

THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

Week of February 4, 2013

FY 2014 MEDICAID BUDGET INCLUDES \$24.4 MILLION TO REDUCE COST SHIFT

The administration's proposed FY 2014 budget includes \$24.4 million to improve Medicaid reimbursement for all types of professionals and facilities that participate in Medicaid. The increase amounts to three percent of the Department of Vermont Health Access' (DVHA) FY 2012 total expenditures on health care providers, and the increased funding will start in October of 2013. VMS believes this is a good first step toward eliminating the \$183 million Medicaid cost shift attributable to physician and hospital care identified in the recently released Health Care Reform Financing Plan.

This reimbursement increase will be built into the base DVHA budget and is intended to apply annually going forward. The budget language explaining this proposal,¹ in Section 307.2, allows the agency to vary the percentage increase to health care providers consistent with participation in payment and delivery system activities authorized or consistent with meeting health care cost and quality performance targets established by DVHA. VMS will meet with DVHA staff to learn more about the proposed cost and quality targets. The text of DVHA's budget document describes the increase as follows²:

"It is a fairly well-known fact that Medicaid rates of reimbursement have not kept up with the rate of inflation. In order for providers to cover their costs, they have had to negotiate disproportionately higher rates of reimbursement with other insurers resulting in a cost shift. In an effort to begin to mitigate this effect, we are proposing to increase provider rates beginning October 1, 2013. While we are expecting providers to receive roughly an additional 3% overall, the manner in which the payments will be adjusted will be a combination of a straight rate increase and a quality incentive component. The Green Mountain Care Board can assure that this investment results in relief for private ratepayers, rather than increased health care costs."

VMS supports this effort and believes that increased Medicaid funding is needed to ensure reasonable access to care and help eliminate the cost-shift to employers. VMS believes the State of Vermont should lead by example as it implements Act 48 – Vermont's health care reform legislation. Under Act 48, 18 V.S.A. § 9371, fourteen principles are adopted as the framework for reforming health care in Vermont. Principle No. 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 states "it is also the intent of the general assembly to eliminate the cost shift between the payers of health services."

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. Vermont's Medicaid program covered 22.5 percent of Vermonters' health care expenditures in 2009, and Vermont's Medicaid program is the second highest in the country as a percentage of a state's total personal health care spending. VMS believes it is reasonable to ask state government to end the long-standing practice of underpayment by the reimbursement systems they control.

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¹ Section E.307.2 of the administration's proposed budget (See page 43):

http://www.leg.state.vt.us/jfo/appropriations/fy_2014/FY%202014%20Governor's%20Proposed%20Budget.pdf

² <http://www.leg.state.vt.us/reports/2013ExternalReports/286704.pdf> See page 63

PHYSICIAN ASSISTED SUICIDE BILL TO BE VOTED ON BY FULL SENATE

After review and action by two Senate Committees, the full Senate could be debating and voting on legislation allowing for physician assisted suicide in Vermont on February 13th. S.77 would create a program similar to the one that has been in effect in Oregon for about 15 years and in Washington State since 2009. VMS testified against the legislation before both the Senate Health and Welfare Committee and the Senate Judiciary Committee based on its current policy¹ on physician assisted suicide adopted in 2003 stating there should be no laws for or against physician assisted suicide due to a concern that such laws could hinder the provision of high quality end-of-life care. The policy was reaffirmed by the VMS Council in February of 2011.

It is anticipated that if the bill passes the Senate, it would be quickly taken up by the House of Representatives where it has the support of House Speaker Shap Smith. Governor Peter Shumlin has also expressed his support for the legislation as a civil rights issue.

VMS Position and Activities

VMS formally considered physician assisted suicide in 2003, and, based on a vote of the entire membership, adopted a policy that affirms the importance of “promoting initiatives that assure all dying Vermonters receive good, comprehensive palliative care.” The policy does not support laws for or against physician assisted suicide, for the reason that laws against assisted suicide could chill the use of medications needed to control symptoms and laws for assisted suicide might discourage or circumvent the provision of good palliative care. Finally, the policy clarifies that VMS does not endorse euthanasia.

In 2003, VMS members expressed the opinion that a law on physician assisted suicide was unnecessary since palliative care treatments could address the types of issues, symptoms and conditions that might arise for dying patients. If pain and symptoms cannot be relieved by other methods, palliative sedation is an available tool to ensure that patients do not suffer while they are dying. The ethical rule of the “Double Effect” is well established and permits the provision of medication to a patient at the end of life if the intent is to ensure comfort even if the treatment unintentionally hastens the patient’s death. The “Double Effect” has been recognized by the Board of Medical Practice in an order addressing an end-of-life case.²

Physicians supporting the VMS policy expressed the belief that decisions about dying should be made at the bedside by physicians with their patients. They did not support using legal procedures requiring additional paperwork and red tape for physicians and their terminally ill patients as they approach the end of their life.

In testifying against S.77, VMS indicated the uncertainty around making a diagnosis of a terminal illness which would result in death within six months. It cited a study indicating that 17 percent of individuals diagnosed with a terminal illness for purposes of the hospice benefit live longer than the six months. This uncertainty has been cited as one of the reasons why the measure failed to pass through public referendum in Massachusetts last November.

VMS also cautioned legislators against enacting such a controversial bill at a time when physicians are already dealing with the changes to medical practice related to Vermont’s efforts to achieve a single-payer healthcare system by 2017. Passing the physician assisted suicide legislation at this time might have the effect of compounding the uncertainty of practicing medicine in Vermont and make it more difficult to attract the needed new physicians to care for an aging population.

Since 2003, VMS members have been leaders in ongoing efforts to improve hospice and palliative care in Vermont, actively participating in and supporting wide-ranging initiatives including:

- Development of educational materials for physicians;
- Palliative care and pain management education;
- Advocacy for pediatric and adult enhanced hospice programs that extend the time period for hospice and permit provision of concurrent curative and hospice services;
- The creation of an advance directive registry;
- The development of a statewide form for “Clinician Orders for Life Sustaining Treatment”;
- Palliative care consults and palliative care case conferences;
- Working with the Vermont Board of Medical Practice to clarify the policy for prescribing controlled substances to treat chronic pain;
- Development and promoting the use of the Vermont Prescription Monitoring System and educational initiatives around prescribing controlled substances; and
- Offering annual CME courses on the topics of hospice, palliative care or pain management services.

¹ <http://www.vtmd.org/sites/all/themes/vms/documents/policies/2003/PASpolicy.pdf>

² http://healthvermont.gov/hc/med_board/2003record/pdf/070203mpc850802.pdf

S. 67 – VERMONT PRESCRIPTION MONITORING SYSTEM

Senator Richard Sears (D - Bennington), chair of the Senate Judiciary Committee, has introduced S. 67 Vermont Prescription Monitoring System (VPMS), a bill that picks up where the conference committee left the bill last year. Most provisions in the new bill were included in the bill last year and are consistent with the resolution passed by the VMS in October of 2012. The VMS resolution affirms that the Vermont Medical Society supports registration with the VPMS for physicians who prescribe controlled substances. To streamline the registration process, the resolution recommends that the Vermont Board of Medical Practice create a process to enroll prescribers automatically in the VPMS at the time of license renewal. The resolution also requires the VMS to encourage the Department of Health to use the VPMS to send out public health alerts about diversion of controlled substances. The resolution also opposes requiring physicians to check the Vermont Prescription Monitoring System each time they prescribe a controlled substance, and suggests instead that VMS work with the Vermont Board of Medical Practice to develop evidence-based guidelines for the appropriate use of the VPMS by prescribers. All of these issues have been addressed in S. 67, at least in part.

Other issues addressed in S. 67 include:

- Prescriptions for regulated drugs will be required to include the quantity of the drug in both numeric and word form;
- Individuals who pick up prescriptions for Schedule II, III, or IV controlled substances will be required to show a photo ID;
- Patients are required to retain drugs in the original containers but may possess up to seven days dosage in other containers;
- The Department of Public Safety is required to adopt operating guidelines for accessing patients' pharmacy records from pharmacies and the initial guidelines and any amended guidelines must be submitted to legislative committees;
- The Medical Director of the Department of Vermont Health Access (DVHA) and the Office of the Chief Medical Examiner are authorized to access the VPMS database;
- Health care professionals or medical examiners licensed in other states are authorized to access the VPMS data base as necessary to provide care to Vermonters or investigate deaths of Vermonters;
- In specified circumstances, the Department of Health may also provide reports of data from the VPMS to: The Commissioner or Deputy Commissioner of Public Safety if the Commissioner of Health or the Deputy Commissioner; a drug diversion investigator; or a prescription monitoring system in another state under a reciprocal agreement;
- The Department of Health is authorized to use information from the VPMS for trend analysis, to post the analyses for use by health professionals and the public, and send alerts about trends by email to prescribers and dispensers;
- Professional boards are required to develop evidence-based standards for prescribing Schedule II, III, and IV controlled substances for treatment of chronic pain;
- All providers who prescribe controlled substances on Schedule II, III, or IV are required to register with the VPMS;
- All dispensers who dispense controlled substances on Schedule II, III, or IV are required to register with the VPMS. Licensing authorities for dispensers must create standards for reporting prescription data to the VPMS, which must be no less frequent than once a week;
- Licensing authorities for prescribers and dispensers will develop standards addressing the recommended frequency for VPMS queries. Standards for querying and reporting to VPMS will be considered in disciplinary proceedings by licensing boards;
- "Replacement" prescriptions will be identified on the prescription and in the VPMS.
- A Unified Pain Management System Advisory Council comprised of clinicians will be created to advise the Commissioner of Health on the appropriate use of controlled substances in treating chronic pain and addiction and preventing drug abuse;
- The Commissioners of Health and Public Safety are required to design, implement and publicize a statewide drug disposal program for unused prescription and over the counter drugs; and
- The Departments of Health and Vermont Health Access (DVHA) are required to work with manufacturers of buprenorphine, prescribing practices and pharmacies to create a "track and trace" pilot project to use to identify irregularities related to buprenorphine dosing and quality.

CONTINUING MEDICAL EDUCATION:

VMS COLLABORATES WITH MASSACHUSETTS MEDICAL SOCIETY

VMS has entered an agreement with the Massachusetts Medical Society (MMS) that will permit VMS members to access CME from the Massachusetts Medical Society for a discounted rate. MMS has a number of courses that address pain management, prescribing controlled substances and end of life care – content specific courses that the Vermont Board of Medical Practice now requires. In addition, MMS has a broad range of general CME courses addressing issues such as risk management and practice management. VMS members will receive a code that permits them to link to the MMS site and access CME courses and receive a 25-percent discount on the per-credit fee charged to non-MMS members which is currently \$20 per credit. VMS members will obtain a CME certificate upon completion of each CME activity.

ENHANCED MEDICAID REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS

Under the federal Patient Protection and Affordable Care Act (PPACA), Medicaid primary care practitioners who practice family medicine, pediatrics, internal medicine, and related subspecialties are eligible for enhanced Medicaid reimbursement for evaluation and management codes and some immunization administration codes for 2013 and 2014. Reimbursement for these codes will increase to 100 percent of the Medicare rate (using July 1, 2009 as a base year) with 100 percent federal funding supporting this increase.

To become eligible for this enhanced payment, a physician must attest that he/she is Board certified with a specialty designation of family medicine, general internal medicine or pediatric medicine and/or a related subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA). Enhanced reimbursement is also available to physicians who practice these specialty areas, but who are not board certified. The attestation form should be filed before March 31, 2013 and is available on the DVHA/HP website at: <http://vtmedicaid.com/Downloads/forms/Provider%20Specialty%20Attestation%20Form.pdf>

Physicians with questions about whether they qualify for this enhanced payment can contact their HP/DVHA provider representative or call DVHA/HP at 802-879-4450, option 4.

2013 ANNUAL ADJUSTMENT TO THE MEDICAID RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

On Dec. 16, 2012, DHVA filed a State Plan Amendment to change the rates paid for services payable under DVHA's Resource Based Relative Value Scale (RBRVS) methodology for calendar year 2013.

For 2013, DVHA calculates that the overall Medicaid fee schedule will reimburse health care professionals at approximately 86 percent of Medicare. The procedures not impacted by the federal increase for primary care physicians will be reimbursed at approximately 79.8 percent of Medicare. DVHA's calculations, however, do not reflect a two-percent reduction that has been in effect since July of 2009 when Medicaid rates paid to physicians for all services except evaluation and management (office visit) codes were reduced. The two-percent reduction is applied in the last step of claim processing and included in the remittance advice sent to participating providers. The two-percent reduction is not reflected in the rates for CPT services posted on the DVHA website, or included in the RBRVS calculations. VMS has recommended that DHVA eliminate the additional two-percent cut applied to all professional services, except for the evaluation and management (E&M) codes.

VMS has consistently recommended that DHVA adopt a single conversion factor for its 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." In addition, under 42 U.S.C. § 1396a. (30) (A), 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."

V.S.A. Title 32, § 307(d)(6) 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." VMS recommends that the budget direct DHVA to use a portion of the \$24.4 million in the SFY2013 budget to fully adopt Medicare's Part B RBRVS reimbursement system with its single conversion factor at 100 percent of Medicare.

By way of contrast, DVHA reimburses federally qualified health centers (FQHCs) on a cost basis at 125 percent of Medicare, and the University of Massachusetts Medical Center in the recent Financing Plan determined that private health insurance companies reimburse professional services at rates of 155 percent of Medicare. Therefore, even with the additional federal funds for primary care physicians, at 86 percent of Medicare, DHVA would be reimbursing physician services at 55 percent of the rate of private insurance companies.

PHYSICIAN ASSISTED SUICIDE

(Cont'd from pg. 2) Recently Vermont has received the highest ranking in the country for hospitals with palliative care programs; 100 percent of large and mid-size hospitals having palliative care programs compared to a national rate of 53 percent. Hospice spending for Medicare patients in Vermont, however, is reported to be well below the national average. VMS also recognizes the need to continue to work on these issues.

Content of S.77

S.77 is based on the laws passed in Oregon and Washington. The bill creates a process that patients may use to request medication from their physicians to be self-administered for the purpose of ending life. Only allopathic physicians and osteopathic physicians would be permitted to prescribe the medication. Patients are required to make both an oral and a written request to their physician and to reaffirm the oral request no sooner than 15 days after the initial request. The written request must be signed and witnessed.

Additionally:

- The attending physician must make a determination that the patient is suffering from a terminal condition, is a Vermont resident, has capacity and has made a voluntary request for the medication;
- The physician must inform the patient in person of his or her diagnosis, prognosis, risks associated with taking the medication, probable result of taking the medication, and all feasible end-of-life services;
- The physician must refer the patient to a consulting physician for medical confirmation of capacity, diagnosis, prognosis, and voluntariness;
- The physician must refer the patient for counseling to confirm capacity and to ensure that the patient does not have impaired judgment;
- The physician must recommend that the patient notify his or her next of kin, must advise the patient to have another person present when he or she takes the medication, and must inform the patient that the patient may rescind the request at any time;
- Prior to writing the prescription, the physician must verify that the patient is making an informed decision; and,
- The bill includes a 48-hour waiting period after the physician has received the patient's written request and the patient's second oral request (15 days after the first request) and specific requirements for the type of documentation to be included in the patient's medical record.

Finally, there is a requirement that the physician submit a report to the department of health noting compliance with all requirements of the law. The number of requests must be reported as well as the number of prescriptions actually written. The department of health is required to review the medical records of patients who hastened their death and to prepare an annual statistical report. The bill makes it clear a physician is not required to provide a qualified patient with medication to hasten their death and that a decision not to provide the medication does not constitute the abandonment of the patient or unprofessional conduct.

For the full text of S.77, please go to: <http://www.leg.state.vt.us/docs/2014/bills/Intro/S-077.pdf>.



BILLS INTRODUCED 2013-2014 SESSION

To see full text of bills introduced this session go to:
www.leg.state.vt.us/database/rintro/rintro.cfm?Session=2014

ROSTERS OF KEY LEGISLATIVE COMMITTEES

You can reach legislators by using the contact information listed below, by mailing correspondence to their attention to 115 State Street, Montpelier, VT 05633, or by leaving a message at the statehouse by calling (802) 828-2228.

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