The Legislative Bulletin

A publication of the Vermont Medical Society

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In This Issue:

House Rejects Governor's Proposal to Cut Medicaid Reimbursement to Physicians by 8 Percent

On April 3rd the House of Representatives passed their state fiscal year 2010 (SFY10) budget. The Office of Vermont Health Access (OVHA) section of the budget does not include Governor Douglas' proposal to cut physician Medicaid reimbursement in three areas by at least $6.6 million, which represented an eight-percent cut based on $81.7 million in projected physician payments in SFY10. In rejecting the Governor's proposal, the House understood that a payment cut of this magnitude would force physicians to limit the number of Medicaid patients they see simply in order to stay in business, thereby making patients access more expensive forms of health care such as emergency room visits.

Since the federal government and state government pay for Medicaid jointly, any reduction in payments to physicians would be significantly less than the savings to the state. The recently passed economic stimulus package increased federal support for the state's Medicaid program in SFY10 from 60 percent to approximately 70 percent. With this additional federal financial support Vermont would have to cut physician reimbursement by $3.33 for every $1.00 in state savings, thus the proposed $6.6 million cut in reimbursement to physicians would only save the state $2 million in expenditures.

While the Senate Appropriations Committee has only recently begun its work on the SFY10 budget, it has not ruled out enacting the Medicaid reimbursement cuts rejected by the House. Among the Gov. Douglas and OVHA proposals still on the table in the Senate are:

- **A Four-Percent Cut in Physician Reimbursement for All Non-Evaluation and Management Procedures: $1.7 Million Reimbursement Cut Yields Only $0.5 Million State Savings -** OVHA has recommended that Medicaid reimbursement for all non-evaluation and management procedures be reduced by four percent. This four-percent reduction is on top of the 7.5-percent reduction for the same procedures that took place on July 1, 2005 (there has not been an increase for these procedures since that date). Reimbursement for evaluation and management codes (99201-99499) would not be effected by the reduction and they would continue to be reimbursed at the 2006 Medicare rate.

- **A 50-Percent Cut in Primary Care and Case Management Fees: $2.6 Million Reimbursement Cut Yields Only $0.8 Million in State Savings -** OVHA has also recommended that the primary care and case management fees paid to primary care physicians be cut from five dollars per month to $2.50 per month. This reduction will put at risk the primary care case management program in which 60,000 beneficiaries select their Primary Care Provider (PCP). The primary care physicians seeing the most Medicaid patients would be the hardest hit under this proposal.

- **A 20-Percent Cut in Reimbursement on Most Procedures for 16,000 Medicare/Medicaid Eligible Patients: $2.3 Million Reimbursement Cut Yields Only $0.7 Million in State Savings -** OVHA has recommended paying crossover-claims at the Medicaid rate in instances in which the patient is covered under both Medicare and Medicaid. Under this proposal, the state's Medicare 20 percent beneficiary co-insurance payment (50 percent for mental health services) on behalf of the patient would be limited

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VMS-Convened Study Groups Recommendations Lead to Contract Standards Legislation in H. 444

After hearing from VMS about the need to reduce administrative burdens and red tape for physicians, the Health Care Commission last year recommended that VMS work to develop legislation to address contract and credentialing standards. Four issues addressed by the resulting legislation, Act 203, were:

- Overpayment recovery (one-year limit on recovery);
- Claim processing standards (established national coding standards and Web site disclosure);
- Prior authorization standards (if prior authorization is received, plan may not deny claim for service); and,
- Credentialing timeframes (60 days for insurers).

Other proposals addressing contracting standards and rental networks were deferred to a study led by VMS in collaboration with insurers, government agencies, practice managers and other interested parties. The study group met and issued its report to the legislature in January, including a draft bill, which was largely incorporated into this year's H. 444.

The final House Health Care committee bill, H.444, addresses timely payment, access to fee schedule information, access to claim edit information, rental networks, and most-favored nation clauses.

Timely Payment
Vermont's timely payment law, requiring payment of clean claims within 45 days was adopted more than 10 years ago. Now most health claims are submitted electronically and many other states have updated their laws to require plans to pay claims sooner than 45 days. The bill requires payment of clean claims, both paper claims and electronic claims in 30 days.

Access to Fee Schedules
Some health plans have been unwilling to provide participating health care practitioners with complete information about the fees they will pay doctors for providing health care services to their patients.

H. 444 requires plans to provide physicians with the fee schedule amounts, on request, for any codes they actually bill, or codes that physicians in the same specialty typically bill. Health care practitioners are required to maintain the confidentiality of fee schedule information they receive from a health plan and fee schedule information would also be available to practitioners who are considering whether to contract with a plan.

Access to Claim Editing Information
Act 203 required health plans to accept claims submitted consistent with national coding guidelines and standards and to disclose the standards they use on their Web sites and in their practitioner newsletters. H.444 requires plans to disclose the software they use and the additional percentage they pay for modifiers, such as those for multiple procedures, assistant surgeon, office visit on same day as surgery, or bilateral procedures. The bill also requires interested parties to study and make recommendations about the most appropriate way to ensure that health care practitioners can obtain information about edit standards.

Contract and Amendment Standards
A large percentage of Vermont's health insurance market is controlled by a few major health plans. As a result, practitioners not contracting with and joining the panels of all plans disrupt the continuity of care for their patients, and most health care practitioners, particularly small ones, have very little ability to negotiate the terms of their contracts with insurers. In addition, their expertise is practicing medicine, not contract negotiation. The bill creates standards for contracts addressing contract amendment, disclosure of products covered by the contract, term of the contract, termination notice period, and mechanisms for resolving grievances.

The bill also requires a summary disclosure form or executive summary of the contract to be included with contract and amendments as contracts are often more than 20 pages long.

Most Favored Nation Clauses
Most favored nation clauses are used by health plans to prevent practitioners from granting better discounts to other health plans. Examples include clauses that require practitioners to accept lower payment from one payer if they agree to accept lower payment from another payer or clauses that allow payers to terminate contracts if practitioners agree to lower rates with other payers. The bill prohibits the use of "most-favored nation" clauses.

Rental Networks (Silent PPOs)
Some entities such as health plans, employers and brokers have created a secondary market in renting the networks of physicians who have contracted with one plan to other plans, thereby renting the reimbursement rates that the physicians have agreed to in their contracts with the first health plan. This rental is done without government regulation and often without the physician's knowledge or consent. The renter of the network may not be required to comply with all the terms of the underlying contract and a renter using the discounted rate may not cease use

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H. 444 Addresses Partner Treatment for Chlamydia, Stroke Treatment and Adult Vaccines

In addition to contract standards *(see page 2)*, H. 444 addresses three other areas of concern to Vermont's physicians. They are:

Partner Treatment for Chlamydia
Section 40 of H. 444 will enable health care practitioners to treat partners of patients with chlamydia without examination. Referred to as expedited partner therapy (EPT) this involves treating the sex partners of persons with sexually transmitted diseases without a medical evaluation or professional prevention counseling, most often through patient-delivered partner therapy. Wendy Davis, M.D., Commissioner of Health testified in support of this section of this bill, which is consistent with Centers for Disease Control (CDC) guidelines. According to the Department of Health, approximately 1,000 cases of chlamydia are reported each year in Vermont, which may result in a larger number of infected partners, many of whom do not receive treatment. For more information, please see the CDC Final Report on Expedited Partner Treatment in the Management of Sexually Transmitted Diseases: *http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf*

Stroke Treatment
Section 41 authorizes the Vermont Association of Hospitals and Health Systems to convene stroke treatment specialists from Fletcher Allen and Dartmouth-Hitchcock, along with representatives of the American Heart Association/American Stroke Association, in order to report on ways to integrate timely and effective evidence-based treatments into the delivery of health care in Vermont. The report will include information about the capacity of hospitals to provide emergency treatment of strokes following evidence-based guidelines, services offered by hospitals and hours of availability. The report will also include recommendations on needed additional services or infrastructure and ways to improve coordination and communication between hospitals and treating physicians.

Adult Vaccine Program
Section 42 creates an immunization pilot program designed to enable the Department of Health to purchase adult vaccines in bulk and distribute them to health care professionals throughout the state. If passed, an advisory group would identify vaccines to be included in the pilot project, target a patient utilization goal for each vaccine, calculate the administrative surcharge needed to run the program, and design an evaluation to measure the program's success. The pilot would run from Jan. 1, 2010 through Dec. 31, 2012 and is intended to operate in the same manner as the highly successful program for purchase and distribution of pediatric vaccines.

House Rejects Governor's Proposed Reimbursement Cuts

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to the Medicaid amount. For procedures where the Medicaid fee schedule is less than 80 percent of Medicare, physicians would receive no payment for the 20 percent co-insurance amounts paid by patients under Medicare Part B.

Under the proposed policy, primary care physicians would receive a 12-percent cut in their reimbursement for most routine office visits, since Medicaid is paying 88 percent of the current Medicare rate for 99213, the most frequently billed evaluation and management code. Based on information from FAHC, VMS believes the impact of this cut might be as much as $8 million, four times greater than the OVHA estimate.

In order to help ensure that Vermonters covered by the Medicaid program have continued access to medical services, VMS urges you contact members of the Senate Appropriations Committee by calling the Statehouse at 802-828-2228 or writing a letter and asking them to reject the Governor's proposals to cut Medicaid reimbursement to physicians.

Senate Appropriations Committee

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Sen. M. Jane Kitchel, Vice Chair
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Sen. Vincent Illuzzi
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Sen. Peter Shumlin
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Sen. Diane Snelling, Clerk
304 Piette Rd., Hinesburg, VT 05461–*dsnelling@leg.state.vt.us*

Contract Standards Legislation Considered in House

(cont'd from page 2)
of the discount when the underlying contract is terminated. In all, about 15 entities engage in this practice in Vermont.

The bill ensures oversight and accountability by requiring contracting entities to register with the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) if they are not already licensed or registered. The bill also creates transparency and legal requirements for rental networks. As well, health care practitioners must agree to this type of rental transaction in the underlying contract and a contracting entity engaging in this practice must:

- Create a list – posted on its Web site and updated at least every 90 days – of third parties with access to the network and discounts;
- Require the third party to identify the source of the contract discount on each remittance advice or explanation of payment form; and
- Notify the third party of termination of the underlying contract and require the third party to cease claiming the discount or other contract rights after termination.

The bill clarifies BISHCA's authority to enforce the contract standards provisions enacted last year and this. BISHCA may examine and investigate contracting entities, order them to cease violations and may impose administrative penalties of up to $1,000 for each violation and up to $10,000 for each willful violation. At the option of either party, the law may also be enforced by binding arbitration.

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