Access.pdf>.

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## LEGISLATURE PASSES 2014 SESSION'S HEALTH CARE REFORM BILL

The General Assembly passed H.596 – this year's health care reform bill – and sent it to Governor Shumlin for his signature. The bill seeks to update the Act 48-related assumptions that will form the basis for the General Assembly's efforts to enact Green Mountain Care (GMC) - a publicly financed health care system - during the 2015-2016 legislative session.

While the bill mainly focuses on a number of health care reform-related studies, it codifies current state policy and allows small employers to purchase their health insurance plans directly from health insurance companies instead of having to pay their premiums to the problem-plagued health benefit exchange. H.596 requires the Agency of Human Services to identify by Jan. 15, 2015, the elements of GMC, such as claims administration and provider relations, for which it plans to solicit bids for an outside administrator for GMC. The bill also defines non-emergency walk-in clinics and requires them to accept patients of all ages for diagnosis and treatment of illness during all hours that the center is open to see patients. It also mandates that centers not discriminate against any patient on the basis of insurance coverage.

H.596 mandates a number of studies, including:

- On Jan. 15, 2015, the Director of the Blueprint for Health shall review evidence-based materials on the relationship between adverse childhood experiences (ACEs) and population health and recommend to the General Assembly whether ACE-informed medical practice should be integrated into Blueprint practices and community health teams;
- On Oct. 1, 2014, the Secretary of Administration shall recommend to what extent to increase payments to health care providers and community health teams for their participation in the Blueprint for Health;
- On Dec. 1, 2014, the Secretary of Administration shall recommend whether the State should prohibit health insurers from reimbursing physicians in independent practices at lower rates than those at which they reimburse physicians in hospital-owned practices for providing the same services;
- On Jan. 15, 2015, the Secretary of Administration shall report on the financial impact of increasing Medicaid reimbursement rates to providers to match Medicare rates; and,
- Before Jan. 15, 2015, the Secretary of Administration in collaboration with VMS and VAHHS shall conduct a symposium to address the impacts of moving toward universal health care coverage on Vermont's health care workforce.

## H. 350

### Revisions to Vermont Board of Medical Practice procedures

Legislation that addresses the Vermont Board of Medical Practice's investigative procedures has passed. The bill, H. 350, introduced by Reps. Kate Webb and George Till, MD., clarifies what information about disciplinary actions taken against licensees is posted on the "Board Actions" website and the Department of Health's physician profiles site. The bill requires the Board and the Department to remove information from the public websites when a charge filed against a licensee is dismissed by the Board or the court, or when a licensee is found to be not guilty of unprofessional conduct.

Information about disciplinary charges dismissed by other states is also required to be removed on request of a licensee, and the Board will post a summary of the final disposition of cases indicating any charges that were dismissed and any charges resulting in a finding of unprofessional conduct. Currently when a charge is dismissed, the information about the entire history of the case is retained on the "Board Actions" site and on the physician profiles site, which can be picked up by search engines.

H. 350 also sets educational standards for Board investigators. Investigators who are not currently certified as law enforcement officers must take 25 hours of relevant continuing education every year, which is comparable to the 25 hours required to maintain law enforcement certification. In addition, investigators will be required by the bill to "obtain and maintain certification from a national or regionally recognized entity regarding investigation of licensing cases as approved by the Board." VMS supports this requirement for professional training in investigating licensing cases since the investigation of medical professional licensing and discipline cases differs from the investigation of criminal cases.

Finally, the bill requires the Board to review, and revise as appropriate, its policies and procedures for conducting unprofessional conduct investigations. As part of this review, the Board is required to accept suggestions from interested stakeholders, such as VMS. The bill also requires the Board to report to the legislature next year on the outcome of the review and any resulting changes the Board has made to its investigation policies and procedures. VMS supported H. 350 throughout the legislative process and looks forward to working with the VBMP to review and revise its investigation procedures. *Continued on page 9*

## S. 287 – MENTAL HEALTH / INVOLUNTARY MEDICATION

Consistent with the VMS Policy on Acute Inpatient Mental Health Care adopted at the February 2014 VMS Council meeting (*link below*), VMS worked in partnership with the Vermont Association of Hospitals and Health Systems (VAHHS), the Department of Mental Health, and Fletcher Allen Health Care (FAHC) to pass S. 287, a bill that improves timeliness of treatment for acutely ill psychiatric patients.

Delayed treatment for acutely ill psychiatric patients has been a serious problem in Vermont. Data from the Vermont Department of Mental Health found that in Vermont the average time from a patient's admission to a level 1 acute care hospital to a medication court order that permits the administration of involuntary medication was 72 days. This time period did not include the time spent waiting in emergency departments for a bed in a level 1 acute care hospital. A national comparison done by the Treatment Advocacy Center found that Vermont was one of only five states with significant delays in delivering medication over patients' objections. The study found that in Vermont the typical delay in providing medication to patients in psychiatric crisis who were unable to recognize their need for treatment was more than two months.

### Commitment process will begin in the emergency department

Acknowledging the reality of the decentralized mental health acute care system in Vermont, S. 287 requires the legal commitment process to start when a patient is held in an emergency department prior to admission to a level 1 acute care psychiatric bed.

As of Nov. 1, 2014, an emergency examination (EE) by a psychiatrist will be required within 24 hours after the patient arrives in the emergency department or hospital, and an application for involuntary commitment must be filed within 72 hours after the emergency examination, even if the patient is still in the emergency department.

Patients are deemed to be in the temporary custody of the Commissioner of Mental Health when they are held involuntarily in a hospital or emergency department prior to commitment. The Commissioner must ensure that patients in temporary custody are receiving temporary care and treatment as needed to protect the safety of the patient and others, respect the privacy of the patient and other patients, and prevent physical and psychological trauma. Under current law a patient is not placed in the custody of the Commissioner until a court orders involuntary commitment, which can take many weeks.

### Expedited review of commitment cases

H. 287 expressly permits the court to authorize an expedited review in certain types of cases. Expedited review is permitted for patients who, even when hospitalized, demonstrate a risk of causing "serious bodily injury" to self or others. The term "serious bodily injury" is narrowly defined as injury that creates a substantial risk of death, impairment of function, impairment of health, or disfigurement. Expedited reviews are also available for patients who have received involuntary medication in the past two years and it is unlikely that additional time will lead to a

therapeutic relationship or the patient's regaining competence. If the court grants an expedited review, the commitment hearing must be held within 10 days after the expedited hearing is ordered. Commitment cases that are not expedited can take up to 20 days or longer if continuances are granted and the bill authorizes the court to grant each party a onetime continuance of seven days and authorizes the court to grant one or more additional seven-day continuances if the court finds that the parties would be prejudiced or if the parties stipulate to the continuance.

When commitment cases are not heard in 60 days, the Commissioner of Mental Health is required to ask the attorneys and the court to provide the reasons for the delay and the Commissioner is required to submit a report to the Court and the Secretary of Human Services explaining why the delay was warranted or making recommendations about how delays of this type can be avoided in the future.

### Time for filing involuntary medication applications and consolidation of medication and commitment cases

In cases involving a risk of serious bodily injury that the court has expedited, an application for involuntary medication may be filed prior to the commitment order. In these cases, the court is required to consolidate the medication hearing and the commitment hearing.

An application for involuntary medication may also be filed prior to commitment in cases where the case has been pending without a hearing for more than 26 days and the treating psychiatrist certifies that additional time will not lead to a therapeutic relationship or regained competence and serious deterioration of the patient's mental condition is occurring. In these cases, after a review of the psychiatrist's certification, the court must consolidate the medication and commitment hearings and hold a hearing within ten days.

The bill removes the automatic 30-day stay for involuntary medication orders, allowing medication orders to be enforced immediately, while retaining the patient's ability to apply for a stay when they plan to appeal the order.

VMS thanks Jill Olson of VAHHS for her outstanding leadership on this bill and also thanks the Vermont Hospital and Community Psychiatrists and the Vermont Psychiatric Association for their support on this complex issue.

Link to VMS resolution: [http://www.vtmd.org/sites/default/files/files/VMS\\_Council\\_Policy\\_Inpatient\\_Mental\\_Health\\_Services\\_adopted\\_02-8-14.pdf](http://www.vtmd.org/sites/default/files/files/VMS_Council_Policy_Inpatient_Mental_Health_Services_adopted_02-8-14.pdf)

Link to Treatment Advocacy Center Survey of State Mental Health Commitment Laws: <http://tacreports.org/state-survey>

Link to Department of Mental Health data on treatment delays: <http://www2.leg.state.vt.us/CommitteeDocs/Senate%20Health%20and%20Welfare/Bills/S.287/Witness%20Testimony/1-15-2014~Emma%20Harrigan~S.287~Court%20Ordered%20Involuntary%20Medication-%20Time%20Between%20Significant%20Events-%20January%202012%20-%20November%202013.pdf>

### H.123 LYME DISEASE

For the past six years VMS and the Department of Health have opposed bills that would create disciplinary immunity for physicians and others who prescribe long-term antibiotics to treat “chronic Lyme disease.”

This year a bill was enacted that will require licensing boards to issue policy statements communicating to licensees that the boards will not take disciplinary action against a physician, solely for the use of medical care recognized by the guidelines of the Centers for Disease Control (CDC), the Infectious Diseases Society of America (IDSA) or the International Lyme and Associated Disease Society (ILADS) for treatment of patients who are clinically diagnosed with Lyme disease or other tick-borne illness (ILADS guidelines support treatment of Lyme with long term antibiotics). The policy will not preclude board discipline for other unprofessional conduct that occurs when a practitioner follows the guidelines. While VMS opposes the bill, it believes that version of the bill that passed is much better than the bill that was introduced.

As introduced, H.123 included a number of provisions that were of great concern to VMS. The bill as introduced expressly permitted a physician to prescribe long-term antibiotics for Lyme disease, created licensing board immunity for treating chronic Lyme disease with long-term antibiotics, and mandated that insurers cover long-term antibiotic therapy for Lyme disease. These provisions were removed in the legislative process and did not pass.

VMS strongly opposes legislating the standard of medical practice, which must change as science and evidence change. The legislature does not have the expertise or the flexibility to set the standard of care for medical practice, or the ability to make modifications in a timely manner.

### VMS FOUNDATION AWARDED \$549,000 GRANT FOR CHOOSING WISELY PROJECT

The Vermont Medical Society Education and Research Foundation has been awarded a \$548,829 grant to develop a statewide program that reduces unnecessary and potentially harmful medical testing. The grant, awarded by the Vermont Health Care Innovation Project (VHCIP) Grant Program, will be used to launch the Vermont Hospital Medicine Choosing Wisely® Project, a 26-month effort focused on decreasing waste and potential harm in the hospital setting. The principal activity will be two IHI Breakthrough Learning Collaboratives, which most hospitals in Vermont and Dartmouth-Hitchcock Medical Center have either already committed to attending or have expressed interest in doing so.

### H.217 - SMOKE FREE WORKPLACES AND PROHIBITING SMOKING IN VEHICLES WITH MINORS

H.217 takes significant steps to protect children and adults in Vermont from secondhand smoke exposure by addressing smoking in several venues:

- Hotels – expands current law to prohibit smoking in guest rooms, making all Vermont hotels 100% smoke free;
- State owned property – creates a 25-foot smoke free zone around all state owned buildings and prohibits smoking on the grounds of any state owned hospital or residential recovery facility;
- Public schools – expands current tobacco prohibition to include electronic cigarettes on public school grounds and at public school-sponsored events;
- Child care facilities – expands current tobacco prohibition to include electronic cigarettes on the premises of any licensed child care facility or after school program;
- State parks and forests – prohibits smoking in designated smoke free properties or grounds owned or leased by the state; and
- Prohibiting smoking in motor vehicles when children under the age of eight are present. This is the section of the bill that the VMS most strongly advocated for.

### H.314 - USE OF HANDHELD PORTABLE DEVICES WHILE DRIVING

The ban on portable handheld devices while driving passed both the House and Senate after being stalled in the Senate. The bill was tacked on to a miscellaneous motor vehicles bill (H.314) in the last week of the session. The new compromise plan will make it illegal to talk on a phone or use other electronic devices while operating a motor vehicle beginning Oct. 1, 2014, and also directs the state to launch educational public service announcements by Aug. 1, 2014.

The bill will carry a fine of at least \$100 for a first offense, followed by fines up to \$500 for subsequent offense. The violation will not carry points against a driver’s license, however.

The Governor has not been supportive of this legislation, but with the bill on the fast-track to his desk, Shumlin’s office indicated Wednesday he will sign it.

The VMS advocated in strong support of this legislation as a result of our 2011 resolution on distracted driving:  
<http://vtmd.org/sites/default/files/files/2011%20Distracted%20Driving.pdf>.

### **S. 295 - PRETRIAL SERVICES, RISK ASSESSMENTS, MEDICATION ASSISTED TREATMENT**

S. 295 establishes a process for risk assessments, needs screenings and referrals for substance abuse treatment to be conducted at all stages of the criminal justice system.

The screenings and referrals are designed to identify and divert individuals from the traditional criminal justice response and serve them through programs such as recovery support, restorative justice programs, community-based treatment, rehabilitative services, case management, drug treatment, and offender reentry programs. The bill also requires the Department of Corrections to establish a pilot project that would allow detainees and sentenced inmates in Department of Corrections facilities to continue to receive medication-assisted treatment.

#### **Rules for Buprenorphine Prescribers**

Because of concerns raised about the diversion of buprenorphine, the bill requires the Secretary of Human Services to adopt rules requiring physicians who prescribe buprenorphine to query the Vermont Prescription Monitoring System (VPMS) the first time they prescribe buprenorphine and at regular intervals thereafter. The Commissioner of Health is also directed to promulgate rules that include requirements that physicians treating fewer than 30 patients with buprenorphine ensure that their patients are screened to determine their need for counseling and that patients who are determined to need counseling or other support services are referred as needed.

VMS will work with the Agency of Human Services and the Department of Health as the rules are promulgated. Earlier versions of the bill had required the rules to mandate that physicians to check the VPMS each time they prescribed buprenorphine and to ensure that their patients received counseling. While the final version of the bill was an improvement, VMS remains concerned that imposing administrative burdens on physicians who prescribe buprenorphine may create a disincentive for physicians in smaller practices to prescribe buprenorphine. If physicians refer their patients to one of the seven medication-assisted treatment hubs in Vermont, it could result in longer waiting lists at the hubs. Currently the state's hub and spoke program is unable to support the smaller practices that prescribe buprenorphine to fewer than five patients.

### **H. 874 - FAMILY CONSENT TO HOSPICE ADMISSION; RULES FOR CONSENT TO DO NOT RESUSCITATE (DNR) AND CLINICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (COLST)**

H. 874 allows a family member or person with a known close relationship to a patient to consent to admit the patient to hospice care if the person does not have an agent or guardian, or if the agent or guardian is unavailable. The bill also specifies that decisions made by the family member or person with a known close relationship must protect the patient's own wishes in the same manner as an agent is required to make decisions under the advance directive statutes. Whenever possible the person providing consent must base the hospice admission decision on the patient's wishes or substituted judgment. When the patient's wishes about hospice care are unknown, the person providing consent must base the decision on the patient's best interests.

The bill also delayed until July 1, 2016, a requirement that the Department of Health promulgate rules adopting criteria for surrogate consent to DNR or COLST orders when patients do not have agents or guardians and deleted a requirement that the rules address access to a hospital's "internal ethics protocols" in the event of disagreement about who should give informed consent to DNR/COLST for a patient. Hospitals testified that they do not have "internal ethics protocols."

#### **PRIOR AUTHORIZATION PILOT PROJECT**

A pilot project workgroup led by Allan Ramsay, MD, of the Green Mountain Care Board, is in the process of designing a prior authorization pilot for primary care physicians. The group has recommended three-year authorizations for chronic medications and payers and is discussing whether to implement a common three-year prior authorization process across insurers for these medications.

The Board has also recommended eliminating prior authorization for two therapeutic drug classes such as proton pump inhibitors and statins. All payers would eliminate prior authorization for the two selected classes for primary care physicians participating in the pilot. Drug spending for physicians in the pilot would be compared to spending for other physicians who remain subject to prior authorization requirements. Because these classes of drug are not prescribed for children, elimination of prior authorization for Insulins, asthma drugs or ADHD drugs is also being considered for pediatricians and family physicians.

Other issues being considered by the prior authorization pilot group include transportability of prior authorizations among insurers in Vermont and establishing a pilot for imaging.

## GREEN MOUNTAIN CARE BOARD APPROVES SIMPLIFIED PATIENT CONSENT POLICY

On March 13, the Green Mountain Care Board (GMCB) voted unanimously to significantly simplify the state's policy for obtaining patient consent in order for physicians to access protected health information (PHI) from other providers on the Vermont Information Technology Leaders' (VITL) health information exchange. This step should help promote greater use of the Vermont Health Information Exchange (VHIE) provider portal when it goes live this May and help improve patient care and reduce duplicative diagnostic testing. The Board action will also make the consent process less burdensome and confusing for patients.

The action was initiated by an October 2013 request to GMCB made by VMS, Fetcher Allen Health Care and the Vermont Assembly of Home Health and Hospice Agencies. The three organizations asked the Board to revise the existing multiple consent policy and instead allow for a onetime global patient consent for provider access to information on the VHIE. The former consent policy

required a separate patient consent for each participating health care provider caring for the patient. Participating health care provider was defined as a health care provider or a physician practice in any health care organization. Therefore, under the former consent policy, a patient would potentially be required to provide separate written consent to both multiple individual physicians and to different health care organizations during the course of their treatment.

Throughout the deliberations on the development of the former consent policy, concerns were raised by VMS and FAHC that the proposed policy would create significant administrative burdens for Vermont providers and their staff and it would also create significant confusion for their patients who would be faced with multiple and similar forms to sign. And as a consequence, the consent policy could result in a high degree of reluctance for health care providers to participate in the VHIE due to the lack of certainty regarding the consent status.

## H. 645 – WORKERS COMPENSATION / OPIOID USAGE

This year the legislature added a provision requiring the Commissioner of Labor to promulgate rules about opioid prescribing to a bill that made various changes to the workers' compensation laws. When this provision was proposed VMS expressed concern about different state agencies adopting rules that potentially could have required physicians to apply different rules to treating patients with the same condition. The bill was amended to require the Commissioner of Labor to consult with the Department of Health and VMS about promulgating the rules. The rules will address "prescription of opioids, including patient screening, drug screening, and claim adjudication for patients prescribed opioids for chronic pain." Requirements that the rules address appropriate diagnoses for opioid treatment and opioid dosage amounts were removed in the final version, based on VMS' concerns.

To address VMS' concerns about different state agencies creating multiple standards for patients with chronic pain, physicians specializing in occupational medicine and rehabilitation medicine were added to the Department of Health's Uniform Pain Management System Advisory Council (UPMSAC), a large group of clinicians, licensing board representatives, and consumer groups. The purpose of the UPMSAC is to advise the Commissioner of Health on rules, standards and guidelines for treating chronic pain. Adding the Commissioner of Labor and physicians who specialize in occupational and rehabilitation medicine to this group will ensure that the standards created by the Department of Labor are consistent with the standards endorsed by the Department of Health.

## COMMISSIONER OF HEALTH ISSUES EMERGENCY RULE THAT REGULATES THE PRESCRIPTION OF ZOHYDRO

The Commissioner of Health issued an emergency rule that regulates the prescription of Zohydro in order to address potential drug overdose, abuse and diversion. Zohydro is a controversial extended release hydrocodone that is manufactured without abuse deterrent formulations (ADF). The emergency rule became effective, on April 4, 2014 and requires prescribers, prior to prescribing an extended release hydrocodone without ADF, such as Zohydro, to take the following steps:

1. Conduct a thorough medical evaluation and physical examination;

2. Perform a risk assessment such as SOAPP (Screener and Opioid Assessment for Patients with Pain) and evaluate and document risks and benefits of using the drug;
3. Document that a hydrocodone without an ADF is needed to manage severe pain that requires daily, around-the-clock long-term opioid treatment, and that alternative treatment options are ineffective, not tolerated or would be inadequate to provide sufficient management of pain;
4. Obtain a signed Informed Consent from the patient or the patient's legal representative that addresses the drug's

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## NEW POLICY ON THE USE OF OPIOID ANALGESICS FOR THE TREATMENT OF CHRONIC PAIN ADOPTED BY VERMONT BOARD OF MEDICAL PRACTICE

At its April meeting, the Board adopted a Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain. While the policy serves as a guideline, not a hard and fast rule, it will be used by the Board when they review medical care in investigations, and physicians who do not follow the policy should document their rationale. In its introduction to the policy, the Board included the following statement about how it will apply the policy in determining whether a licensee has followed the standard of care:

This is a policy that provides guidelines. On its own, the policy will not be the basis for an allegation of unprofessional conduct. It is offered to assist providers. However, parts of the policy reflect Vermont and federal laws and regulations that must be followed.

In addition, the policy reflects the Board's understanding of the standard of care at the time the policy is adopted. Thus, failure to follow the guidance may put a provider at risk of failing to meet the standard of care, which could lead to an allegation of unprofessional conduct.

The VMS Council and primary care physicians and physicians with expertise in pain management and addiction treatment reviewed the draft policy prior to its adoption and based on the review, VMS submitted comments. The Board considered the VMS comments at their March meeting and accepted some of them.

The Board Policy updates the VBMP's prior (2006) policy on Use of Controlled Substances for the Treatment of Pain and, like the current policy, includes specific and detailed guidelines. The guidelines in the new 2014 VBMP policy include detailed provisions addressing:

1. Patient Evaluation and Risk Stratification,
2. Development of a Treatment Plan and Goals,
3. Informed Consent and Treatment Agreement,
4. Initiating an Opioid Trial,
5. Monitoring and Adapting the Treatment Plan,
6. Periodic Drug Testing and Response to Evidence of Aberrant Behavior,
7. Consultation and Referral,
8. Discontinuing Opioid Therapy,
9. Medical Records,
10. Compliance with Controlled Substance Laws and Regulations, and
11. Practice Systems.

The Board policy is based on the Federation of State Medical Board's (FSMB) 2013 Model Policy on the Use of Opioid Analgesics for the Treatment of Chronic Pain. While the Board policy tracks the FSMB policy quite closely, it makes a number of changes.

VMS appreciates the Board's adoption of clear guidelines for physicians and other licensees who are prescribing opioids, and also appreciated the opportunity to provide input to the Board on the draft policy.

Link to VBMP policy: [http://healthvermont.gov/hc/med\\_board/documents/opioid\\_pain\\_treatment\\_policy.pdf](http://healthvermont.gov/hc/med_board/documents/opioid_pain_treatment_policy.pdf)

Link to FSMB policy: [http://www.fsmb.org/pdf/pain\\_policy\\_july2013.pdf](http://www.fsmb.org/pdf/pain_policy_july2013.pdf)

### DVHA REPORTS ABOUT 2,600 VERMONT PATIENTS IN GRACE PERIOD, AMA ISSUES GRACE PERIOD GUIDE FOR PHYSICIANS

A rule published by the Centers for Medicare & Medicaid Services (CMS) provides individuals who purchase subsidized coverage (advanced payment of tax credits) through health insurance exchanges with a 90-day grace period before their coverage is cancelled for non-payment. AMA has released resources that offer step-by-step help for physician practices related to this rule.

Under the CMS rule, insurers in health exchanges are required to pay any claims incurred during the first 30-days of the grace period, but insurers are not required to pay claims incurred during the last 60-days for any patient whose coverage is terminated. Patients are considered to be covered for care during the entire grace period, but insurers are allowed to place all the claims during the last two-thirds of the period in a pending status and retroactively deny them when coverage is terminated at the end of the grace period.

Vermont Health Connect data as of May 2014 shows that about 2,600 Vermont patients have failed to pay their premiums and are in the 90-day coverage grace period. Most of these, about 2,300, are in the first 30 days when claims are paid by insurers, but about 200 are between 30 and 60 days and about another 100 are between 60 and 90 days. Claims for patients in the second and third months may be pending by insurers and retroactively denied if coverage is terminated at the end of the grace period.

Information and resources for physicians are available from the AMA at <http://bit.ly/1jHavv9> and include:

- Step-by-step guide to the ACA grace period
- Grace period collections policy checklist
- Model financial agreement language for patients receiving Advance Premium Tax Credits
- Sample letter: Grace period notice to patients

## PHYSICIAN IDENTITY THEFT AND FRAUDULENT TAX RETURNS SURFACE IN VERMONT

VMS has received reports about an Internal Revenue Service (IRS) tax scam directed at Vermont physicians. According to the reports, someone is filing fraudulent federal income tax returns using physician names, addresses and Social Security numbers. It appears to be a national problem, since it has also impacted physicians in Maine, Indiana, South Dakota, Iowa, New Hampshire and Puerto Rico.

The IRS has not issued an alert. Rather, the majority of affected physicians are first becoming aware of it when they receive an IRS 5071C letter advising them of possible fraud.

Other physicians are receiving a rejection notification when attempting to electronically file their taxes. It indicates the return cannot be submitted because a return has already been filed under that Social Security number. At least one physician learned of the fraud when he received a large tax refund check before filing a tax return.

VMS continues to monitor this matter and forward information to relevant agencies, and has introduced a resolution with the support of the other New England

states for consideration at the AMA's annual meeting in June. The resolution states:

*RESOLVED: That our American Medical Association petition the Internal Revenue Service (IRS) to adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers; and be it further*

*RESOLVED: That our AMA petition the IRS and CMS to promulgate regulations to prohibit the use of Social Security Numbers by insurers, health care vendors, state agencies, other than tax agencies, and non-financial businesses.*

In addition, VMS has raised the issue with Vermont's Congressional delegation and asked them to pursue the issues identified in the above resolution with the IRS and CMS.

Please notify VMS if you have been victimized by this tax scheme so we can convey the scope of the situation to the proper authorities. Contact VMS at (802) 223 7898 or email Madeleine Mongan at [mmongan@vtmd.org](mailto:mmongan@vtmd.org).

## BUDGET

*(Cont'd from pg. 1)*

### Tax Increases – Employer Assessment and Tobacco Taxes

The tax bill included the revenue increases needed to support the spending in the budget. The tax conference committee extended the assessment on employers who do not offer health insurance to employers who do offer insurance but whose employees enroll in Medicaid. The amount of the quarterly employer assessments for the third and fourth quarters of calendar year 2014 will increase from \$91 to \$133, and future increases will be tied to premium increases. The increased assessments will raise \$2.8 million.

The tax bill also increased cigarette taxes 13 cents per pack, to \$2.75 and increased the tax on tobacco products such as snuff and smokeless tobacco an equivalent amount. These tobacco tax increases will raise \$1.1 million and \$850,000 respectively.

### Loan Repayment

The Department of Health and the Area Health Education Centers (AHEC) have applied for a \$1 million federal loan repayment grant that will be matched by \$1 million state funds. Over the four-year grant period, a total of \$2 million, or \$500,000 per year, would become available for loan repayment for primary care clinicians, ob-gyns, and psychiatrists who work in Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs). The 2015 budget includes the matching funds for this grant. This new loan repayment funding will supplement the annual amount of state loan repayment funds, approximately \$800,000, and help recruit and retain clinicians to address the shortage of primary care physicians. Last year about 450 primary care clinicians in Vermont applied for loan repayment, but there was only enough funding to make awards to about 100 clinicians.

Link to VMS loan repayment resolution:

<http://www.vtmd.org/sites/default/files/files/2012%20Cost%20of%20Medical%20Education.pdf>.



## H.350

(Cont'd from pg. 2) Link to VMS resolution:

<http://www.vtmd.org/sites/default/files/files/2013%20VBMP%20Procedures.pdf>

Link to Board of Medical Practice's Board Actions website:

[http://healthvermont.gov/hc/med\\_board/actions.aspx](http://healthvermont.gov/hc/med_board/actions.aspx)

### **Amendments to gift ban and disclosure requirements for educational sessions offered by device**

**manufacturers** - H. 350 permits device manufacturers to sponsor and provide educational programs at national or regional professional society meetings where accredited professional education programs, such as CME courses, are also offered. Manufacturer funding may be used for the educational programs and for meals and food for program participants at these sessions.

VMS heard from physicians that device manufacturers have barred Vermont physicians and other health care professionals from attending educational sessions at national and regional conferences, and from attending meals associated with the educational sessions. Vermont law prohibits manufacturers from offering educational sessions and food, unless the educational sessions have received formal accreditation from an organization such as the Accreditation Council for Continuing Medical Education (ACCME). When manufacturers support accredited CME, they may not specify or direct the content of those sessions.

Physicians reported that manufacturer-sponsored sessions can be the only way to obtain current information about

devices and issues related to the use of devices. Vermont is the only state that bans this type of educational sessions and Vermonters attending their national conferences reported feeling singled out. Massachusetts had a similar ban but repealed it in 2012 and now permits payment for modest meals provided for the purpose of educating health care practitioners about drugs or devices. The Vermont gift ban prohibition on educational sessions and associated food also affected other Vermont professionals such as nutritionists and nurses who reported either being banned from attending sessions at their national meetings or billed for expensive sandwiches after the fact.

To address this issue, VMS met with the Office of the Attorney General and worked with Rep. Till to introduce H. 633, a bill that would permit Vermonters to attend manufacturer-sponsored educational sessions at their national and regional conferences. The text of this bill, H. 633, was added to H. 350 at the end of the session.

Unlike device manufacturers, pharmaceutical manufacturers are still not permitted to sponsor this type of educational sessions and food to Vermonters. They may continue to support more formal educational sessions that are accredited by the ACCME or a similar accrediting entity. Legislators stated that while access to device education is limited, there are many ways to obtain education about drugs, such as academic detailing.

## EMERGENCY RULES

(Cont'd from pg. 6) potential for addiction, abuse, misuse, and the risks associated with the drug including life-threatening respiratory depression, potentially fatal overdose especially in children, neonatal opioid withdrawal symptoms and potentially fatal overdose when interacting with alcohol;

5. Obtain a signed Controlled Substance Treatment Agreement from the patient that includes urine screening (at least every 120 days) pill counts, safe storage and disposal;
6. Query the Vermont Prescription Monitoring System and review other controlled substances prescribed to the patient prior to the first prescription; query the VPMS at least every 120 days for patients prescribed 40 mg or more per day;
7. Determine a maximum daily dose or a not-to-exceed value for the prescription to be transmitted to the pharmacy; and,
8. Write a prescription that must be filled within seven days that does not exceed 30 days in duration, and schedule and undertake periodic follow-up visits and evaluations.

At follow up visits, the prescriber must evaluate, determine and document whether to continue the treatment, whether there is an alternative treatment, and whether to refer the patient for a pain management or substance abuse consultation. If the patient has failed to adhere to the Controlled Substances Treatment Agreement, the prescriber shall evaluate, determine and document a plan for discontinuance of the drug.

The Department of Health provided an early draft of the emergency rule to VMS, which was distributed to the VMS Council for review and comment. VMS received positive feedback about the draft emergency rule, and informed the Department of Health.