Legislative Bulletin April 17, 2015

H. 481 – Medicaid Reimbursement Increases, Loan Repayment Restored, Tobacco Tax and Sweetened Beverage Tax

A bill that would restore Medicaid reimbursement for primary care to the Medicare level, raise reimbursement for specialty care from 80 percent of Medicare to about 84 percent of Medicare, restore level funding for the primary care educational loan repayment program, and increase primary care medical home payments has cleared two committees and will be reviewed this week by the House Appropriations Committee.

Last week, the House Ways and Means Committee raised about $20 million in new revenue to support these health care initiatives by including a half-cent, per-ounce tax on sweetened drinks (sugar sweetened and diet), by increasing the cigarette tax $0.25 per pack, by increasing the tax on other tobacco products a comparable amount, and by removing the sales tax exemption for supplements. Representative George Till, M.D., worked tirelessly with the Ways and Means Committee to find a package of revenue increases that had a nexus to public health and could be passed by the committee. The bill is now in the Appropriations Committee and then must pass the House floor. It will be challenging to get the votes to pass the revenue increases. The beverage manufacturers and others are working hard against the taxes.

VMS strongly supports this bill and asks members to contact their representatives to encourage them to pass this bill. Find your representatives at http://legislature.vermont.gov/people.

Vermont Board of Medical Practice Initiatives: Interstate Licensing Compact and Telemedicine Policy

S. 8 Interstate Licensing Compact

The Vermont Board of Medical Practice (Board) is supporting S. 8, a bill that would establish and Interstate Licensing Compact for physicians. If Vermont joined the interstate licensing compact, by passing the compact law, qualified physicians would be able to obtain licenses in other states through an expedited procedure. To be eligible for expedited compact licenses, physicians would have to meet a number of specific criteria, including board certification. They would be required to have background checks and could not have been the subject of license discipline.

Physicians with expedited licenses would have unrestricted licenses in multiple states. They would be required to meet the standards of professional conduct in the state where the patient they are treating is located. Maintenance of certification is not required for renewal of compact licenses.

VMS members have expressed concerns that Vermont physicians who do not have expedited compact licenses could see their licensing fees increase to support the administrative expenses of the compact. The Board reports that the Federation of State Medical Boards (FSMB) is applying for federal license portability funding, and hopes to be able to minimize the cost to participating states. The FSMB predicts a state assessment of $5000. The Board does not intend to shift the cost to non-compact licensees. Many details of the compact will be clarified through the rule-making process once the compact is established.

So far six states have joined the compact by passing the law: Idaho, Montana, South Dakota, Utah, West Virginia, and Wyoming. Another 11 states, including Vermont, have introduced the compact legislation; Alabama, Illinois, Iowa, Maryland, Minnesota, Nebraska, Nevada, Oklahoma, Rhode Island, and Texas, and Vermont. VMS has learned that neighboring states, including New York, Massachusetts and New Hampshire do not have current plans to join the compact. The compact can be formed and start rulemaking when seven states have enacted the compact law.

VMS will form a small group to review the compact law with the Board and report to the VMS Council.

Telemedicine Policy

The Vermont Board of Medical Practice (Board) is proposing to adopt a policy on appropriate use of telemedicine when practicing medicine. The policy requires physicians to be licensed in the state where the patient is located when telemedicine is used. A physician-patient relationship must be established and a medical history and evaluation of the patient must be performed and documented in the patient's medical record. The proposed policy describes the components of informed consent for telemedicine, which include providing information about the physician's credentials, the type of transmission used, and details on security measures.

Patients should be able to obtain follow-up care or information and physicians must have an emergency plan in place and provide it to patients. Advertising products or services as part of a telemedicine portal is not permitted if the physician receives any remuneration, benefits

Quick Links

- 2019 206th VMS Annual Meeting
- Vermont Guide to Health Care Law
- Thursday Webinars
- Opiate Prescribing & Substance Use Disorder Information
- Vermont Practitioner Health Program
- VMS Rounds Newsletter
- VMS Physician Executive Leadership Institute

or incentives for including the information. When drugs are prescribed by telemedicine, a physician must implement measures to uphold patient safety in the absence of a traditional physical examination. The procedures for prescribing must ensure that the identity of the patient is established and that the clinical evaluation and prescription are documented.

The Board is accepting comments on this policy and expects to finalize its work on the policy it at the Board meeting on May 6, 2015.

S. 62 Surrogate Consent to DNR Orders and COLST Orders/DNR Identification Rules

Vermont is one of a handful of states that does not have a law addressing health care decision making for patients who have not appointed agents through an advance directive and do not have guardians appointed by the probate court.

Last year Act 127 created a process for a family member or a person with a known close relationship to a patient to elect hospice care for a patient who does not have an agent or guardian. S. 62 establishes a similar process for identification of surrogates to consent to Do Not Resuscitate (DNR) orders or Clinician Orders for Life Sustaining Treatment (COLST). Surrogates must be family members or individuals with a close relationship to the patient. The bill requires surrogates to use a substituted judgment standard if the patient's wishes are known or if they are not known, a best interests standard. The bill authorizes surrogates to access the patients' medical information and establishes immunity for surrogates consenting to DNR or COLST orders and for clinicians who rely on their decisions made by surrogates. If no family member or individual with a close relationship to the patient is available to act as a surrogate or if there is disagreement among interested individuals, an application for an emergency guardianship may be filed in probate court. S. 62 also amends the law for patients in nursing homes, creating a parallel process to identify a surrogate and make decisions for nursing home residents.

S. 62 also requires the Department of Health to complete rulemaking specifying uniform minimum requirements for DNR identification, such as bracelets.

S. 108 - Physician Assisted Suicide

A bill repealing a sunset on the Vermont physician aid in dying law passed in 2013 has passed the Senate. The effect of this bill is to maintain the current requirements in the physician aid in dying law. Not all patients are eligible to participate in this process and there are 15 legal requirements that physicians must follow in order to write a lethal prescription for a patient without legal liability. Physicians not required to participate in this process.

- Link to Department of Health Patient Choice website
- Link to VMS Physician Assisted Suicide policy

Organ Donor Taskforce extended

H. 141, which has not passed the House, extends the work of the Organ and Tissue Donation Working Group through June of 2017. The charge of the group is to develop recommendations to the Vermont General Assembly and the Governor with respect to:

- Creation of a statewide program for organ and tissue conations and transplants;
- Strategies for increasing donation rates or organs and tissues in Vermont from live and deceased donors;
- Issues related to employment, including sick time for persons willing to be live organ or tissue donors; and
- Coordination of the efforts of public and private entities in Vermont, such as the DMV, the Department of Health, and the Organ Procurement Organizations that are involved with the donation and transplantation of organs and tissues.

VMS is represented on the group, which receives administrative support from the Department of Health. VMS adopted a resolution addressing anatomical gifts at the 2010 Annual Meeting.

Mental Health – Secure Residential Facility – H. 241 Capital Bill

The capital appropriation bill requires the Agency of Human Services to conduct an examination of the needs of the Agency for siting and designing a secure residential facility, and report back to the legislature by February 1, 2016. The examination must address the operating costs for the facility including staffing, size of the building, quality of care and options for ownership and management of the facility. This facility will not be available to relieve the pressure on emergency departments anytime soon.

License renewal fees for physicians to increase in 2016

License renewal fees for physicians will increase from $500 to $525 in 2016. The fee will continue to include $25 for the Vermont Practitioner Health Program (VPHP) that is operated by VMS. Fees for initial license applications for physicians will increase from $625 to $650, and fees for limited temporary licenses for residents will increase from $115 to $120. Fees for physician assistants will increase from $170 to $225. Physician assistants have changed from a certification model to a licensing model and will no longer be required to obtain additional certificates for additional sites where they work. Anesthesiologist assistants and radiologist assistants' fees will increase from $115 to $120 for initial certification and renewal, and from $50 to $55 for each additional application for certification or renewal if they work at different sites.

Congress approves, President signs bill that permanently repeals SGR

This week, the U.S. Senate approved and President Obama signed H.R. 2, thereby enacting sweeping changes in the way Medicare pays physicians and other health professions. The bill, drafted in the House in negotiations between Speaker John Boehner and Representative Nancy Pelosi, the Democratic leader, permanently repeals the sustainable growth rate (SGR) formula and also extends the Children's Health Insurance Program (CHIP) for two years, through 2017. Without action by Congress, physicians would have faced a 21-percent cut in Medicare fees.

The Vermont Medical Society, the American Medical Association and over 750 national and state-based physician and specialty organizations have gone on record in support of H.R. 2, the "Medicare Access and CHIP Reauthorization Act." Below are responses to frequently asked questions about the major provisions of H.R. 2 that will affect Medicare physician payments.

Some of the most important features of H.R. 2 are:

- The sustainable growth rate (SGR) is permanently repealed, effective immediately.
- Positive payment updates of 0.5 percent are provided for four-and-a-half years, through 2019.
- Physicians in alternative payment models (APMs) receive a 5-percent bonus from 2019 to 2024.
- In 2026 and beyond, physicians in APMs qualify for a 0.75-percent update; all others will receive a 0.25-percent annual update.
- The fee-for-service payment model is retained, and physician participation in APMs is entirely voluntary.
- Funding is provided for quality measure development, at $15 million per year from 2015 to 2019. Physicians retain their preeminent role in developing quality standards.
- Current quality incentive and payment programs are consolidated and streamlined, and the aggregate level of financial risk to practices from penalties has been mitigated in comparison to current law.

How does the legislation support transitions to APMs?

The bill provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians participating in patient-centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other models would require some degree of downside risk in addition to the opportunities for increased revenues that many APMs provide if the physician practice generates savings. To encourage physicians to assume this risk, and to provide a financial cushion, the legislation provides 5 percent bonus payments from 2019 to 2024 for those who join new models. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their APM; they would be exempt from the new Merit-based Incentive Payment System (MIPS) quality program described below. The bill also supports the use of telemedicine in new models of care and creates an advisory panel to consider physicians' proposals for new models.

What is the Merit-based Incentive Payment System or MIPS?

Beginning in 2019, H.R. 2 provides for bonuses ranging from 4 to 9 percent for physicians who score well in the MIPS, a new pay-for-performance program under the current Medicare fee-for-service payment system. The current matrix of penalties under the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM), would end at the close of 2018. In 2019, the MIPS program would become the only Medicare quality reporting program. Performance under the MIPS would be based upon four categories: quality, resource use, meaningful use, and clinical practice improvement activities. These would build and improve upon the current quality measures and concepts in PQRS, MU, and VBM. Physicians are specifically encouraged to report quality measures through certified EHR Technology or qualified clinical data registries. Participation in a qualified clinical data registry would also count as a clinical practice improvement activity.

Would the MIPS do a better job of rewarding physicians for high quality performance than current programs?

Performance scoring under the MIPS program has several advantages over current quality programs:

- The MIPS does not employ the VBM's "tournament model" which requires both winners and losers, thereby potentially penalizing even-high performing physicians since someone has to be a loser. In the MIPS, if all physicians perform at or above the performance threshold, no one would get a penalty.
- Performance assessment under the MIPS program would be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit would be provided to those who partially meet the performance metrics.

The bill has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.

At the start of each performance period, physicians would know the threshold score for successful performance, and they would receive timely (such as quarterly) feedback on their

individual performance.

- Physicians could receive substantial credit for clinical practice improvement activities and for improving (and achieving) quality of care.
- Physicians with a low level of Medicare claims, and those who are in APMs, would be exempt from the MIPS requirements and payment adjustments.
- The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high quality of care. For exceeding the performance threshold, physicians could earn bonuses of up to: 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and beyond. Additional funding is provided for exceptional performance, up to $500 million per year, from 2019 through 2024. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike current law, the MIPS penalties provide greater certainty, and have a maximum range in future years.

Does the bill include any liability protection for physicians?

Yes, the bill contains a provision similar to the Standard of Care Protection Act. This will protect physicians by preventing quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in medical liability cases.

How does the bill support chronic care management services?

H.R. 2 would require Medicare to reimburse, under at least one payment code, monthly care management services for individuals with chronic care needs. Payment would go to one professional practicing in a patient-centered medical home or comparable specialty practice certified by a recognized organization. No linkage is required to an annual wellness visit or initial preventive physician examination.

What does the bill say about the release of physician claims data?

Starting in 2014, CMS began to publicly release physician-identified Medicare claims data on an annual basis. The bill would continue to allow the public release of these data.

Does H.R. 2 make any positive changes to the EHR Meaningful Use program?

The bill sets a target of achieving interoperability of electronic health records by the end of 2018. It also prohibits the deliberate blocking of information sharing.

Will Medicare's plans to eliminate the 10-day and 90-day global surgical service bundles be addressed?

The decision by the Centers for Medicare & Medicaid Services (CMS) to eliminate bundled payments for 10-day and 90-day global surgical services has been reversed; instead, CMS will collect data on these services beginning in 2017 to determine the accuracy of payment rates. These data will be collected from a sample of physicians, rather than from all who bill global surgical services. To encourage participation, a 5 percent payment withhold may be applied until the required data are submitted.

Legislation removing the philosophical exemption from immunizations reborn in Senate

On Wednesday, Senators Kevin Mullin, John Campbell and Dick Sears submitted an amendment to H.98, an act relating to reportable disease registries and data, to remove the philosophical exemption to vaccines for school entry. After much debate, the vote on the bill was delayed until next Wednesday, April 22, to allow the Senate Health and Welfare Committee to hear testimony. We will be working to gather witnesses for the testimony and will keep members informed of this progress. If this amendment passes it would be sent back to the House Human Services Committee for approval.

S.141 – An act relating to possession of firearms

S.141 was voted out of House Judiciary on Tuesday. The bill in its current state would make it a crime for people convicted of violent or drug-related offenses to possess a firearm. The bill would also require the Vermont Department of Mental Health to report people with mental illness that have been adjudicated by a court to the National Instant Criminal Background Check System (NICS). In the previous version of the bill, there would have been an 18-month waiting period for people who want to remove their names from NICS, but that waiting period has been removed and instead replaced with a higher level of evidence.