HEALTH POLICY TASK FORCE
Coeur d’Alene Golf & Spa Resort
Saturday, May 16, 2009
1 – 2:30 p.m.
Coeur d’Alene, Idaho

BUSINESS MEETING
Presiding:
Co-Chair: Kentucky Sen. Julie Denton
Co-Chair: Alabama Sen. Vivian Davis Figures

I. Welcome and Member Introductions

II. Review & Approval of Meeting Summary from 2008 Annual Meeting

III. Suggested State Legislation
(http://ssl.csg.org/dockets/2010cycle/30B/30Bdocmins/docket30bfinal.pdf, pp. 181 and following)

21-30B-01 Hospital Uninsured Patient Discount IL
21-30A-14 Health Care Cost Containment and Transparency MA
21-30B-02 Long-Term Care Patient Access to Pharmaceuticals PA
21-30B-03 Heart Attack and Stroke Centers MO
21-30B-04 Surrogate Decision-Making Committees NY
21-30B-05 Physician Orders for Life-Sustaining Treatment ID
21-30B-06 Advocating Donating Organs NJ
21-30B-07 Disclosure of Contractual Arrangements with Health Insurance Carriers VA
21-30B-08 Opioid Treatment IN
21-30B-09 Medication Therapy Management MODEL
21-30A-10 Health Information Exchange RI
21-30B-10A Health Informatics Corporation IN
21-30B-10B Health Services Authority TX
21-30B-10C Health Information Technology VT
21-30B-11 Advancement in Stem Cell Cures and Therapies OK

Task Force members will consider, discuss, and vote on health legislation submitted for review. Recommendations are forwarded to the Suggested State Legislation Committee for consideration and final determination about inclusion in CSG’s annual Suggested State Legislation publication.

IV. Health Policy Task Force Work Plan for 2009-2010: Task Force Discussion
V. Federal Stimulus Impacts on State Health Policy and Services: Discussion

Jim Mason, Senior Advisor to the Director
Office of Intergovernmental Affairs,
U.S. Department of Health and Human Services (Invited)

VI. Adjourn
HEALTH POLICY TASK FORCE
POLICY & BUSINESS SESSION
Friday, Dec. 5, 2008
9 a.m.-12:15 p.m.
Omaha, NE

MEETING SUMMARY
Presiding:
Co-Chair: Ms. Paula Roy, Delaware Health Care Commission
Co-Chair: Senator Mattie Hunter, Illinois

Members in Attendance:
Gary Blalack, GlaxoSmithKline
Laura Boone, Alzheimer’s Association
Ellen Brull, M.D., American Academy of Family Physicians
Representative Jeff Delzer, North Dakota
Joan Gardner, Blue Cross Blue Shield Association
Janet Haebler, American Nurses Association
Kristin Hellquist, National Council of State Boards of Nursing
Senator Linda Higgins, Minnesota
Nancy Hublar, Golden Living
Senator Mattie Hunter, Illinois
Julie Idelkope, Pfizer
Archie Shew, Roche
Craig Mischo, Bayer
Senator Dave Pankonin, Nebraska
Paula Roy, Delaware Health Care Commission

Guests in Attendance:
David Albert, Maximus
Linda Brown, Centers for Medicare and Medicaid Services
Jean Cantrell, EDS
Carly Cole, Mutual of Omaha
David Crichlow, Hospital Corporation of America
Kristine Day, Centers for Disease Control and Prevention
Dave Dederichs, Express Scripts
Diane Ewert, American Academy of Family Physicians
Melissa Garrett, American Specialty Health
Senator Tim Gay, Nebraska
Representative Mary Glenski, South Dakota
Kellie Harry, Mutual of Omaha
Welcome & Member Introductions
Sen. Hunter, Task Force co-chair, welcomed attendees and asked all task force members seated at the table and then other guests to introduce themselves. She reminded all persons in the room to sign the attendance roster.

Policy Discussion: Likely Federal and State Roles in Health Care Reform

Guest speaker Catherine Hess, Senior Program Director of the National Academy for State Health Policy (NASHP) was introduced by Ms. Hunter. Ms. Hess discussed a conceptual framework for high performing health systems developed by NASHP with funding from the Commonwealth Fund and various state roles within the framework. States have been most active in expanding health insurance coverage and less active in adopting policies to address quality, safety and value. She also reviewed possible federal roles within the conceptual framework she
presented. She concluded with a few predictions of what health policy actions are likely in 2009 given the new Obama administration and Congress. Ms. Hess answered questions from the Task Force and guests.

**Policy Discussion: State Health Reform Initiatives in the States**

Ms. Hunter introduced Senator Chris Steineger, Kansas, who presented his proposal for state health reform. Then in round table fashion, other task force members reviewed significant health policy actions in their states. Sen. Higgins talked about scaled back health transformation in Minnesota; Sen. Delzer reviewed action in South Dakota; Ms. Roy discussed coverage, patient-centered medical home and health information technology initiatives in Delaware. Sen. Hunter reviewed health policy in Illinois.

**Review & Approval of Minutes from the 2008 Spring Meeting**

Ms. Roy took the chair to preside over the business portion of the meeting. She received a motion and a second to approve the minutes from the 2008 Spring Meeting and 75th CSG Anniversary Celebration held in Lexington, Kentucky.

**Policy Resolutions**

*Resolution on Transparency for Patients in Prescription Drug Care*

Chairperson Roy announced that the Resolution on Transparency for Patients in Prescription Drug Care was withdrawn at the request of its sponsor, Senator Kevin Coughlin (Ohio).

*Resolution Supporting Medicaid Financial Assistance in a Congressional Economic Stimulus Package*

Sen. Hunter explained that the resolution’s purpose is to urge Congressional approved of an enhanced federal matching rate for the Medicaid program as part of any economic stimulus package with direct aid to states. Further, the resolution supports establishing a provision to automatically increase the federal medical assistance percentage (FMAP) in the event of certain defined triggering events. The resolution was adopted.

*Resolution to Reduce Health Disparities Affecting HIV/AIDS*

This resolution was referred to CSG by the National Hispanic Caucus of State Legislators. Sen. Hunter reported that Representative Deborah Hudson would present this resolution to the Intergovernmental Affairs (IGA) Committee and Executive Committee on behalf of
Representative Joe Miro. The resolution expresses the support of CSG in urging Congress and the President to take decisive action to reduce health disparities, particularly as they relate to the impact of HIV/AIDS on persons of color. Three technical amendments to the resolution were adopted before the amended resolution was adopted.

Resolution to Urge Congress to Support Fair and Equal Treatment Regarding Tricare Health Benefits for All Veterans

This resolution was referred to CSG by the National Hispanic Caucus of State Legislators. Sen. Hunter reported that Representative Deborah Hudson would present this resolution to the Intergovernmental Affairs (IGA) Committee and Executive Committee on behalf of Representative Joe Miro. The Task Force discussed the resolution and agreed to defer voting on the resolution to the Spring 2009 meeting after discussing with NHCSL about whether the resolution should address other territories besides Puerto Rico.

Suggested State Legislation

Ms. Roy introduced the process and criteria which are used to select suggested state legislation (SSL). The following recommendations were adopted by the Health Policy Task Force for each piece of suggested state legislation referred to the Task Force for consideration.

21-29B-07 Outside the Hospital Do-Not-Resuscitate Order
Motion to reject adopted.

21-29B-08A Confidentiality of Prescription Drug Information
(29B-c) Request staff check on legal status, e.g., NH, VT.
Motion to reject adopted.

21-29B-09 Prescription Drug Academic Detailing Program
Motion to reject adopted.

21-29B-11 Third Party Rights and Responsibilities Under Health Care Contracts
Motion to reject adopted.

21-30A-01 Medicaid Nursing Home Bed License Buyout
Motion to reject adopted.

21-30A-02 Cancer Incidence Map
Motion to reject adopted.
21-30A-03 Long-Term Care Insurers: Genetic Tests, Genetic Information
Motion to reject adopted.

21-30A-04 Standardized Health Plan Card
Motion to reject adopted.

21-30A-05 Health Access Program Statement
Motion to reject adopted.

21-30A-06 Prescription Drug Marketing Code of Conduct
Motion to reject adopted.

21-30A-07 Volunteer Health Insurance
Motion to reject adopted.

21-30A-08 Hospital Assessment
Motion to include adopted.

21-30A-09 Health Partnership
Motion to reject adopted.

21-30A-10 Health Information Exchange
Motion to reject adopted.

21-30A-11 Remote Dispensing Pharmacy
Motion to reject adopted.

21-30A-12 Internet Prescription Sales
Motion to reject adopted.

21-30A-13A Pharmacy Benefit Managers – Registration
Motion to reject adopted.

21-30A-13B Pharmacy Benefit Managers – Disclosures
Motion to reject adopted.

21-30A-13C Pharmacy Benefit Managers – Pharmacy and Therapeutics Committees
Motion to reject adopted.
21-30A-13D Pharmacy Benefit Managers – Therapeutic Interchanges
Motion to reject adopted. MD

21-30A-13E Pharmacy Benefit Managers – Contracts with Pharmacies
Motion to reject adopted. MD

21-30A-14 Health Care Cost Containment and Transparency
Motion to reject adopted. MA

Adjournment

A motion to adjourn was made, seconded and passed unanimously.
HEALTH POLICY TASK FORCE
Coeur d’Alene Golf & Spa Resort
Sunday, May 17, 2009
9 – 11:30 a.m.
Coeur d’Alene, Idaho

WORKSHOP
“Building Blocks of Health Care Reform: State Experiences”

VII. Welcome

VIII. Expanding Coverage: Innovative SCHIP and Medicaid Policies to Increase Coverage of Uninsured Children

National Perspective: Tricia Brooks, Senior Fellow, Center for Children and Families, Georgetown University

State Perspective: Washington State speaker (to be announced)

Q and A

IX. Increasing Quality and Reducing Costs: Using Comparative Effectiveness Research and other Evidence in Health Care Policy

National Perspective: Dr. Martha Gerrity, Clinical Evidence Specialist, the Medicaid Evidence-based Decisions Project, Oregon Health and Science University

Q and A

X. Roundtable Discussion with the Experts: Redesigning Medicaid

Additional Panelists:

Shannon Turner, Executive Vice President, University Health Care Inc., Louisville, Ky.
Joan Gardner, Executive Director, State Services, Blue Cross Blue Shield Association

XI. Adjourn
Speaker Biographies
Health Workshop
Sunday, May 17, 9-11:30 a.m.

Tricia Brooks
Senior Fellow, Center for Children and Families
Georgetown University Health Policy Institute

Tricia Brooks works on policy and implementation issues affecting coverage for children and families with a focus on children who are eligible but not enrolled in Medicaid and SCHIP in her position at CCF at Georgetown University. Prior to joining CCF, Ms. Brooks served for 15 years as the SCHIP director in New Hampshire, responsible for coordinating outreach and application assistance for Medicaid and SCHIP and administering NH’s SCHIP program as a public-private partnership. Ms. Brooks holds a master in business administration from Suffolk University and a bachelor of science with honors from Mars Hill College.

Martha Gerrity, MD, MPH, PhD,
Clinical Evidence Specialist, Medicaid Evidence-based Decisions Project
Oregon Health and Science University

Martha Gerrity assists states participating in the Medicaid project to identify and prioritize topics for review, develop key questions related to the topics, review and evaluate evidence, write policy relevant reports summarizing the evidence, and she facilitates participants’ access to other resources that might inform their policy decisions. Dr. Gerrity is a professor of medicine at Oregon Health & Science University and a staff physician at the Portland VA Medical Center.

She sees patients on the inpatient wards and in the primary care clinic at the VA Medical Center. Dr. Gerrity graduated from Northwestern University’s Honors Program in Medical Education, a six-year combined BS/MD program. She did her internal medicine residency at Oregon Health & Science University (OHSU) and a fellowship at the University of North Carolina at Chapel Hill. Dr. Gerrity also completed a MPH in epidemiology and a PhD in education at UNC-CH.

Shannon R. Turner, JD
Executive Vice President
University Health Care, Inc. Louisville, KY

Prior to her current position at University Health Care, Ms. Turner served as commissioner of the Kentucky Department of Medicaid Services. In her role as commissioner, she engineered a complete Medicaid
transformation plan design and received approval from CMS for the first Deficit Reduction Act reform plan in the country. Shannon started her career in the commercial health insurance market. Ms. Turner's private health care experience includes corporate compliance, government affairs, HIPAA implementation and oversight of the clinical appeals department. She received her bachelor of arts degree from Georgetown College and her law degree from the University of Kentucky College of Law.

**Joan M. Gardner, JD**
Executive Director, State Services
Office of Policy and Representation
Blue Cross and Blue Shield Association

Joan Gardner is responsible for assisting Blue Cross and Blue Shield Plans to achieve their legislative and regulatory goals at the state level. She represents the Blue Cross Blue Shield perspective as model legislation and policy positions are developed by national organizations of state officials concerned with health insurance and managed care issues, including the financing and delivery of quality health care. The Blue Cross and Blue Shield Association is a national federation of 39 independent, community-based and locally operated companies that collectively provide healthcare coverage for more than 102 million individuals. Before joining the national Association in 1995, Ms. Gardner was vice president and government affairs counsel with Anthem Blue Cross Blue Shield in Richmond, Va., having begun her career there as associate general counsel. She has achieved the designation, Professional, Academy for Healthcare Management, and is a member of the Health Law Sections of the American Bar Association and the Virginia State Bar. She received her JD from Washington and Lee University and her BA from the University of Arkansas.

**Senator Julie Denton**
Health Policy Task Force Co-Chair
Louisville, Kentucky

Sen. Julie Denton was first elected to the Kentucky Senate in 1994 and chairs the Senate Health and Welfare committee. She also serves on the Banking and Insurance committee, as well as Tourism, Labor and Industry. Currently, she is co-chair of Kentucky's Brain Injury Task Force. Sen. Denton is from the 36th district in Jefferson County (Louisville).

She is a graduate of the University of Louisville and a dental hygienist. Sen. Denton is a member of Leadership Kentucky and has participated in a political exchange program in Japan with the American Council of Young Political Leaders (ACYPL). In 2000 she hosted political dignitaries from the Philippines through ACYPL. Sen. Denton has received numerous awards for her work and dedication to the people of her district and Kentucky.
I. Welcome
Debra Miller, health policy director, The Council of State Governments
Moderator: Patricia Stewart, Coordinated School Health Director, Idaho Department of Education

II. Reducing Disparities in HIV/AIDS, other Sexually Transmitted Diseases and Teen Pregnancy
Topic: reducing adolescent sexual risk behaviors through effective school and community strategies
- Brad Victor, Oregon Department of Education, to discuss the Oregon Youth Sexual Health Plan (http://www.oregon.gov/DHS/children/teens/ttp/yhsp-021109.pdf)
- Cynthia Morrison, Washington Department of Health

III. State Legislation to Prevent HIV/AIDS and other STDs
- Expedited partner therapy legislation – Utah HB17 (enacted March 2009), Sen. Stephen H. Urquhart
  - Related bill: Utah HB 15 (enacted March 2008), to educate public and medical providers on prevention and treatment of STDs
- HIV testing as part of routine medical care – Montana SB350 (enacted April 2009), Sen. Kim Gillan

IV. Panel Discussion: State Policies to Prevent HIV/AIDS, other STDs and Teen Pregnancy
Speakers will participate in the panel discussion and respond to audience questions.

V. Complete session evaluation and adjourn.
HEALTH WORKSHOP
“Preventing HIV/AIDS, STDs and Pregnancy in Youth”
Sunday, May 17, 2009, 1:30-3 p.m.
Coeur d’Alene, Idaho

Patricia Stewart, Director of Coordinated School Health
Idaho Department of Education

Pat Stewart directs the Idaho Coordinated School Health program and has more than 30 years experience in health and physical education, including HIV Health Education. She has program oversight responsibilities for health education programs throughout the state and has worked in research, training and management of federal programs. Pat has worked in both the public and private sector in Idaho for the last seven years. Her experience prior to that included more than 10 years with the South Dakota Department of Education as well as 13 years as a teacher in South Dakota public schools.

Brad Victor, Sexuality Education Programs Specialist
Oregon Department of Education

Brad Victor has worked as the sexuality education specialist at the Oregon Department of Education for the past 11 years. He has taught health, sexuality education, fitness and substance abuse education at the middle school, high school and college level for 23 years. Brad participates in many health-related organizations in Oregon and has presented more than 100 workshops on student health issues across the state. Brad was honored with the Oregon Health Educator of the Year award of 2006, and the Indian Education Administrator of the Year award in 2006. Brad is also pursuing a Ph.D. in Adult Learning at Oregon State University.

Cynthia M. Morrison, Sexually Transmitted Disease Education Coordinator
Washington Department of Health

Cynthia Morrison manages the STD Education program for Washington State’s Department of Health. She is a frequent speaker and has conducted multiple workshops on prevention and treatment of STDs for health services professionals. Cynthia was professor of psychology and human sexuality at South Puget Sound College for several years where she received the Eleanor Neal Judah Exceptional Faculty Award for 2001. She holds a B.A. in psychology from the University of Washington and a master of Applied Behavioral Science from the Bastyr University in Washington.
Utah Senator Stephen H. Urquhart

Sen. Stephen Urquhart has been a member of the Utah State Legislature since 2000, and a Senator since 2008. He is a member of the Business and Labor Committee and is Chair of the Transportation and Public Utilities and Technology Committee. Sen. Urquhart practices law in St. George, Utah, and has been active in the leadership of CSG-WEST and was a 2002 CSG Toll Fellow graduate.

Montana Senator Kim Gillan

Sen. Kim Gillan is currently serving her second 4-year term in the Montana State Senate and served in the Montana Legislature since 1997. She is the Senate Minority Whip, and is a member of Committees on Taxation, Local Government and Rules. Sen. Gillan is a Workforce Development and Training Coordinator at the Montana State University, Billings. She is active in CSG-WEST and serves as Chair of WESTRENDS, and was a 2000 CSG Western Legislative Academy graduate as well as a 2002 CSG Toll Fellow graduate.
Suggested State Legislation
2009 Spring Meeting Docket Book
Health
SSL CRITERIA

- Does the issue have national or regional significance?
- Are fresh and innovative approaches available to address the issue?
- Is the issue of sufficient complexity that a bill drafter would benefit from having a comprehensive draft available?
- Does the bill or Act represent a practical approach to the problem?
- Does the bill or Act represent a comprehensive approach to the problem or is it tied to a narrow approach that may have limited relevance for many states?
- Is the structure of the bill or Act logically consistent?
- Is the language and style of the bill or Act clear and unambiguous?

The word —Act‖ as used herein refers to both proposed and enacted legislation. Attempts are made to ensure that items presented to committee members are the most recent versions. However, interested parties should contact the originating state for the ultimate disposition in the state of any docket entry in question, including substitute bills and amendments. Furthermore, the Committee on Suggested State Legislation does not guarantee that entries presented on its dockets or in a Suggested State Legislation volume represent the exact versions of those items as enacted into law, if applicable.

PRESENTATION OF DOCKET ENTRIES

Docket ID#

Title State/source Bill/Act Summary: [These are typically excerpted from bill digests, committee summaries, and related materials which are contained in or accompany the legislation.]

Status: [Action taken on item in source state.]

Comment: [Contains references to other bills or information about the entry and issues the members should consider in referring the entry for publication in SSL. Space may also be used to note reaction to an item, instructions to staff, etc.]

Disposition of Entry: [Action taken on item by the taskforce(s) and committee(s).] CSG policy task force recommendations to The Committee on Suggested State Legislation:
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action (The task force did not make a recommendation about this item.)

Comments/Note to staff:

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This Act:

- provides that a hospital, other than a rural hospital or critical access hospital, shall provide a discount from its charges to any uninsured patient who applies for a discount and has family income of not more than 600% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter;
- provides that a rural hospital or critical access hospital shall provide a discount from its charges to any uninsured patient who applies for a discount and has annual family income of not more than 300% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter;
- provides that hospitals may make the availability of a discount and the maximum collectible amount under the act contingent upon the uninsured patient first applying for coverage under public programs, such as Medicare, Medicaid, Allkids, the state Children's Health Insurance Program, or any other program, if there is a reasonable basis to believe that the uninsured patient may be eligible for such program;
- provides for exemptions and limitations;
- provides for enforcement of the act by the attorney general,
- provides for the assessment of a civil monetary penalty not to exceed $500 for a hospital's knowing violation of the Act by pattern or practice; and
- limits the concurrent exercise of home rule powers.

Submitted as:
Illinois
Public Act 095-0965

Comment: According to a September 24, 2008 article in the Chicago Tribune,

“A groundbreaking bill extending hospital discounts to people without health insurance has become law, after the legislature overturned Gov. Rod Blagojevich’s amendatory veto.

“The legislation requires hospitals to offer significant discounts to uninsured Illinoisans. Instead of paying the full stocker price – typically two to three times the actual cost of care – consumers will pay charges based on the actual cost of care plus a 35 percent markup.”

“Illinois will become the first state in the nation to limit the amount that uninsured consumers pay any given hospital in a single year under the new legislation. That cap is set at 25 percent of an individual’s gross income.”

According to the Illinois General Assembly website: A summary of the Governor’s Amendatory Veto Message:
• Recommends that the definition of “uninsured discount factor” mean 1.0 less the product of a hospital’s cost to charge ratio multiplied by 1.20 for uninsured patients with family income above 200% of the federal poverty level and 1.0 for uninsured patients with family income at or below 200% of the federal poverty level (instead of just multiplied by 1.35).

Makes changes in family income requirements in the provision concerning eligibility for uninsured patient discounts.

• Provides that for all children with juvenile diabetes, a hospital shall provide children with juvenile diabetes who are admitted for a diagnosis related to juvenile diabetes a 50% discount on any co-pay, coinsurance, or deductible that they would have otherwise owed if such a discount were not available.

• Deletes certain patient disclosure requirements in the provisions concerning uninsured patient discounts and patient responsibility.

• Provides that hospitals shall permit an uninsured patient to apply for a discount within 120 days (instead of 60 days) of the date of discharge or date of service.

• In the provision concerning enforcement, replaces all references to the Attorney General with the Illinois Department of Public Health; replaces the Attorney General Court Ordered and Voluntary Compliance Payment Projects Fund with the General Revenue Fund; and deletes a requirement for the use of moneys in the Attorney General Court Ordered and Voluntary Compliance Payment Projects Fund.

• Makes other changes.

Disposition: 21-30B-01

CSG policy task force recommendations to The Committee on Suggested State Legislation:
2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action

Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
   ( ) next task force mtg.
   ( ) next SSL mtg.
   ( ) next SSL cycle
( ) Reject

Comments/Note to staff:
This Act establishes a state health care quality and cost council to promote public transparency about the quality and cost of health care in the state, improve health care quality, reduce racial and ethnic health disparities and contain health care costs. It will do this by collecting and disseminating health care quality and cost data to consumers, health care providers and insurers, establishing quality improvement and cost containment goals; and establishing standard performance measures, quality performance benchmarks and statewide health information technology adoption goals for health care providers.

The council shall disseminate the data it collects through a publicly-accessible consumer health information website; reports on performance provided to health care providers; and any other analysis and reporting the council deems appropriate.

When collecting data, the council shall, to the extent possible, use existing public and private data sources and agency processes for data collection, analysis and technical assistance. The council may enter into an interagency service agreement with the division of health care finance and policy for data collection analysis and technical assistance. The council can also contract with an independent health care organization for data collection, analysis or technical assistance related to its duties.

Insurers and health care providers must submit data to the council, to an independent health care organization with which the council has contracted, or to the division of health care finance and policy, as required by the council’s regulations. The council, through its rules and regulations, may determine what type of data may reasonably be required and the format in which it shall be provided.

The council can ask third-party administrators to submit data to the council, to an independent health care organization with which the council has contracted, or to the division of health care finance and policy. The council, through its rules and regulations, may determine the format in which the data shall be provided. The council shall publicly post a list of third-party administrators that refuse to submit requested data.

The council must maintain a consumer health information website. The website shall contain information comparing the quality and cost of health care services and may also contain general health care information as the council deems appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website.

The Act establishes an advisory committee to the health care quality and cost council.

It establishes an institute for health care innovation, technology and competitiveness, to be known as the e-Health Institute. The institute shall advance the dissemination of health information technology across the commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.
The Act establishes a health information technology council to advise the institute on the dissemination of health information technology across the state, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.

The Act sets up a fund dedicated to supporting the advancement of health information technology in the commonwealth, including, but not limited to, the full deployment of electronic health records. There shall be credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized by the general court and designated thereto; any federal grants or loans; any private gifts, grants or donations made available; and any income derived from the investment of amounts credited to the fund.

Any plan approved by the board and every grantee and implementing organization that receives monies for the adoption of health information technology shall:

- establish a mechanism to allow patients to opt-in to the health information network and to opt-out at any time;
- maintain identifiable health information in physically and technologically secure environments by means including, but not limited to: prohibiting the storage or transfer of unencrypted and non-password protected identifiable health information on portable data storage devices; requiring data encryption, unique alpha-numerical identifiers and password protection; and other methods to prevent unauthorized access to identifiable health information;
- provide individuals the option of, upon request, obtaining a list of individuals and entities that have accessed their identifiable health information; and
- develop and distribute to authorized users of the health information network and to prospective network participants, written guidelines addressing privacy, confidentiality and security of health information and inform individuals of what information about them is available, who may access their information, and the purposes for which their information may be accessed.

The Act establishes a health care workforce center to improve access to health care services. The center, in consultation with the health care workforce advisory council shall coordinate health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention and monitor trends in access to primary care providers, nurse practitioners practicing as primary care providers, and other physician and nursing providers. This includes:

- reviewing existing data and collection of new data as needed to assess the capacity of the health care workforce to serve patients, including patient access and regional disparities in access to physicians or nurses and to examine physician and nursing satisfaction;
- reviewing existing laws, regulations, policies, contracting or reimbursement practices, and other factors that influence recruitment and retention of physicians and nurses;
- making projections about the ability of the workforce to meet the needs of patients over time;
- identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention;
- studying the capacity of public and private medical and nursing schools in the commonwealth to expand the supply of primary care physicians and nurse practitioners practicing as primary care providers;
- establishing criteria to identify underserved areas and to determine statewide target areas for health care provider placement based on the level of access;
- address health care workforce shortages through the following activities, including coordinating state and federal loan repayment and incentive programs for health care providers;
- providing assistance and support to communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives;
- maximizing all sources of public and private funds for recruitment initiatives;
- designing pilot programs and make regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and
- making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians and nurses.

The Act directs the institute director to prepare and annually update a statewide electronic health records plan, and an annual update thereto. Each plan must contain a budget for the application of funds from the E-Health Institute Fund for use in implementing each such plan. The institute director shall submit such plans and updates, and associated budgets, to the council for its approval. Each such plan and the associated budget must be subject to approval of the board following action on it by the council.

Components of each such plan, as updated, shall be community-based implementation plans that assess a municipality’s or region’s readiness to implement and use electronic health record systems and an interoperable electronic health records network within the referral market for a defined patient population. Each such implementation plan shall address the development, implementation and dissemination of electronic health records systems among health care providers in the community or region, particularly providers, such as community health centers that serve underserved populations, including, but not limited to, racial, ethnic and linguistic minorities, uninsured persons, and areas with a high proportion of public payer care.

The Act establishes a health care workforce loan repayment program, administered by the health care workforce center. The program shall provide repayment assistance for medical school loans to participants who:
- are graduates of medical or nursing schools;
- specialize in family health or medicine, internal medicine, pediatrics, psychiatry, or obstetrics/gynecology;
- demonstrate competency in health information technology, including use of electronic medical records, computerized physician order entry and e-prescribing; and
- meet other eligibility criteria, including service requirements, established by the board.
The Act directs the state health department shall, in cooperation with state university medical school develop, implement and promote an evidence-based outreach and education program about the therapeutic and cost-effective utilization of prescription drugs for physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs.

The law requires all insurance carriers to recognize nurse practitioners as participating providers and include coverage on a nondiscriminatory basis to their insured’s for care provided by nurse practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a nurse practitioner who is a participating provider and is practicing within the scope of his professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the state.

The Act directs the state Medicaid office to establish a medical home demonstration project to the extent certain funding is available.

The Act directs the state university medical school to establish and maintain an enhanced learning contract program available to medical students every academic year. The program shall provide full waivers of tuition and fees at the state university medical school. In exchange for the waivers, the contract shall require at least 4 years of service within the state in areas of primary care, public or community service or underserved areas, as determined by the health care workforce center.

The Act sets up a Nursing and Allied Health Workforce Development Trust Fund to develop and support short-term and long-term strategies to increase the number of public and private higher education faculty and students who participate in programs that support careers in fields related to nursing and allied health.

This Act establishes a pilot grant or loan program to assist hospitals, community health centers, and physician practices in providing housing grants or loans for health care professionals who commit to practicing in underserved areas.

Submitted as:
Massachusetts
Chapter 305 of the Acts of 2008
Comment:

Disposition: *21-30A-14

CSG policy task force recommendations to The Committee on Suggested State Legislation:
2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
   ( ) next task force mtg.
   ( ) next SSL mtg.
   ( ) next SSL cycle
( ) Reject

Comments/Note to staff:

21-30B-02 Long-Term Care Patient Access to Pharmaceuticals    PA

This Act provides a mechanism whereby patients who have the ability to acquire lower cost drugs through the Veterans' Administration have access to those drugs if they reside in a long-term care facility. This means permitting the pharmacy within the long-term care facility or which has a contract with the long-term care facility to receive the lower cost drugs directly from the Veterans' Administration Drug Benefit Program in the patient's name and repackage and relabel those drugs so they may be dispensed in unit doses to the patient.

Submitted as:
Pennsylvania
HB2034

Comment:

Disposition:

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:
SSL Committee Meeting: 2010B

( ) Include in Volume
( ) Defer consideration
  ( ) next task force mtg.
  ( ) next SSL mtg.
  ( ) next SSL cycle
( ) Reject

Comments/Note to staff:

21-30B-03 Heart Attack and Stroke Centers     MO

Under prior law, a hospital could be designated as a trauma center so severely injured patients can be transported to the nearest designated trauma center. The Act changes the laws regarding hospital designations by the state department of health and senior services to include a STEMI center and a stroke center if it meets the department's applicable level of STEMI or stroke center criteria. "ST-Elevation Myocardial Infarction" (STEMI) is defined as a type of heart attack in which impaired blood flow to the heart is evidenced by findings in electrocardiogram analysis.

This Act directs the department of health to:

- compile and assess peer-reviewed and evidence-based clinical research and guidelines that provide or support recommended treatment standards for STEMI and strokes;
- assess the capacity of the emergency medical services system and hospitals to deliver recommended treatments in a timely fashion;
- establish protocols for transporting STEMI patients to STEMI centers and stroke patients to stroke centers;
- establish regions within the state for coordinating the delivery of STEMI and stroke care;
- promote the development of regional or community-based plans for transporting STEMI and stroke patients to STEMI and stroke centers; and
- establish procedures for the submission of community-based or regional plans for department approval.

Submitted as:
Missouri
Senate Substitute for House Committee Substitute for House Bill No. 1790
[Truly Agreed to and Finally Passed]

Disposition: 21-30B-03

CSG policy task force recommendations to
This Act provides that a surrogate decision-making committee shall act as guardian of a mentally retarded person who otherwise has no other person to act as a guardian for the purpose of making a decision to withhold or withdraw life-sustaining treatment. It also provides for nonbinding dispute mediation when a party objects to a decision relating to life sustaining treatment of a mentally retarded person.

Submitted as:
New York
Chapter 262 of 2008
Comment:
(EXCERPTED FROM) SPONSORS MEMO:
NEW YORK STATE SENATE INTRODUCER'S MEMORANDUM IN SUPPORT
BILL NUMBER: S7752
SPONSOR: HANNON
JUSTIFICATION:

The Health Care Decisions Act (HCDA) for persons with Mental Retardation was originally enacted as Chapter 500 of the Laws of 2002. It has been subsequently amended three times to expand decision making authority to all types of guardians appointed pursuant to Article 17-A. Most recently, it was amended to authorize family members close to an individual with mental retardation to act as a guardian for purposes of making a decision regarding life-sustaining treatment.
The HCDA gives these guardians and family members the authority to withhold or withdraw life-sustaining treatment, subject to extreme end-of-life circumstances and rigorous oversight. The HCDA recognizes that under New York State law persons with mental retardation may be denied their right to refuse life-sustaining treatment, which only serves to prolong the agony of death since, as a class, they often lack the ability to make their wishes known in clear and convincing terms.

The HCDA has been steadily expanded, both to protect vulnerable persons who cannot speak for themselves and in recognition of court decisions which characterized the Act's standards and procedures as very significant, substantial and strict (MATTER OF MB, 6 NY3d 437 2006). Further, the Court Of Appeals noted that in light of the significant procedural protections afforded in SCPA 1750-b, the rights of mentally retarded persons would be safeguarded. In other court decisions, the HCDA has been upheld because these protections, among other things, require a thorough analysis of all aspects of the patient's medical state, prognosis and expressed wishes before permitting the rejection of life-sustaining treatment (MATTER OF CHANTEL, 34AD3d99 2006).

Consecutive lower court decisions have echoed these themes. The strength of the HCDA is not that guardians are decision makers but that their decisions, as noted by New York's courts, are subject to such strict oversight.

The HCDA has functioned smoothly for six years, earning the trust of advocates, parents and state officials. It has consistently passed court muster as a means of making end-of-life decisions in the best interests of individuals who cannot decide for themselves. It has given innumerable families the assurance that their loved one will be spared a painful death prolonged by futile treatment.

However, laws have not yet been enacted to cover all of those individuals with mental retardation who cannot decide for themselves. Still remaining are those who have no guardian or committed family members to advocate for them. Of the vulnerable individuals that the HCDA was intended to protect, these are the most vulnerable. Yet, they, of all individuals, are not afforded the HCDA'S protections. Many are elderly, without living family members. Many were institutionalized and abandoned by their families years ago. They are, with no entity to act on their behalf, disproportionately victimized by futile medical care which only serves to prolong the agony of death. This bill would resolve this problem. It expands the authority of SDMCs, which now make major medical decision for exactly this population, to make a decision to withhold or withdraw life-sustaining treatment. To do this, SDMCS would be required to follow the strict standards and procedures, tailored specifically for this decision, contained in Section 1750-b of the SCPA, the HCDA. SDMCs are administered by the Commission on the Quality of Care and Advocacy for people with Disabilities (CQCAPD). Created in 1985, SDMCs operated on a pilot basis in a handful of counties. In 1995 advocates successfully persuaded the Governor to expand SDMC coverage into every county in New York State. SDMCs have the explicit responsibility for making major medical decisions for persons who do not have the capacity to make those decisions for themselves and have no surrogate, such as a parent or guardian, to decide on their behalves. SDMCs have, over the years, gained a superb reputation among advocates, providers and family members for their compassion and competence. They consist of
trained volunteers who hear individual cases, backed up by staff from the CQCAPD, and utilize the extensive advice of medical personnel including physicians, nurses and other professionals.

In giving SDMCs the authority to make this critical decision for individuals without a guardian or involved family member, this bill would complete the Health Care Decisions Act. It would finally provide a uniform process, approved by the courts and lauded by parents and advocates, to protect the right of all persons with mental retardation to refuse treatment that only prolongs the agony of death.

Further, by using existing mechanisms in the health care system, the bill seeks to moderate the complexity and expense now required to resolve disputes emanating from an objection to a decision rendered pursuant to Section 1750-b. Specifically, instead of going directly to court, the bill would refer disputes to dispute resolution systems established pursuant to section 2972 of the Public Health Law or hospice ethics committees, if available, for non-binding resolution. In the event such mediation entity is not available or cannot resolve a dispute within 72 hours, the time period currently specified in statute for dispute resolution systems, the matter would be referred to court for judicial review.

Courts are often unfamiliar and uncomfortable with these kinds of issues. They lack knowledge of the unique needs of persons with mental retardation. Families often cannot afford legal representation. Certainly it makes sense to provide a means to resolve an objection before it goes to court and avoid the needless expense and inconvenience to courts and families as well as the suffering of the individuals with mental retardation who are intended to benefit from the HCDA.

LEGISLATIVE HISTORY:

Disposition: 21-30B-04

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action

Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
( ) next task force mtg.
This legislation enables the use of an end-of-life planning form called a “Physician Orders for Scope of Treatment (POST).” Although similar in intent to a “Do Not Resuscitate” (DNR) order or other advance directives, the form provides greater flexibility in selecting treatment options, acts as a physician’s order, and provides a high degree of portability because it is recognized across care settings.

Submitted as:
Idaho
HB119
Status: Enacted into law in 2007.

Comment:

According to the Alzheimer’s Association, a physician orders for life-sustaining treatment (POLST) form is a form an individual voluntarily completes with his or her doctor clearly stating which treatments are to be given to that person at the end of his or her life. At least eight states currently recognize POLST forms, including California, Idaho, New York, North Carolina, Oregon, Tennessee, Washington and West Virginia. Although the names of the program may differ slightly (such as the Idaho’s POST program), the programs are essentially the same.

A POLST form is a standardized form and easily recognizable because it is printed on brightly colored paper. It is intended for people with a terminal illness, anyone in a nursing home, or anyone expected to die within the next year. The POLST form offers more choices than a DNR, which typically gives people just two choices if they go into cardiac arrest: resuscitate or do not resuscitate. On a POLST form, people can record their choices about feeding tubes, intubation, mechanical ventilation, IV fluids, comfort measures, or other treatments.

The elections in a POLST form constitute a physician’s order. While advance directives merely express a person’s wishes, the POLST form translates those wishes into medical orders that healthcare professionals such as EMT’s and physicians must follow.

POLST follows patients across care settings. When someone moves from a nursing home to the hospital or is discharged from the hospital and returns to his or her own home, a DNR or advance directive is not guaranteed to stand in the new setting. With a POLST form, however, the physician’s order is enforceable regardless of setting. Most states with POLST programs, such as Idaho, include in their POLST laws that if there is a disagreement between an advance
directive or other end-of-life planning document and a POLST form, the POLST form legally trumps the advance directive.

If the person lives at home, the brightly colored POLST form is taped to the refrigerator, so it can be located easily in a medical emergency. If the person lives in a long-term care facility, the form goes in his or her chart. In Idaho, the state also authorized the development of a standardized piece of identification jewelry POST program participants can wear. Paramedics in POLST states are trained to check for a POLST form before making treatment decisions. When transporting a person to a hospital, paramedics physically attach the POLST form to the patient, so physicians and other hospital staff can align care with the person’s wishes as expressed on the POLST form.

Disposition: 21-30B-05

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
( ) next task force mtg.
( ) next SSL mtg.
( ) next SSL cycle
( ) Reject
Comments/Note to staff:
This Act mandates instructing public high school, higher education, medical school and nursing school students and professionals about the myths associated with organ donation, provide accurate information, and emphasize the fundamental responsibility of people to take appropriate action, when able, to help save another person’s life. The Act also directs the state motor vehicle commission to develop an Internet-based process to enable people to designate their preference to donate an organ if they use the Internet to obtain or renew a driver’s license or personal identification card.

The Act directs the state board of education, in consultation with the organ procurement organizations, to review the state Core Curriculum Content Standards for Comprehensive Health and Physical Education to ensure that information about organ donation is included therein to students in grades 9 through 12, beginning with the 2008-2009 school year. The goals of the instruction are to emphasize the benefits of organ and tissue donation to the health and well-being of society generally, and to individuals whose lives are saved by organ and tissue donations, so that students will be motivated to make an affirmative decision to register as a donor when they become adults. The instruction is to explain the options available to adults, including the option of designating a decision-maker to make the donation decision on one’s behalf, and instill an understanding of the consequences when an individual does not make a decision to become an organ donor and does not register or otherwise record a designated decision-maker. Students also will be advised that beginning five years from the date of enactment of this bill, the MVC will not issue or renew a driver’s license or personal identification card unless a prospective or renewing licensee or card holder makes an acknowledgement regarding the donor decision. Instructional materials are to be made available to private high schools, which are encouraged to use them.

Similarly, this information is to be provided at each public institution of higher education in the State beginning with the 2008-2009 school year, either through student health services or as part of the curriculum, and the information likewise is to be prepared in collaboration with the State’s federally-designated OPOs. Independent institutions of higher education in the State are encouraged to provide this information to their students.

The State Board of Medical Examiners and the state Board of Nursing, in collaboration with the designated OPOs, are to prescribe by regulation requirements for physician and professional nurse training as follows:

- The curriculum in each school in the state shall include instruction in organ and tissue donation and recovery designed to address clinical aspects of the donation and recovery process. Completion of such instruction will be required as a condition of receiving a diploma.
- A college of medicine or nursing program which includes instruction in organ and tissue donation and recovery in its curricula shall offer such training for continuing education credit.
- A physician licensed to practice prior to the effective date of this bill, who was not required to receive and did not receive such instruction as part of the physician’s school curriculum, is encouraged to complete training in organ and tissue donation and recovery no later
than three years after the effective date of the bill through an on-line credit-based course developed by or for the OPOs.

- a professional nurse registered in this state prior to the effective date of this bill, who was not required to receive and did not receive such instruction as part of the nurse’s school curriculum, shall be required, as a condition of license renewal, to document completion of such training no later than three years after the effective date of the bill. The training may be completed through an on-line, one credit hour course developed by or for the OPOs and approved by the board. The board may waive this training requirement if an applicant for relicensure demonstrates that he or she has attained the substantial equivalent to the required training.

Within six months after the effective date of the bill, the Chief Administrator of the MVC is to ensure access by residents to an Internet-based interface, to be known as the Donate Life NJ Registry, that promotes organ and tissue donation and enables residents who are 18 years of age or older to register as donors and have their decisions immediately integrated into the current database maintained by the commission. The database shall include only affirmative donation decisions. Registration shall be provided at no cost to the registrant. Donor information entered into the registry shall supersede any prior conflicting information provided to the registry or on the individual’s driver’s license or identification card.

Within one year of the effective date of the bill, the MVC is to establish a system allowing holders of state driver’s licenses or identification cards who do not have access to the on-line Donate Life Registry to add their donor designation to the registry by submitting a paper form to the MVC, at no cost to the registrant. The form and content of the registry shall be designed in collaboration with the State’s federally-designated OPOs.

Beginning five years after the effective date of the bill, no driver’s license or personal identification card shall be issued or renewed unless the applicant first addresses the issue of donation through a portal associated with the Donate Life Registry or at MVC agencies and regional service centers. The portal shall be accessible to applicants seven days per week, 24 hours per day, and shall provide for adequate security to protect an individual’s privacy. The form and content of the portal shall be designed in collaboration with the OPOs. A resident who has not registered as an organ donor, and who seeks a driver’s license or identification card or seeks renewal thereof, will have to register as an organ donor through the Donate Life Registry; or acknowledge an understanding of the life-saving potential of organ and tissue donation, and an understanding of the consequences when an individual does not make a decision to become an organ donor, and does not register or otherwise record a designated decision-maker.

Within one year of the effective date of the bill, both the registry and the official website of the MVC shall provide links through which individuals may make voluntary contributions of $1.00 or more to an Organ and Tissue Donor Awareness Education Fund established by another state law.

The MVC shall collaborate with the OPOs in applying for any federal or private grants recommended by the OPOs related to developing and implementing the Donate Life NJ Registry. The Chief Administrator of the MVC shall collaborate with the OPOs to identify, and if appropriate, apply for and accept relevant grants from the federal government, or any foundation, corporation, association or individual. The MVC, and the Departments of Human Services,
Health and Senior Services, and Law and Public Safety may collaborate with the OPOs in applying for any federal or private grants recommended by the OPOs.

This bill also provides that a designated decision-maker or agent at the time of the decedent’s death who could have made an anatomical gift immediately before the decedent’s death shall be given first priority for making a gift of a decedent’s body or part.

The bill amends a provision of the Uniform Anatomical Gift Act and provisions of the motor vehicle statutes to incorporate references to the Donate Life Registry established in the bill and to ensure that any information provided to the OPOs for related educational initiatives is aggregated and non-identifying.

Submitted as:
New Jersey
Chapter 48 of 2008

Comment:

Disposition: 21-30B-06

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
   ( ) next task force mtg.
   ( ) next SSL mtg.
   ( ) next SSL cycle
( ) Reject
Comments/Note to staff:
Section 21 of this Act requires the state health commissioner to negotiate and contract with a nonprofit organization for an annual survey of carriers offering private group health insurance policies and that are subject to reporting, to determine the reimbursement that is paid for a minimum of 25 most frequently reported health care services, and to make the survey reports public through a website operated by the contracting organization. This bill also requires carriers to report the average reimbursement paid for a specific service from all providers and provider types.

Submitted as:
Virginia
Chapter 71 of 2008

Comment:

Disposition:

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
    ( ) next task force mtg.
    ( ) next SSL mtg.
    ( ) next SSL cycle
( ) Reject
Comments/Note to staff:
This Act changes the term “methadone treatment” to “opioid treatment” for purposes of the law concerning certification of opiate addiction treatment facilities. The Act requires approval and certification for each location that an opioid treatment program is operated. It requires an opioid treatment program to periodically and randomly test a patient for the use of specified drugs; and take certain actions if the drug test is positive for an illegal drug other than the drug being used for the patient’s treatment.

This Act requires the state division of mental health and addiction to adopt rules about standards for operation of an opioid treatment program; a requirement that the opioid treatment facilities submit a current diversion control plan; and fees to be paid by an opioid treatment facility. The Act requires the division to create a central registry and prepare a biennial report.

Submitted as:
Indiana
Senate Enrolled Act No. 157

Comment:

Disposition:

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action

Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
    ( ) next task force mtg.
    ( ) next SSL mtg.
    ( ) next SSL cycle
( ) Reject

Comments/Note to staff:
The federal Medicare Part-D program requires PDPs and MA-PDs to establish medication therapy management (MTM) programs designed to ensure appropriate use of drugs by “targeted beneficiaries,” lower health care costs by improving patients’ health care outcomes, and reduce the risk of adverse events. This model legislation would create similar MTM pilot programs at the state level.

The bill generally defines “Medication Therapy Management” and related components, including the provision of the certain services by licensed pharmacists to optimize the therapeutic outcomes of a patient’s use of medications. It directs the State Medical Assistance program and State Employee Benefit Plan to reimburse pharmacists for certain MTM services separate from dispensing services; and requires the Secretary to appoint an MTM Advisory Committee, evaluate the impact of MTM on care, outcomes, and costs, and provide a report to the legislature of program results and savings directly attributable to MTM.

Submitted as:
Model
National Association of Chain Drug Stores

Status: As of March 16, 2009, no state has passed this model bill. This legislation was drafted by NACDS last fall and is based on a Minnesota statute with a number of updates. This current version has not been passed in any states.

According to the NACDS, the federal Medicare Part-D program requires PDPs and MA-PDs to establish medication therapy management (MTM) programs designed to ensure appropriate use of drugs by “targeted beneficiaries” and reduce risk of adverse events. The attached model legislation would create similar MTM pilot programs at the state-level, similar to successful efforts briefly described below, and break through the inertia in the marketplace and drive forward proven improvements to the health care system.

The health care debate has begun in earnest, with the goal of providing broad coverage to our citizens through the delivery of high-quality, efficacious and cost-effective services. During a breakout session of the White House Forum on Health Reform on March 5, 2009, Kendall Powell, chairman and CEO of General Mills, emphasized the importance and value of prevention. Powell participated on behalf of his company and on behalf of The Business Roundtable. The Associated Press said Powell “came with an idea that generated interest. His company offers several preventive coverage packages, tailored specifically to people with one of four conditions: asthma, diabetes, cardiovascular problems and back pain.” Powell said employees are “profoundly grateful” for General Mills’ emphasis on prevention: “We keep them healthy; we keep them out of the hospital; we save money for the company, which benefits everybody in the company.” In elaborating on prevention, Powell specifically mentioned the role of pharmacy: “Someone said something about medications; and I think it was the difficulty and just how hard it is... I will tell you that we have studied this for several years at General Mills. No one understands these medications. They are too complex. We have white collar,
professional, highly educated people at General Mills who do not know how to follow their meds. And so what we’re doing now – again on this prevention tact – is we’re sitting them down with a pharmacist. For as long as they need to, to understand what they’re taking, why, the consequences of withdrawal, all the interactions. And again it makes a huge difference in the management of chronic disease.”

Here are a few additional facts that emphasize the importance of medication to reduce costs, if used properly.

- U.S. spends 53% more per person on healthcare than any other industrialized nation.
- The seven most common chronic diseases inflict a $1.3 trillion annual drag on the economy.
- Failure to take medications as prescribed costs an estimated $177 billion annually.
- More than 1.5 million preventable medication-related adverse events occur each year.

Over more than a decade, the focus of pharmacy education has changed to now emphasize the role of pharmacists as the medication expert in the health care system, in preparation for an integral role of pharmacists to assure the best outcomes from medication selection and usage. Today’s pharmacists go beyond the traditional dispensing role, and provide quality patient-care services that improve health and reduce health care costs. Here are a few examples:

- In its first year, the Iowa Medicaid Pharmaceutical Care Management Project identified 2.6 medication-related problems per patient; 52% of the time pharmacists recommended new medication and 33% of the time pharmacists recommended stopping a medication. Patients receiving services had a 12.5% increase in the Medication Appropriateness Index, and a 24% decrease in the use of inappropriate meds for elderly, 60 years of age or older.
- The Minnesota Department of Health established a Medication Therapy Management Care Program. In its first year, 789 drug therapy problems were identified and resolved from among 259 patients, 73% due to inadequate therapy. The annual cost savings of $403.30 per patient were estimated for patients over 18 achieving “optimal care” for diabetes, with 41 of the 114 patients with diabetes receiving “optimal care.”
- The Missouri Medicaid Program Disease Management Program projected annualized program savings of $2.4 million based on its first year results. Patients enrolled experienced a 7.6% net decrease in healthcare utilization. Total healthcare expenditures for patients receiving services fell $6,084 per patient per year vs. the control group.

Finally, after 5 years, the Asheville Project continues to demonstrate significant savings and improved outcomes.

- Diabetes: Decrease in average direct medical costs -$1,200 to $1,872 per patient per year; 50% decrease in use of sick days; increased productivity estimated at $18,000 annually; annual average insurance claims decreased by $2,704 per patient in first follow-up year and by $6,502 per patient in fifth year.
- Cardiovascular (after 6 yrs.): Average cost per CV event decreased from $14,343 to $9,931; rate of CV events dropped from 77 out of 1,000 people to 38 out of 1,000 during the...
study period; observed > 50% decrease in risk of CV-related ED/hospital visit.

Asthma: Visits to ED dropped from 9.9% to 1.3%; hospitalizations decreased from 4% to 2%; direct cost savings averaged $725 per patient per year and indirect cost savings $1,230 per patient per year; lost work days decreased from 10.8 days per year to 2.6 days per year.

Comment:

Disposition: 21-30B-09

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
( ) next task force mtg.
( ) next SSL mtg.
( ) next SSL cycle
( ) Reject
Comments/Note to staff:

*21-30A-10 Health Information Exchange RI

This Act establishes a statewide Health Information Exchange (HIE) under state authority to allow for the electronic mobilization of confidential health care information in the state. Confidential health care information may only be accessed, released or transferred from the HIE in accordance with this Act. Patients and health care providers can choose to participate in the HIE, provided however, that provider participants must continue to maintain their own medical records documentation and other standards imposed by other applicable law.

Participation in the HIE shall have no impact on the content of or use or disclosure of confidential health care information of patient participants that is held in locations other than the HIE. Nothing in this Act shall be construed to limit, change or otherwise affect entities’ rights to exchange confidential health care information in accordance with other applicable laws.

The state imposes on the HIE the obligation to maintain, and abide by the terms of, HIPAA compliant business associate agreements, including, without limitation, using
appropriate safeguards to prevent use or disclosure of confidential health care information in accordance with HIPAA and the Act, not to use or disclose confidential health care information other than as permitted by HIPAA and this Act, or to make any amendment to a confidential health care record that a provider participant so directs and to respond to a request by a patient participant to make an amendment to the patient participant’s confidential health care record.

Under the Act, the director of the department of health shall develop regulations regarding the confidentiality of patient participant information received, accessed or held by the HIE and is authorized to promulgate such other regulations as the director deems necessary or desirable to implement the provisions of this Act.

The Act directs that a health information organization (HIO) shall be responsible for implementing recognized national standards for interoperability and all administrative, operational, and financial functions to support the HIE, including, but not limited to, implementing and enforcing policies for receiving, retaining, safeguarding and disclosing confidential health care information as required by the Act.

The Act directs that a patient participant’s confidential health care information may only be accessed, released or transferred from the HIE in accordance with an authorization form signed by the patient participant or the patient’s authorized representative. No authorization for release or transfer of confidential health care information from the HIE shall be required in the following situations:

- to a health care provider who believes, in good faith, that the information is necessary for diagnosis or treatment of that individual in an emergency; or
- to public health authorities in order to carry out their functions as described in state statutes, and rules promulgated under those titles. These functions include, but are not restricted to, investigations into the causes of disease, the control of public health hazards, enforcement of sanitary laws, investigation of reportable diseases, certification and licensure of health professionals and facilities, review of health care such as that required by the federal government and other governmental agencies, and mandatory reporting; and
- to an HIO in order for it to effectuate the operation and administrative oversight of the HIE.

The content of an authorization form for access to, or the disclosure, release or transfer of confidential health care information from the HIE shall be prescribed by the HIO in accordance with applicable department of health regulations, but at a minimum shall contain the following information in a clear and conspicuous manner:

- a statement of the need for and proposed uses of that information; and
- a statement that the authorization for access to, disclosure of and/or release of information may be withdrawn at any future time and is subject to revocation.

that the patient has the right not to participate in the HIE; and
the patient’s right to choose to enroll in and participate fully in the HIE or designate only specific health care providers that may access the patient participant’s confidential health care information.
Except as specifically provided by the Act, a patient participant’s confidential health care information shall not be accessed by, given, sold, transferred, or in any way relayed from the HIE to any other person or entity not specified in the patient participant authorization form meeting the requirements the Act without first obtaining additional authorization.

Nothing contained in this Act shall be construed to limit the permitted access to or the release, transfer, access or disclosure of confidential health care information.

Confidential health care information received, disclosed or held by the HIE shall not be subject to subpoena directed to the HIE or HIO unless the person seeking the confidential health care information has already requested and received the confidential health care information from the health care provider that was the original source of the information, and a determination has been made by the superior court upon motion and notice to the HIE or HIO and the parties to the litigation in which the subpoena is served that the confidential health care information sought from the HIE is not available from another source and is either relevant to the subject matter involved in the pending action or is reasonably calculated to lead to the discovery of admissible evidence in such pending action. Any person issuing a subpoena to the HIE or HIO pursuant to this section shall certify that such measures have been completed prior to the issuance of the subpoena.

The HIE must be subject to at least the following security procedures:

- authenticate the recipient of any confidential health care information disclosed by the HIE pursuant to this Act;
- limit authorized access to personally identifiable confidential health care information to people who need to know that information;
- identify an individual or people who have responsibility for maintaining security procedures for the HIE;
- provide an electronic or written statement to each employee or agent as to the necessity of maintaining the security and confidentiality of confidential health care information, and of the penalties for the unauthorized access, release, transfer, use, or disclosure of this information;
- take no disciplinary or punitive action against any employee or agent for bringing evidence of violation of this chapter to the attention of any person.

Under the Act, any confidential health care information obtained by a provider participant may be further disclosed by such provider participant with or without authorization of the patient participant to the same extent that such information may be disclosed pursuant to existing state and federal law, without regard to the source of the information.

A patient participant who has his or her confidential health care information transferred through the HIE shall have the right to:

- obtain a copy of his or her confidential health care information from the HIE;
obtain a copy of the disclosure report pertaining to his or her confidential health care information;

- be notified as required by the state Identity Theft Protection Act, of a breach of the security system of the HIE;
- terminate his or her participation in the HIE in accordance with rules and regulations promulgated by the agency; and
- request to amend his or her own information through the provider participant.

Any health care provider who relies in good faith upon any information provided through the HIE in his, her or its treatment of a patient, shall be immune from any criminal or civil liability arising from any damages caused by such good faith reliance. This immunity does not apply to acts or omissions constituting negligence or reckless, wanton or intentional misconduct.

This Act shall only apply to the HIE system, and does not apply to any other private and/or public health information systems utilized in the state, including other health information systems utilized within or by a health care facility or organization.

As this Act provides extensive protection with regard to access to and disclosure of confidential health care information by the HIE, it supplements, with respect to the HIE only, any less stringent disclosure requirements, including, but not limited to, those contained in of this title, the Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated thereunder, and any other less stringent federal or state law.

The Act shall not be construed to interfere with any other federal or state laws or regulations which provide more extensive protection than provided in this chapter for the confidentiality of health care information. Notwithstanding such provision, because of the extensive protections with regard to access to and disclosure of confidential health care information by the HIE provided for in this Act, patient authorization obtained for access to or disclosure of information to or from the HIE or a provider participant shall be deemed the same authorization required by other state or federal laws including information regarding mental health.

Submitted as:
Rhode Island
Chapter 08-466

Comment: Per (30A-f): Get similar legislation from other states for Idaho Docket.

A March 10, 2008 report entitled State Level Health Information Exchange: Final Report Part 1, by the Foundation of Research and Education of American Health Information Management Association says, “Although more than three-quarters of the states are pursuing HIE strategies of some kind, they vary considerably in their level of development. On the basis of a categorization developed by RTI International, state-level initiatives can be organized into the categories and development continuum described below.
Early Planning (15 states as of January 2008): An agency or government body conducted assessment of HIE efforts in the state.

Foundational Component (12 states as of January 2008): A central body was identified and established to coordinate HIE development. A governing body (e.g., board of directors) was appointed, operating committees established, and a strategic plan or road map completed.

Early Implementation (13 states as of January 2008): Some of the key road-map implementation steps have been undertaken, the state-level HIE initiative has begun coordination activities and/or selected a technology vendor, and pilot implementation has begun.

Operating Implementation (five states as of January 2008): A fully functioning state-level HIE is fulfilling either governance and/or technical operation roles, and the effort may be supporting only one or just a few types of clinical electronic HIE.

State-level HIEs derive their ability to serve in a statewide capacity from a wide variety of sources. Research in 2006 revealed that launching of state-level HIE initiatives does not depend on the formation of a new legal entity. States demonstrated that a preexisting entity can be used, or a virtual state-level HIE initiative can be established through the use of contracts and memoranda of understanding to establish the relationships between the parties or stakeholders and the governing structure for decision making. In addition, state-level HIE initiatives frequently solicit participation of state government representatives on their boards and committees.

A state-level HIE initiative’s scope of authority is commonly established by gubernatorial executive orders, legislation, agency regulations and rules, or contracts that specify performance of certain tasks (e.g., privacy assessment, technical services, standards implementation). A number of state-level HIE efforts have also used less formal mechanisms to gain recognition as entities that serve statewide interests. For example, gubernatorial campaign platforms and state agency policy briefs have been used effectively to confer recognition on state-level HIE efforts.”

Per 30A-f, NCSL’s Health Information Technology 2007 and 2008 State Legislation reports “States have taken significant steps during the past two years to address policy issues associated with health IT. From January 2007 through August 2008, more than 370 bills with provisions relating to health IT were introduced in state legislatures.

The National Conference of State Legislatures found that 132 bills with health IT content were enacted in 44 states and the District of Columbia (see Figure 1). This represents a more than threefold increase compared to 2005 and 2006, during which 36 bills were enacted, according to the eHealth Initiative. Many early health information exchange efforts began in the private sector, and state governments were asked to join. The current wave of health information exchanges, by contrast, is as likely to originate at the state level.

Texas and Indiana created bodies to run the state-level health information exchange; and Connecticut, Vermont and Rhode Island designated existing independent nonprofit entities. Whether they create new entities or bless existing activities, statutes that define a state-level health information exchange confer formal status and authority, charge the health information exchange to promote health IT in both private and public sectors, define governance to include
state agencies, and determine that they may receive and disburse funds on behalf of statewide health IT initiatives. Beyond these broad elements, various models have been adopted, reflecting existing activity in the state. Statutes that create these entities typically are comprehensive measures that, among other things, include: start-up support for a designated group, a state governance role, ongoing funding, and unique state-level responsibilities.

Accordingly, Indiana Senate Enrolled Act No. 551 of 2007, Texas H.B 1066, and Vermont H229 were added to the docket as items 21-30B-10A, 21-30B-10B and 21-30B-10C, respectively.

21-30B-10A Health Informatics Corporation IN

This Act establishes the Indiana Health Informatics Corporation (IHIC). It provides that the IHIC is a body politic and corporate. It requires the IHIC to encourage and facilitate the development of health informatics functions in Indiana. The bill provides that the IHIC is governed by a board consisting of the following nine members: the secretary of family and social services, or the secretary's designee; the state health commissioner, or the state health commissioner's designee; seven people appointed by the governor; one of which must be a physician; and one of which must be a hospital administrator.

This Act authorizes the IHIC board to appoint any advisory panels that the board considers useful in advising the board and the corporation on issues determined by the board. The bill requires the IHIC to do the following:

- encourage and facilitate the development of a statewide health information exchange system;
- encourage and facilitate users of the statewide health information exchange system and other interested parties in developing and adopting standards;
- develop programs and initiatives to promote and advance the exchange of health information;
- recommend policies and legislation that advance the development and efficient operation of the statewide health information exchange system; and
- report on Indiana's progress toward implementing the statewide health information exchange system.

The legislation requires the IHIC's plan to create a statewide health information exchange system to provide for procedures and security policies to ensure compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), protection of information privacy, and the use of information in the system only in accordance with HIPAA and as required by public health agencies. It requires the state board of accounts to examine the IHIC and its funds, accounts, and financial affairs. It specifies that the IHIC is subject to the open door law and the public records law. It provides that the IHIC must comply with current statutory provision when adopting rules. The bill provides the IHIC board may adopt emergency rules. It provides that the IHIC shall determine qualifications, duties, compensation, and terms of service for IHIC employees.
The legislation prohibits the IHIC from issuing bonds or other debt obligations. The bill authorizes the IHIC to make grants, loans, and loan guarantees. It authorizes the IHIC to establish a nonprofit subsidiary to solicit and accept nonprofit entity funding.

Finally, the Act provides that the IHIC is abolished June 30, 2015.

Submitted as:
Indiana
Senate Enrolled Act No. 551
Status: Enacted into law in 2007.

21-30B-10B Health Services AuthorityTX

This Act creates the Texas Health Services Authority as a public-private collaborative to implement the state-level health information technology functions identified by the Texas Health Information Technology Advisory Committee. The bill provides for the authority's powers and duties, organization, and funding. This Act prohibits the authority from engaging in activities relating to the collection, analysis, and use of certain health-related information and to performance measures of physicians. The Act requires the authority to submit an annual report to the governor, lieutenant governor, speaker of the house of representatives, and appropriate legislative committees.

Submitted as:
Texas
HB 1066
Status: Enacted into law in 2007.

21-30B-10C Health Information TechnologyVT

Part of this Act directs the state commissioner of health to facilitate the development of a statewide health information technology plan that includes the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. The plan shall include standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in the state.

The health information technology plan shall:
• support the effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvements;
• educate the general public and health care professionals about the value of an electronic health infrastructure for improving patient care;
- promote the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;
- propose strategic investments in equipment and other infrastructure elements that will facilitate the ongoing development of a statewide infrastructure;
- recommend funding mechanisms for the ongoing development and maintenance costs of a statewide health information system, including funding options and an implementation strategy for a loan and grant program;
- incorporate the existing health care information technology initiatives in order to avoid incompatible systems and duplicative efforts;
- integrate the information technology components of several other state agency initiatives; and
- address issues related to data ownership, governance, and confidentiality and security of patient information.

Submitted as:
Vermont
Act 70 / H229
Status: Enacted into law in 2007.

Disposition: 21-30A-10

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
    ( ) next task force mtg.
    ( ) next SSL mtg.
    ( ) next SSL cycle
( ) Reject
Comments/Note to staff:
Disposition: 21-30B-10A

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
    ( ) next task force mtg.
    ( ) next SSL mtg.
    ( ) next SSL cycle
( ) Reject
Comments/Note to staff:

Disposition: 21-30B-10B

CSG policy task force recommendations to
The Committee on Suggested State Legislation: 2010B
( ) Include in Volume
( ) Defer consideration to next task force meeting
( ) Reject
( ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
( ) Include in Volume
( ) Defer consideration
    ( ) next task force mtg.
    ( ) next SSL mtg.
    ( ) next SSL cycle
( ) Reject
Comments/Note to staff:
21-30B-11 Advancement in Stem Cell Cures and Therapies OK

This Act sets guidelines to perform stem cell research. It limits such research to embryonic stem cell lines created prior to August 1, 2001, in accordance with federal law as it existed on November 1, 2007 and without the use of a human embryo, including a human embryo produced using cloning technology. The bill requires the state department of health to establish a reporting system for stem cell research.

Submitted as:
Oklahoma
HB 3126 (Enrolled version)
(  ) No action
Comments/Note to staff:

SSL Committee Meeting: 2010B
(  ) Include in Volume
(  ) Defer consideration
   (  ) next task force mtg.
   (  ) next SSL mtg.
   (  ) next SSL cycle
(  ) Reject
Comments/Note to staff:
• Definition
• Our role in evidence
• Experience with evidence into policy
• Challenges
• Solutions
“Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”

David Sackett
October 24, 2008

OP-ED CONTRIBUTORS

How to Take American Health Care From Worst to First

By BILLY BEANE, NEWT GINGRICH and JOHN KERRY

IN the past decade, baseball has experienced a data-driven information revolution. Numbers-crunchers now routinely use statistics to put better teams on the field for less money. Our overpriced, underperforming health care system needs a similar revolution.

Data-driven baseball has produced surprising results. Michael Lewis writes in “Moneyball” that the Oakland A’s have won games and division titles at one-sixth the cost of the most profligate teams. This season, the New York Yankees, Detroit Tigers and New York Mets — the three teams with the highest payrolls, a combined $486 million — are watching the playoffs on television, while the Tampa Bay Rays, a franchise that uses a data-driven approach and has the second-lowest payroll in baseball at $44 million, are in the World Series (a sad reality for one of us).

Remarkably, a doctor today can get more data on the starting third baseman on his fantasy baseball team than on the effectiveness of life-and-death medical procedures. Studies have shown that most health care is not based on clinical studies of what works best and what does not — be it a test, treatment, drug or technology. Instead, most care is based on informed opinion, personal observation or tradition.
Mission is to address public policy challenges by identifying and applying the best available evidence through self-governing communities of interest.
OHSU Center for Evidence-based Policy

- Pooling resources among like-minded parties interested in using research evidence in decision-making
- Working with qualified researchers to commission original research that provides evidence-based answers to policy questions
- Helping collaborations use high quality research in the decision making processes by providing necessary tools and translation
National Medicaid Collaborations

- Drug Effectiveness Review Project (DERP)
- Medicaid Evidence-based Decisions Project (MED)

Federal projects
AHRQ Effective Healthcare Program Scientific Resource Committee
Drug Effectiveness Review Project - DERP

- Established in 2003
- 14 organizations participating
- OHSU Evidence-based Practice Center
- 35 Original Drug class reports
- 65 updates
Drug Effectiveness Review Project - DERP

- Independent and objective resource
- States select priorities and contribute to key questions relevant to Medicaid
- Improved safety and quality of care
- States have saved between 7 to 80 million dollars
Medicaid Evidenced-based Decisions Project - MED

• Eleven State Medicaid collaborative
• Benefit and coverage decisions
• Started in 2006
• Over 80 reports produced
2009 MED Participants

- Alaska
- Alabama
- Arkansas
- Minnesota
- Missouri
- Montana
- New York
- North Carolina
- Oklahoma
- Oregon
- Washington
- West Virginia
MED Reports

• Participant Inquiries
• Rapid Reviews
• Systematic Reviews/Technology Assessments
• Policy Companion Papers
• Vendor/Guideline reviews
Policy Companion Papers

- Document that may accompany evidence reports based on the Governance group preferences
- Policy implications
- Existing policies and guidelines
- External and environmental factors
- Financial and economic considerations
- Policy decision making guide
MED Evidence Reports

- 15 Reports delivered 2006
- 25 Reports delivered 2007
- 29 Reports delivered 2008
- 9 Reports completed in 2009 YTD
- 9 Reports in process currently
- 8 Topics referred to AHRQ/4 in progress
MED Meetings and Communications

- Conference calls twice a month
  Governance – second Wednesday, 10-12 PT
  Open Forum – fourth Wednesday, 10-12 PT

- Face-to-Face meetings twice year - Fall and Spring

- Durable Medical Equipment (DME) meetings

- Weekly electronic newsletter
Medicaid Evidence-based Decisions Project

- Non-coverage decisions for arthroscopy of knee for osteoarthritis
- Non-coverage for some low back pain treatments
- Non-coverage negative pressure therapy for select conditions
- PA MRI and CT chest = 3.2 million savings over 2 years
- PA MRI and CT of spine = 5.5 million savings over 15 months
- IV home services policy change = 1 million annual savings
Challenges for State Medicaid Programs

- Advocates and industry pressure for more service
- Balanced budget requirements
- Poor Economy = increased demand for services
- Need to make coverage and policy decisions
Solutions that have been used by states:

- Used better tools for promoting high quality care and reducing waste (vs. reducing access or entire areas of care).
- Developed strategies to acknowledge relative value of drugs and technologies and improved decision making.
- Engaged in activities to evaluate comparative effectiveness (CER), benefits, and harms.

- States have been among the most successful pioneers in sponsoring high quality evidence and making policy decisions
- Need more evidence and more tools
Thoughts about the Future

• Tough economic times may force increased use of blunt instruments for decision making and/or continued increase in the use of evidence for improved decision making
• Stimulus Package includes 1.1 billion dollars for CER
• Greatest opportunities – apply evidence at all levels purchasing and contracting, clinical professionals, patients and citizens, public and private policies, and public relations efforts
• Goal: high quality evidence serves as the foundation for understanding, debate, and honest decision making
“If you are poor, actually you need more evidence before you invest, rather than if you are rich.”
CHIPRA - The Basics

- **CHIP – Children’s Health Insurance Program**
  - Enacted in 1997 as a block grant program
  - State flexibility in program design
  - Enhanced federal match (minimum 65%)

- **CHIPRA – CHIP Reauthorization Act**
  - Signed by President Obama on Feb. 4, 2009

- Much more than CHIP; also impacts Medicaid
- Increased funding to cover 4.1 million children
- New coverage and benefit options
- New tools to enroll eligible children
Children’s Coverage Status

Children = 78.6 million

- Employer-Sponsored Insurance: 55%
- Medicaid/CHIP and Other Public Coverage: 29%
- Individual Coverage: 4%
- Uninsured: 11%

Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS.
70% of Uninsured Children are Below 200% FPL

Children = 8.9 million

- 70% below 200% FPL
  - 42%
- 200-299%
  - 15%
- 100-199%
  - 15%
- 300% +
  - 15%
- Under 100%
  - 28%

Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS.
Decline in Children under 200% FPL is Attributable to Medicaid and CHIP

Source: Data reflects low-income (<200% FPL) children. Johns Hopkins University Bloomberg School of Public Health analysis of the National Health Interview Survey for the Center for Children and Families (March 1, 2008).
Medicaid/CHIP Coverage Improves Access to Care

Source: Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC. 2007. Summary of Health Statistics for U.S. Children: NHIS, 2007. Note: Questions about dental care were analyzed for children age 2-17. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. An asterisk (*) means in the past 12 months.
Children Currently Eligible but Not Enrolled

8.9 Million Uninsured Children

4.4 Million are Eligible for Medicaid

1.7 Million are Eligible for SCHIP

Coverage for 4.1 Million Children Who Otherwise Would Be Uninsured

83% Eligible Under Current Program Rules

Newly Eligible Uninsured Children (700,000)

Already Eligible Uninsured Children (3,400,000)

Medicaid and CHIP Eligibility Levels for Children, January 2009

Note: States with asterisks (*) have enacted, but not yet implemented to the levels shown.
CHIPRA Coverage Provisions

- Gives explicit option to cover children to 300% FPL
  - over 300% reverts to Medicaid match
- Allows CHIP coverage for pregnant women
- Removes 5-year waiting period for covering legally residing immigrant children and pregnant women (Medicaid or CHIP)
- Phases out adults, no new parent waivers
- New quality initiative
CHIPRA Benefit Provisions

• Mental health parity in CHIP; but no mandate
• Dental mandate and must meet equivalency test
• Dental coverage only for privately-insured kids otherwise eligible for CHIP
CHIPRA Financing Provisions

• New, higher national funding levels

• Change in allotment formula to send money to states that use it
  • 2-year availability of allotment until redistribution
  • Allotments after 2010 based on expenditures

• Multiple “safety valves” to avoid shortfalls
CHIP Tools to Enroll Eligible Children

- Outreach grants
- Enhanced translation & interpretation match
- New option to document citizenship
- Express lane eligibility
- Performance bonuses for adopting simplification measures and increasing enrollment
$100 Million Outreach Fund

• Broad discretion by HHS Secretary
• $10 million national campaign
  • Partnerships with other agencies
  • National hotline ensuring all states participation
• $10 million for Native American outreach
• $80 million in grants
  • Areas with high rates of eligible but not enrolled, including rural areas
  • Minorities and health disparities
$80 Outreach Grant Pool

• Grantees can be state or local government, other public programs, nonprofits, safety net provider
• No state match required
• MOE on prior year outreach expenditures for states
• Related enhanced match for translation & interpretation
  • 75% or CHIP match + 5%, if higher
  • Outreach, enrollment, retention, services
It’s No Secret

Outreach matters!

But enrollment and retention simplification measures are critical to boost coverage!
Citizenship Documentation Changes

- Effective *immediately*
  - Three amendments to DRA

- Effective January 1, 2010
  - New option to confirm US citizenship through match with SSA records with enhanced systems match (90%/75%)
  - Applies to separate CHIP programs but exempt from 10% admin cap

- Opportunity for CMS to reissue current regulations
Express Lane Eligibility

• Allows use of information from other public programs to verify eligibility & enroll
  • Food Stamps, TANF, WIC, School Lunch, Childcare, HeadStart, HUD...
  • Disregards differences in methodology

• No application required if family consents

• Enhanced federal systems match
  • 90% systems development and implementation
  • 75% ongoing
Performance Bonus Opportunity

- Implement specific enrollment and retention efforts
  - At least 5 of 8
- Increase enrollment
  - Cumulative annual increases
  - Adjustment for increase in child population
5 of 8 Measures in Medicaid & CHIP

- Adopt 12 month continuous coverage
- Eliminate asset test
- Eliminate face-to-face interview
- Use same forms/verification process
- Implement administrative renewals
- Adopt presumptive eligibility
- Implement express lane eligibility
- Offer premium assistance
Performance Bonus Calculation

• Two bonus levels
  • On enrollment above the target (tier 1)
    Bonus = 15% of state Medicaid share
  • On enrollment that is 10% above target (tier 2)
    Bonus = 62.5% of state Medicaid share

• Calculated only on enrollment above the target

• Paid in lump sum (not from allotment) in first quarter after fiscal year end
New Reporting Requirements Key to Enrollment & Retention Improvement

- Highlight successes
- Identify barriers, bottlenecks and gaps
- Target actions

Children's Enrollment in Washington's Public Insurance Programs, April 2002-October 2005

What About Health Reform?
Broader Health Reform – □
Risk Points for Children

• Failure to acknowledge and address the unique needs of children
• Politicians using mandates to claim victory on enrollment issues
• Poor coordination between existing programs and new initiatives
• Fracturing of coverage within families
• Criticism of Medicaid/CHIP
Broader Health Reform – What Do Children Need?

- Access to affordable coverage for all children
- Stronger financing structure
- A benefit package designed for children and their unique developmental needs
- High quality care with access to needed providers
- Family-based coverage
For more information

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Our website:
http://ccf.georgetown.edu/

Say Ahhh! Our child health policy blog:
http://www.theccfblog.org/
Reducing Sexually Transmitted Diseases in Washington State Adolescents

Cynthia Morrison, MA ABS
Coordinator, STD Education Program
Washington State Department of Health
Washington 2008

Chlamydia

6,637 teens / 20,000 cases

Gonorrhea

680 teens / 3,000 cases

* 758 cases of salmonella, 32 cases of meningitis in 2007
Infertility Prevention Project

Family Planning Clinics
School Based Health Centers
Juvenile Detention Centers
Community Health Centers
Tribal Collaboration
Health Youth Act  2007

Requires medical and scientific accuracy

Emphasizes abstinence but must also include other forms of prevention

Age appropriate

Optional
Barriers

Healthy Youth Survey

(Washington State version of Youth Risk Behavior Survey)

Washington State law excludes questions regarding sexual behavior of any kind
Barriers

Access to services
  Reductions in public health clinics available to youth

  Health care provider and teen (lack of) awareness about STD prevalence

  Changes to Medicaid eligibility have increased difficulty for teen access.
Health Department Clinics 2003
Reported Cases

STD Clinic

0.0%  1.0%  2.0%  3.0%  4.0%  5.0%  6.0%  7.0%


PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON
For more information

Cynthia Morrison
STD Education Program
Washington State Department of Health
360.236.3498
cynthia.morrison@doh.wa.gov
The Oregon Youth Sexual Health Plan is designed so that each community, agency or group can approach the youth sexual health in a manner that is relevant to its setting and circumstances.
We want: Healthy Outcomes for Oregon Youth
Content of the Plan was informed by literature reviews, medical studies, Oregon Healthy Teens survey data and youth-led research.
Input from 5,128 Oregonians Guided the content of The Plan
*25 youth from Deschutes, Jackson, and Multnomah Counties were trained in “action research” methodology and designed projects to explore youth sexual health issues in their communities.

*2333 youth completed questionnaires or participated in focus groups as part of youth action research.

*57 youth from Deschutes, Jackson, Lane, and Multnomah counties participated in focus groups to review and give feedback on a draft of the plan.
* 881 people participated in 9 community forums in Clatsop, Deschutes, Lane, Lincoln, Marion and Multnomah Counties.

* 1733 adults completed a questionnaire related to contraceptive access and school sexual health curricula for teens.

* 32 people who provide services in culturally specific contexts (Latino, LGBTQ, African American, Native American) participated in focus groups to give feedback on the plan.

* 67 people gave feedback on a draft of the plan via email during the month-long external review process.
Teen Pregnancy Promotion – Sexual Health Partnership

- Oregon Commission for Children and Families
- Oregon Department of Education
- Oregon Department of Human Services:
  - Public Health Division
  - Children, Adults and Families Division
  - AmeriCorps HOPE

- Oregon Teen Pregnancy Task Force
- Planned Parenthood – Columbia Willamette
- Planned Parenthood – Southwestern Oregon
- Benton County Health Department
- Jackson County Health Department
- Multnomah County Health Department
Overarching Goals:

• Youth use accurate information and well-developed skills to make thoughtful choices about relationships and sexual health
• Sexual health inequities are eliminated
• Rates of unintended pregnancy are reduced
• Rates of sexually transmitted infections are reduced
• Non-consensual sexual behaviors are reduced.
8 Objectives

- Infrastructure
- Policy
- Address Health Inequities
- Youth Development
- Education for Youth and Families
- Services for Youth and Families
- Data
- Assurances
Oregon Teen Pregnancy Rates (per 1,000 females)
The Work Is Just Beginning
Ideas for Involvement

• Provide ways for your audience members to participate in the issue.
  – Is there a class they can attend?
  – Are there services they can access?
  – Is there something they can advocate for?
Contact information:
Brad Victor, MAT
Sexuality Education Program Specialist
Oregon Department of Education

brad.victor@state.or.us
503-947-566
Download the Oregon Youth Sexual Health Plan: