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DVHA ADOPTS MEDICAID FEE SCHEDULE REVISION; ACCEPTS NUMEROUS VMS RECOMMENDATIONS

The Department of Vermont Health Access (DVHA) has indicated that is ready to work with its partners in other state leadership roles to enhance the funding it pays for professional service rates.

On December 16th, it announced it was amending the Medicaid fee schedule for the medical care services provided by physicians and other health care professionals. At 22.5 percent in 2009, Vermont's Medicaid program is the second highest in the country as a percentage of a state's total personal health care spending¹, so its fee schedule has a disproportionately large impact on the viability of physician practices in Vermont.

While VMS strongly supports the Department's efforts to improve its fee schedule methodology, the Society opposed the Department's proposed amendments for a number of policy reasons, as well as serious concerns regarding the lack of due process in the amendment adoption process and the fee schedule's inconsistency with Act 48 – Vermont's health care reform legislation. In outlining its specific policy and adoption process concerns, VMS also provided DVHA with recommendations for improving the Department's fee schedule and its amendment process.

DVHA accepted many of VMS' suggestions, however the final Medicaid fee schedule falls far short of Act 48's principles for health care reform. The multiple state officials involved in implementing Vermont health care reform legislation have made it clear that they anticipate major changes in the way physicians and other health care providers are reimbursed in the future. VMS believes it is reasonable to ask state government to lead by example and end the long-standing practice of underpayment by the reimbursement systems they control.

VMS requested that the comment period be extended to allow for a comment period of at least 30 days from the date of the original announcement. In addition, VMS requested that a public hearing be held. However, DVHA finalized its amendments on the Medicaid fee schedule on December 29, with an effective date of Jan. 1, 2012.

Under Act 48, 18 V.S.A. § 9371, fourteen principles are adopted as the framework for reforming health care in Vermont. Principle 12 states that the system must enable health care professionals to provide, on a solvent basis, effective and efficient health services. In addition, 18 V.S. A. § 9376 charges the Green Mountain Care Board (GMCB) with setting reasonable rates for health care professionals, and it states "it is also the intent of the general assembly to eliminate the cost shift between the payers of health services."

Vermont physicians had the nation's lowest level of spending per capita below Medicare's sustainable growth rate formula (SGR) target. This is based on a recent article in the New England Journal of Medicine² on a scheduled cut in Medicare physician fees of 27.4% for 2012 due to the SGR. Since Medicare uses a single-fee schedule, this measure of comparative efficiency is based on the conservative utilization and low intensity of services provided by Vermont physicians to their patients when compared to their national peers.

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¹Health Spending by State of Residence, 1991–2009; Medicare & Medicaid Research Review 2011: Volume 1, Number 4; Cuckler, G. et al; pages E12-E13.

²The Sources of the SGR "Hole"; Ali Alhassani, M.Sc., Amitabh Chandra, Ph.D., and Michael E. Chernew, Ph.D.; December 21, 2011 (10.1056/NEJMp1113059)

ADMINISTRATION SEEKING PRESCRIPTION DRUG ABUSE PREVENTION MEASURES

On the second day of the new legislative session, Vermont Commissioner of Health Harry Chen, M.D., testified to the House Human Services Committee about the administration's proposals to address prescription drug abuse. The specifics of the proposals have not been provided yet, but they are expected to be spelled out in a bill that Rep. Ann Pugh, Chair of the House Human Services Committee, will introduce.

Several of the recommendations involve the Vermont Prescription Monitoring System (VPMS), which, as many VMS members know, is a database created in 2009 by the Department of Health to monitor use of controlled substances dispensed by Vermont pharmacies. Pharmacies report all prescriptions for controlled substances to the database on a weekly basis and physicians and other prescribers can register with the system and access information about the prescriptions for controlled substances that their current patients are receiving. The information reported by the pharmacies to the database includes the name of the patient, the prescriber, the pharmacy, the drug and the dosage. The database does not include any information about the patient's diagnosis or about other non-controlled drugs that the patient may be taking. Currently law enforcement has only limited access to this information, through the Commissioner of Health or through licensing boards.

VMS plans to focus on this issue at the next VMS Council meeting on Saturday, Feb. 11, from 9 a.m. to 12 noon at Fletcher Allen Health Care in Burlington. At that time, the Council will consider an updated VMS resolution that will clarify and update VMS policy on this important issue. See link below for the current VMS policy, adopted in 2008.

The proposals discussed verbally in the committee are outlined below. VMS is concerned about the following proposals, which may be addressed when the specific details of the proposal become available:

1. A proposal to require CME for physicians and other prescribers of controlled substances who have registered with the DEA that addresses addiction and best practices for prescribing controlled substances;
2. A proposal to require prescribers to log in and check VPMS when they write prescriptions for controlled substances; and,
3. A proposal to allow the two drug diversion officers of the state police, and their supervisors, to access VPMS as part of a bona fide investigation without judicial review or a warrant.

VMS Concerns and Rationales

Mandated CME addressing prescribing controlled substances and addiction for physicians with DEA registrations

Last year the Vermont Board of Medical Practice (VBMP) was authorized by the legislature to create a CME requirement for physicians in connection with license renewal, and the board is currently in the process of drafting rules to implement this new requirement. The legislature required the board, through the rules, "to require evidence of current professional competence in recognizing the need for timely appropriate consultations and referrals to endure fully informed patient choice of treatment options," including pain management services. VMS believes that the VBMP should have an opportunity to complete its rulemaking process before the legislature imposes additional CME content-specific requirements, as it believes VBMP can design an effective CME program that is targeted to physicians' specialties and practices.

The VMS Education and Research Foundation, led by Dr. Cy Jordan, M.D., has obtained a grant to perform a statewide survey and needs assessment of the type of education and support that would be helpful to physicians who are prescribing controlled substances. The survey is scheduled to be conducted in April of 2012 and should provide useful information for designing educational initiatives.

Mandated VPMS check before prescribing a controlled substance

Physicians and their office staff are already burdened with administrative tasks and adding another one may discourage physicians from treating patients with chronic pain in their offices. Vermont currently does not have enough pain specialists or pain clinics to address the need for treatment for more complex patients. The state should look for ways to make it easier for primary care physicians to safely treat patients with chronic pain. It is time consuming to manage care for chronic pain patients who may need urine screening, pill counts and pain treatment contracts.

VPMS has the potential to be a helpful tool for physicians. VMS members report however, that the system not easy to use at this time. Members have reported that it takes too long to log on and that the system is not always available. Before the legislature mandates physicians to check VPMS, the system must be easy to use and incorporate in practices' routines. Ideally there would be a single log in and password for all state registries.

BILLS LOOK TO ELIMINATE IMMUNIZATION PHILOSOPHICAL EXEMPTION

Two bills that would remove the philosophical exemption from the requirement that all children attending school and child care facilities receive immunizations have been introduced by Senator Kevin Mullin and Representative George Till, M.D.

According to the Times-Argus, S.199 and H.527 would “revoke the philosophical exemption, leaving parents with the choice of either administering the shots or finding alternative schooling options for their children. Both bills retain the religious and medical exemptions, which combined accounted for fewer than 50 opt-outs in 2010.”

The Times-Argus reported that in the year 2010 “more than 340 parents used the philosophical exemption to enroll their children in public school without the required shots.” In the same article, Christine Finley, immunization program chief for the Vermont Department of Health, suggested that parental choice is the likeliest cause for the Vermont kindergartener vaccination rate to drop from 93 percent in 2006 to 83 percent today.

DVHA ADOPTS MEDICAID FEE SCHEDULE REVISION

(Cont'd from pg. 1) According to DHVA's proposed amendment analysis, the Medicaid fee schedule would reimburse most procedures at approximately 66.5 percent of Medicare, and it would reimburse office visits and maternity visits at approximately 82.7 percent of Medicare — with an overall reimbursement level of 78.7 percent of Medicare. However, the analysis overstates its reimbursement percentages, since it does not reflect an additional 2-percent cut applied to all codes, except for the evaluation and management (E&M) codes.

By way of contrast, DVHA reimburses federally qualified health centers (FQHCs) on a cost basis at 125 percent of Medicare, and VMS estimates that private health insurance companies reimburse professional services at rates in excess of 132 percent of Medicare. Therefore, DHVA is reimbursing most physician services at half the rate of private insurance companies, and it pays non-FQHC primary care physicians at two-thirds the rate paid for similar primary care services in FQHCs.

When DVHA adopted its current Resource Based Relative Value Scale (RBRVS) based system on Jan. 1, 2011, in contrast to Medicare's single conversion factor, DVHA adopted two conversion factors. In the proposed amendments, DVHA

recommended using three different conversion factors for different ranges of procedure codes. DHVA's use of three different conversion factors — instead of Medicare's use of a single conversion factor — fundamentally undermines the rationale of the RBRVS system and destroys the integrity of the RBRVS Payment Methodology as a means to establish appropriate reimbursement amounts. As a consequence, the multiple conversion factors debase the work and practice experience values for many of the procedure Relative Value Units (RVUs) established by CMS by as much as 23 percent.

VMS recommended that DHVA adopt a single conversion factor for its proposed RBRVS fee schedule and the conversion factor should be the one used by Medicare. This recommendation is consistent with the requirements of V.S.A. Title 32, § 307(d)(6) which calls for the governor's proposed financial plan for the Medicaid budget to include “recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement.”

Absent the use of a single conversion factor, VMS recommended that DVHA should not further compromise its RBRVS Payment Methodology by moving away from the current two conversion factors to three conversion factors. One consequence of the proposed amendments new conversion factor was a reduction in payment for E&M codes of \$862,804 from CMS's rebased RVUs. Since E&M codes are typically used by primary care physicians, VMS recommended that the conversion factor be at a sufficient level to allow for the increased reimbursement appropriate to the increased value of the E&M codes' RVUs.

Federal law, under 42 U.S.C. § 1396a.(30) (A), requires that a state Medicaid program must “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

Under the proposal, DVHA recommended a 21.4-percent reduction in payment for radiological procedure codes in 2012. Since DVHA had adopted a 25.3-percent reduction in payment for these same procedure codes in 2011, VMS indicated the two-year cumulative 46.7-percent cut in Medicaid reimbursement for radiology procedures was excessive and it could have an adverse impact on Medicaid beneficiaries' access to radiological services in Vermont.

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MEDICAID FEE SCHEDULE REVISION

(Cont'd from pg. 3) The Medicaid budget for state fiscal year 2011 (SFY11) included \$2 million of anticipated savings to be achieved by requiring prior authorization for selected radiology services. The savings were based on an anticipated reduction of the utilization of high-tech imaging services for Medicaid beneficiaries of 20 percent.

With respect to Computed Tomography (CT) use in Vermont, the state has one of the lowest rates in the country. The Vermont Department of Banking, Insurance, Securities and Health Care Administration reported the following: "While the rates of CT events increased in Vermont over five years, the state has much lower rates than the nation and the adjoining HRR's. The national average for CT events was 63.8 events per 100 people while the Vermont state average was just 41.8."

In order to avoid a two-year cumulative 46.7 percent cut in Medicaid reimbursement for radiology procedures, VMS recommended that DHVA retain radiology procedures under its current conversion factor. If it is necessary to find additional resources to achieve this recommendation and other recommendations, VMS suggested using a part of the \$22 million in savings attributable to decreased physician services identified in the DVHA SFY12 budget adjustment document. Due to the federal government sharing in the cost of the Medicaid program, Vermont would pay approximately 42 percent of any added cost.

In response to VMS' recommendation to utilize one conversion factor, DVHA concurred that it would be optimal to do so in the same manner as implemented by Medicare. However, DVHA indicated it was limited in its ability to pay providers based on the appropriation from the state Legislature and in order to ensure accessibility to high-volume services used by Medicaid beneficiaries, DHVA determine it needed to implement three conversion factors.

Upon further consideration, DVHA decided to change its proposed conversion factor for radiology services. For these services, DHVA will use the same conversion factor that will be used for E&M and maternity-related services. This policy is similar to the policy put in place by DVHA effective Jan. 1, 2011.

Finally, in response to VMS' recommendation for DVHA to have an overall strategy related to the reimbursement for professional services under its Medicaid fee schedule, DVHA stated that its goal for setting rates for all professional services should be at or above the prevailing Medicare rate. And in light of V.S.A. Title 32, § 307(d)(6) and Act 48, DVHA indicated it is ready to work with its partners in other state leadership roles to enhance funding for professional service rates paid by the DVHA.

VMS will continue in its efforts to encourage the administration to submit to the General Assembly recommendations for funding physicians' reimbursement by Medicaid at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement based on the RBRVS methodology.

DHVA Resource Based Relative Value Scale Fee Schedule with 3 Conversion Factors and 2012 RVUs Effective for dates of service on or after January 1, 2013. Medicare Conversion factor for 2012 = \$33,9764. (Note: This table does not reflect an additional 2.0 percent payment cut that will be applied to all professional services except for evaluation and management CPT codes 99201 through 99499.)				
Procedure Code Group	DVHA Conversion Factor	DHVA Payment as % Medicare	Total Payments in model	Percent change From 2011 model
All CPT Codes		78.4%	\$92,354,808	0.0%
Well Child Visit Codes	\$29.0800	85.6%	\$2,511,210	0.0%
Evaluation & Management codes	\$27.9800	82.4%	\$40,812,603	0.0%
Maternity Care	\$27.9800	82.4%	\$4,059,768	8.9%
Behavioral Health codes	\$29.0800	85.6%	\$21,994,140	-1.5%
Radiology	\$27.9800	82.4%	\$4,471,965	-2.3%
Chiropractic codes	\$27.9800	82.4%	\$683,471	-1.2%
Integumentary	\$21.2800	62.6%	\$1,198,760	1.4%
Musculoskeletal	\$21.2800	62.6%	\$2,649,527	-0.5%
Respiratory	\$21.2800	62.6%	\$391,410	1.5%
Cardiovascular	\$21.2800	62.6%	\$937,431	-1.0%
Digestive	\$21.2800	62.6%	\$2,009,471	1.0%
Urinary	\$21.2800	62.6%	\$363,320	-3.2%
Genital Systems	\$21.2800	62.6%	\$977,588	-0.7%
Delivery Services	\$21.2800	62.6%	\$136,440	-1.2%
Endocrine and Nervous	\$21.2800	62.6%	\$975,540	1.3%
Eye and Ocular	\$21.2800	62.6%	\$517,989	0.7%
Pathology	\$21.2800	62.6%	\$552,780	-0.8%
Medicine	\$21.2800	62.6%	\$6,943,049	1.5%
All other	\$21.2800	62.6%	\$168,346	0.9%

PRESCRIPTION DRUG AUBSE PREVENTION

(Cont'd from pg. 2) VBMP is also in the process of updating its policy on the Use of Controlled Substances for the Treatment of Chronic Pain, and intends to make recommendations with respect to use of the prescription monitoring system as part of evidence-based best practices. VMS believes that the legislature should allow VBMP to set the professional standard of care, with respect to use of the VPMS.

Prescribing controlled substances is hard and time-consuming, if government makes it more difficult and imposes more hurdles, physicians may stop prescribing controlled substances in their offices for difficult patients and may stop providing in-office addiction treatment in situations where continued care for these patients becomes too difficult or exceeds physicians' expertise.

Direct Access to Law Enforcement

VMS' concern about allowing direct access to law enforcement has been that the clinical information in the database is limited to the drug dosage, and because it is incomplete, it may lead to investigations of physicians who are prescribing larger doses of controlled substances to patients with terminal pain. There is also the potential for a chilling effect on prescribing controlled substances for patients who need them. VMS prefers that the information be reviewed by a clinician such as the Commissioner of Health or VBMP prior to releasing the information to law enforcement.

Preliminarily, VMS expects to support the following proposals that were made by the Commissioner of Health to the House Human Services Committee:

- A proposal to allow the DVHA Medical Director, Michael Farber, M.D., to access VPMS to review use of controlled substances by patients in connection with prior approval of buprenorphine treatment;
- A proposal to allow the Chief Medical Examiner, Stephen Shapiro, M.D., to access VPMS when he is investigating deaths related to drug use or misuse;
- A proposal to enter an interstate compact that would allow sharing of VPMS data with other states (This is expected to allow physicians to check whether patients are receiving controlled substances from pharmacies in other states.);

- A proposal to incorporate education about addiction and pain into the medical school curriculum;
- A proposal to improve prescribing controlled substances in primary care through Academic Detailing and Clinical Microsystems;
- A proposal to provide education for the public about proper disposal of controlled substances and opportunities for drug take-backs;
- A proposal to require IDs at pharmacies in order to pick up prescriptions for controlled substances;
- A proposal to increase training for law enforcement;
- A proposal to provide increased education for prescribers concerning enrollment in VPMS and accessing it as part of best practices;
- A proposal to provide tools, education, technical assistance, and consultation for prescribers of controlled substances about best practices;
- A proposal to create a study group to report to the legislature on creating a unified pain management program in Vermont;
- A proposal to work with insurers to establish and spread best practices for prescribing controlled substances; and,
- A proposal to require high-risk patients to obtain controlled substances from one pharmacy and one prescriber.

Background information – a link to VMS' 2008 policy on Prescription Drug Abuse and Diversion;

- <http://bit.ly/AtgLOT>

Links to additional information about VPMS, including frequently asked questions for prescribers:

- http://healthvermont.gov/adap/VPMS_about.aspx
- http://healthvermont.gov/adap/documents/VPMS_providerFAQ.pdf

VMS is encouraging its members to review that above proposals and contact the Society with questions and suggestions. The organization is also seeking members willing to contact legislators to discuss these issues, meet them in person or testify before them.



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.