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Advocacy Summit Proposal No. 1

Title of Proposal:
Support HB1755 and SB1408

On behalf of:
Medical Society of Northern Virginia

Describe the Idea or Issue:
Step therapy occurs when a doctor prescribes a treatment, but the insurance company requires the patient to try one or several other drugs first, with no medical justification. The patient must wait for the doctor prescribed treatment, often for weeks, months or even years, as he or she tries each of the insurer-mandated drugs one-by-one, and proves that the insurer’s preferred treatment didn’t work.

Desired Outcome:
Virginia can take Step Therapy in the Right Direction
House Bill 1755 would make step therapy better and safer for Virginians – without inhibiting insurers’ ability to safely use step therapy to save money.
• Better Step Therapy: House Bill 1755 and Senate Bill 1408 put an online process in place for health care providers to request overrides for step therapy protocols and ensures that providers are notified in writing if their request is denied.
• Safer Step Therapy: House Bill 1755 and Senate Bill 1408 help ensure that overrides are granted for Virginians for whom the insurer-mandated drug is clinically determined to cause adverse health events or be ineffective, as well as those who have already met step therapy requirements to receive the same treatment.
• In this capacity, House Bill 1755 and Senate Bill 1408 make step therapy more effective at saving money for insurers and the state alike, as these Virginians are more likely to miss work and require additional in-patient care, hospitalization, and ER visits if they go without the treatment plan prescribed by their health care provider.

Background/Supporting Information:
Step therapy is harmful for Virginians
Insurers use step therapy to cut down on medication costs, and sometimes the insurer-mandated drugs can even end up working for the patient.

But far too often, step therapy keeps Virginians living with dangerous and even life-threatening conditions – from mental illness and cancer to epilepsy and autoimmune diseases – from the therapies they need, causing adverse reactions and allowing their health to deteriorate.
• Step therapy second-guesses a doctor’s orders by assuming that the insurance company – not the doctor – knows best. Step therapy protocols have no medical justification.
• For Virginians who rely on prescription therapies to stay healthy, productive and out of the hospital, step therapy increases health care and societal costs. In a study comparing spending on schizophrenia medications, step therapy saved $19.62 per-member per-month in atypical antipsychotic expenditures. However, these savings were “accompanied by a $31.59 per-member per-month increase in expenditures for outpatient services.” As a result, step therapy
increased health care costs. Similar findings have been observed when step therapy was applied to blood pressure medications.

- Step therapy can prevent Virginians from receiving treatment at all. In fact, studies have shown this to be true for one in five patients.-7

Citations:
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2949902/
7. Yokohama K et al. “Effects of step-therapy program for angiotensin receptor blockers on antihypertensive medication utilization patterns and cost of drug therapy,” J Manag Care Pharm. 2007;13(3)235-44.
Title of Proposal: 
Re-visit step therapy

On behalf of: 
Dr. Mitchell Miller and Dr. Sterling Ransone

Describe the Idea or Issue: 
Step Therapy reform in essence is a follow-up to Prior Authorization reform, which MSV supported a few years ago. Step Therapy reform was supported by MSV this past GA session.

This issue remains a thorn in the side of every patient and every prescribing physician. There are countless examples of how being forced, by insurers, to use a medication which has either failed in the past, or for some other reason is inappropriate, especially if a patient is successfully managed on a medication that is not "first step" per the insurer, can ultimately harm the patient or at minimum severely inconvenience him or her.

The massive hassle factor for physicians and their staffs is another reason for seeking reforms.

Desired Outcome: 
Significant reforms which are both patient and physician friendly, and yet recognize the economic challenges of providing appropriate treatments for patients.

Background/Supporting Information: 
This is basically a follow-up on the same issues as this past year.

West Virginia recently passed legislation on this issue. I have attached it for review.

We need to keep up the pressure on this issue.

Several patient advocacy groups are in full support and are natural allies.

Above all, this is an issue which helps patients immensely, and it simultaneously helps ALL practicing physicians.

*Additional background materials in appendix, pgs. 2-19.*
Title of Proposal:
Resolution to Improve Step Therapy in Virginia

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:
Step therapy or “fail first” protocols are policies, practices and programs established by utilization review agents that establish a specific sequence of interventions for specified medical conditions for enrollees. These protocols appear to be economically based in that they require patients to use a lower cost drug or service before permitting use of more expensive drugs or services. An increasing number of insurers are utilizing step therapy or fail first policies that require patients to try and fail one or more formulary covered medications before providing coverage for the originally prescribed non-preferred or non-formulary medicine, often at the expense of the health of the patient. For example, if a patient changes insurers or if a drug they are currently taking is moved to a non-preferred or non-formulary status, patients may be put through the step therapy process again even if the patient is stable. This could cause great harm to the patient.

Step therapy is an established benefit management tool used by commercial carriers, self-insured employers, Medicare Advantage/Part D programs, and Medicaid as well as other utilization review agents such as pharmacy, radiology and therapy benefit managers and specialty pharmacies. The decision-making process and/or clinical evidence for the step therapy or fail first protocols and appeal/override decisions are frequently not revealed and often with no transparent, efficient or expedited step therapy or fail first protocol appeal process in exceptional clinical situations.

The act of appealing these protocols creates an undue burden on health care providers, their staff and patients, wasting valuable health care resources and increasing costs.

Desired Outcome:
The Richmond Academy of Medicine would like the Medical Society of Virginia, in collaboration with local and specialty physician organizations across the Commonwealth of Virginia [ideally in concert with local and national patient organizations], to work to reform step therapy in Virginia using legislation similar to that passed in New York and other states as a model.

Background/Supporting Information:
Please find the following background items attached:
- CSRO Step Therapy Leave Behind
- NY Bill on Step Therapy - A02834 Summary
- Components to include in Step Therapy Legislation
- MD principles on prior authorization
- Step Therapy Press Release from NY
- VA Legislation HB1755
• VA Legislation SB1408
• West Virginia Step Therapy Bill

Additional background materials in appendix, pgs. 20-67.
Advocacy Summit Proposal No. 4

Title of Proposal:
Clarification of COPN Policy

On behalf of:
Virginia Orthopaedic Society

Describe the Idea or Issue:
The Virginia Orthopaedic Society (VOS) and the Virginia Society of Eye Physicians and Surgeons (VSEPS) strongly support MSV's policy on Certificate of Public Need. The current policy is an appropriate balance of supporting deregulated services, but with quality standards and charity care requirements. Under this policy, MSV has been able to support COPN reform legislation the last two legislative sessions that have met this criteria.

While recent legislation has attempted to reform the entire system, we will likely see a different approach during the 2018 General Assembly Session. Delegate Orrock, the Chair of the House Health, Welfare and Institutions Committee, announced that he welcomes and encourages specific-project COPN legislation. Due to a lack of movement in revamping the entire COPN program, he believes that legislation granting individual exemptions is the best way to address COPN reform. For example, if a physician practice in Richmond wants to purchase a MRI machine, Chairman Orrock is directing them to submit legislation requesting the ability to do so.

Desired Outcome:
With this new environment, we can expect to see numerous bills addressing individual COPN exemptions. We would like to clarify that the current MSV policy allows MSV to support these bills, as long as they include quality standards and charity care requirements. The MSV policy specifically states that MSV will "consider supporting individual COPN legislation on a case-by case-basis, with decision for approval derived from previously adopted principles of patient safety and access to quality, affordable health care." VOS and VSEPS request the MSV Advocacy Committee to confirm that the current policy on COPN allows MSV to support both specific-project and comprehensive reform legislation.

Background/Supporting Information:
MSV's Current COPN Policy:

205.000 Health Planning 205.001 - COPN Policy Date: 1/20/2016 The Medical Society of Virginia supports the deregulation of COPN. MSV will consider supporting individual COPN legislation on a case-by case-basis, with decision for approval derived from previously adopted principles of patient safety and access to quality, affordable health care. The MSV continues to support the economic viability of Virginia's academic health centers. Newly deregulated services should be required to meet a charity care commitment as well as recognized standards of accreditation or quality.

Additional background materials in appendix, pg. 68.
Advocacy Summit Proposal No. 5

Title of Proposal:
Removal of COPN

On behalf of:
Dr. Dishant Shah

Describe the Idea or Issue:
I am a strong advocate for removal of COPN regulations and requirements for opening Radiology out-patient practice in Virginia. If a cosmetologist can open shop with a Virginia license, then why not a board certified medical doctor? Why do we Radiologists have to suffer from not being able to open new business in Virginia and provide more options and locations for patients to seek treatments closer to their homes? Hospitals and large institutions have monopolized the practice of Radiology by means on the COPN law. We need to get this law removed.

Desired Outcome:
Complete removal of COPN law for Radiology MRI and CT outpatient imaging.

Background/Supporting Information:
I am a Radiologist and practice Teleradiology in Virginia. I have 10 active state licenses and read for all states, except Virginia. I did my residency here at VCU and we think Virginia is the best place to live and grow. When it was time for me to start thinking of opening a solo or group out-patient radiology practice, I was shocked to realize the cost and process of going through the process of obtaining a COPN. This hindered my entrepreneurial efforts and it is a shame that living in Virginia, I am unable to provide my medical expertise to patients in my home state.
**Title of Proposal:**
Resolution on Prior Authorization

**On behalf of:**
Richmond Academy of Medicine

**Describe the Idea or Issue:**
Prescription prior authorization is a health plan cost-control process requiring providers to obtain approval before prescribing medications, which most often requires hours of uncompensated physician and staff work. Private offices and hospitals employ numerous people to cope with the added burdens of required prescription prior-authorizations which adds to overall health care costs. In addition, the lengthy processes may have negative consequences for patient outcomes when medications are delayed.

In 2015 (with the help of the Medical Society of Virginia), Governor Terry McAuliffe signed a bill which was meant to improve transparency, uniformity and efficiency in the current prescription prior authorization process. Despite the current law existing, insurers still drag their collective feet when physicians try to settle prior authorization matters in a timely way for their patients. The current prior-authorization appeals process is arduous and oft impossible with the following common practices occurring:

- Many appeals (unless “urgent”) take months to get a decision because most health plans don’t acknowledge receipt of appeal and often claim to not have received the appeal even though a fax confirmation exists;
- Initial authorization requests are directed through an off-shore call center slowing down the authorization because of language barriers.
- Some health plans require a written authorization from the patient in order to do an appeal, which is often required for medical services as well which slows down the process
- When trying to get a drug authorized that is non-formulary, the health plan isn’t required to do a tier exception and the costs of the drug can be outrageous.
- Generic drugs can be as expensive or more expensive than some brand name drugs
- Health plans are requiring physicians to go through the prior authorization process to screen for contraindications, not trusting that the physician (and the pharmacy) is properly screening the patient

**Desired Outcome:**
The Richmond Academy of Medicine would like the Medical Society of Virginia to continue to work with Insurers and request they be more open and transparent about their approval (and rejection) processes and demand that they release information identifying the common evidence-based parameters for insurers’ approval of the 10 most frequently prescribed chronic disease management prescription drugs, as required by the 2015 law.

We would also like the Medical Society of Virginia to work with the General Assembly to push insurance companies to upgrade the electronic approval of prescription requests, which has been shown to bring cost savings in other states within a few years of its implementation.
And finally, we ask that the Medical Society of Virginia join the American Medical Association to aid in prior-authorization reform with a goal of building a dialogue between providers, health plans and their third parties to cut out needless administrative waste from the system.

**Background/Supporting Information:**
Please find attached a 2.11.17 RTD Editorial by Dr. Mark Monahan on the issue.

*Additional background materials in appendix, pgs. 69-75.*
Title of Proposal: Reforming health insurance processes for patients obtaining sleep medicine procedures and therapies

On behalf of: Virginia Academy of Sleep Medicine

Describe the Idea or Issue: The need to reform health insurance processes to eliminate prior authorizations and appeals for patients obtaining sleep medicine procedures and therapies. Insurance companies create barriers to obtain sleep related health care. These processes are interfering with patient care, prolonging hospitalizations, and affecting patient safety, thus increasing short term and long term health care costs.

Desired Outcome: MSV support with communication and policy changes to improve timely delivery of health care by approving procedures and access to sleep medicine therapies.

Background/Supporting Information:

1. Sleep Apnea
   - Prior Authorizations:
     - Several health insurance plans have improperly denied attended/in-lab sleep studies (CPT codes 95810, 95782) on pediatric and adult patients. Insurance companies are citing limited literature, not always based on evidence based medicine, and using selection criteria that is not well defined (such as COPD/severe lung disease, heart failure, stroke within 30 days, or inability to have testing at home) to support their denials. Insurance companies have inappropriately applied the AASM clinical practice guidelines for diagnostic testing and not only denied in-lab studies, but required HSAT (Home Sleep Apnea Tests) for a majority of patients without any justification.
     - Patients with hypoxemia that would also benefit from attended/in-lab titration studies (CPT Code 95811, 95783) are being denied. Previously the criteria for an in-lab positive airway pressure (PAP) titration study was performed if the patient had an oxygen saturation nadir <80%, however these studies are no longer approved. Insurances are requiring providers to order auto-PAP machines and perform home pulse oximetry, which is suboptimal and impacts patient care.
     - According to some insurance plans, pediatric patients are required to have a split- night sleep study since the insurance plan is denying a second study for the purpose of a PAP titration. The insurance companies are incorrectly extrapolating data from the adult studies to pediatric patients. Evidence has shown that PAP desensitization protocols prior to the titration study helps to improve compliance to PAP in the pediatric population (Harford et al, Clin Child Psychol Psychiatry 2012).
     - Managing requests and appeals with peer to peer reviews (usually conducted with a non-sleep physician) is burdensome and time-consuming. Some insurance companies have imposed restrictive and onerous time limitations when the peer to peer reviews can be
completed and can close the case at the end of the day the same day the denial letter was sent.

- On-line precertification which is required by some insurance plans, is returned with a “Pending Review” status. It usually takes 3 days from the time the request is submitted before a response is posted online. The delay is time consuming, particularly since these plans did not require precertification for a sleep study prior to 01/01/2017.
- The delay in approval of authorizations affects timely treatment of comorbidities (such as arrhythmias, hypoxemia, stroke, fatalities linked to driving sleepy).

- Insurance companies are prolonging hospitalizations by demanding unnecessary testing:
  - Criteria for discharging home with PAP may include:
    - Obtaining an arterial blood gas to document elevated CO2 levels. This can increase medical risk (due to infection, bleeding, morbidity due to pain when obtaining a blood gas) and produce inaccurate misleading results by waking the patient up and causing pain, thus increasing ventilation causing falsely normal CO2 values.
    - Performing a polysomnography as an inpatient. This may not be possible since they are not available in some hospitals, and incur more costs when they are obtained as an inpatient versus an outpatient study.
    - Obtaining a Forced vital capacity (a pulmonary function test) which may be difficult to perform as the patient may be unstable to leave the ICU and unable perform an accurate FVC maneuver; pediatric patients are often unable to perform this test even when well.
  - Increasing hospital length of stay due to trying to document sleep apnea and coordination of home supplies
  - Forcing discharge of patients home without positive airway pressure (PAP) therapy and waiting to perform an outpatient study, which increases their comorbidities
  - Decreased quality of life by prolonging time back to work or school since patients are not effectively treated for their underlying health concerns

2. Narcolepsy

- Health insurance plans have denied medications for narcolepsy patients based on age or recommending to trial other medications with “step therapy” such as stimulants (which have side effects such as arrhythmias) or other treatment modalities prior to accessing more effective medications such as Modafinil.
  - Requires patients and physicians to delay optimal treatment which places patients at risk for sleep deprived accidents and fatalities
  - Medication denials create barriers for patients to receive medication that may be their best treatment option. This affects patients quality of life due to untreated excessive sleepiness leading to failing their classes, repeating the school year, and time off work
  - If the patient has been stable on a medication for years and changes insurance companies, then the patient needs to start the entire “step therapy” process again with less effective medications.

Additional background materials in appendix, pgs. 76-103.
Title of Proposal:
Revision of "Good Samaritan" Statutes for Team Physicians

On behalf of:
Dr. Sterling Ransone

Describe the Idea or Issue:
Under current "Good Samaritan" laws in the Commonwealth of Virginia, a volunteer team physician could be held liable for care if, IN RETROSPECT, that care is determined to have been non-emergent.

Desired Outcome:
A change in the Code of Virginia expanding the "Good Samaritan" statutes to include liability protection for non-emergent care by volunteer team physicians.

Background/Supporting Information:
Is a Volunteer Physician for a Team a "Good Samaritan"?
Virginia Medical Law Report; Volume 14, Number1; January 2017

Additional background materials in appendix, pg. 104.
Advocacy Summit Proposal No. 9

Title of Proposal:
Truth in Advertising

On behalf of:
Virginia Society of Plastic Surgeons

Describe the Idea or Issue:
Survival in the modern marketplace requires promotion of one’s practice and credentials in various advertising media. Most practitioners do so ethically, but there currently exists a loophole in Virginia’s health regulations that can be exploited. Virginia’s regulations state under 18VAC85-20-30. Advertising ethics:
D. A licensee shall disclose the complete name of the specialty board which conferred the certification when using or authorizing the use of the term “board certified” or any similar words or phrase calculated to convey the same meaning in any advertising for his practice.

Unfortunately, this language does not specify that such a board has to be a legitimate one. For example, a diplomat of the American Board of Laser Surgery is currently well within his/her rights in Virginia to advertise themselves as "Board-Certified", according to the current regulations. After paying fees and taking an open-book exam, the American Board of Laser Surgery offers “board-certification” and a fancy certificate to virtually anyone, including “non-physician cosmetic practitioners”.

If boards with lower standards are allowed to advertise as board-certified, the term loses its value to Virginia patients seeking an adequately trained and qualified physician.

We suggest changing Virginia’s regulatory code to specify that “board-certified” must refer to an ABMS, AOA, or other boards that maintain similarly high standards of certification.

Although this is a problem being brought forward by the Virginia Society of Plastic Surgeons, this is an issue recognized by many specialty medical societies. Nationwide, there is a coalition of physicians that have approved these efforts in other states and have approved specific language to be included in state regulations. This national Truth in Advertising Coalition includes the following organizations:

American Medical Association
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology – Head and Neck Surgery
American College of Emergency Physicians
American Osteopathic Association
American Society for Dermatologic Surgery Association
American Society of Plastic Surgeons

Desired Outcome:
Change Virginia’s regulatory code to specify that “board-certified” must refer to an ABMS, AOA, or other boards that maintain similarly high standards of certification.
Title of Proposal:
Support gun violence protective order legislation

On behalf of:
American College of Physicians, Virginia Chapter

Describe the Idea or Issue:
More than 33,000 people were killed in 2014 by firearms by either suicide or homicide. This represents a major public health problem that needs to be addressed. Gun Violence Restraining Orders (GVRO) allow law enforcement to remove guns from persons who are a threat of violence to themselves or others. This concept arose in 2013 by the Consortium for Risk Based Firearms Policy, using an evidence based approach. GVROs have been enacted in states such as Connecticut and Indiana, and have been shown to result in decreased deaths from gun violence. HB 1758, a bill that sought to enact GVROs in Virginia, was proposed in the 2017 legislative session by representative Sullivan. It unfortunately was left in the Militia, Police and Public Safety subcommittee. The American College of Physicians, Virginia Chapter, strongly supports re-proposing this legislation in the 2018 session. Our organization participated in a gun violence symposium with the American Bar Association in 2016, where we heard from physicians, pastors, and law enforcement officials on the importance of dealing with the public health crisis of gun violence in Virginia. We ask that the Medical Society of Virginia support this proposed legislation as a step towards decreasing gun related suicides and homicides.

Desired Outcome:
Support GVRO legislation such as HB 1758

Background/Supporting Information:
- “Prosecutors, State Legislators, Law Enforcement Join Forces to Push for Common Sense Gun Laws; Keeping Guns Out of the Hands of Domestic Abusers and People at Risk”
- 2017 Virginia House Bill No. 1758

Additional background materials in appendix, pgs. 105-136.
Title of Proposal:
Medicaid reform for adults receiving social security disability income

On behalf of:
American College of Physicians, Virginia Chapter

Describe the Idea or Issue:
In the state of Virginia, Medicaid is currently available to disabled persons provided that they do not exceed a combined household income threshold or possess other assets that would make them ineligible. The disabled are in most cases unable to work at all or may not have spousal/family financial support, and are often reliant on social security disability (SSDI) as their sole source of income. Accepting SSDI in certain cases can render the recipient to be over income and thus ineligible for Medicaid and often leaving them without health coverage for 2 years when they become eligible for Medicare. SSDI provides at best a modest income that covers basic necessities (food, shelter, and transpiration) and certainly does not provide enough to also purchase medical insurance. The majority of states currently offer automatic eligibility for disabled regardless of income source.

Desired Outcome:
SSDI income as sole source of income for a disabled individual should not render one "over income" and ineligible for Medicaid.

Background/Supporting Information:
http://www.disabilitysecrets.com/resources/health-care/medicare/which-states-automatically-grant-med

Additional background materials in appendix, pgs. 137-138.
Title of Proposal:
Resolution on MSV study of an entity for the state of Virginia to place doctors properly and pay them appropriately

On behalf of:
Dr. Monroe Baldwin

Describe the Idea or Issue:
Our medical profession has several issues
1. We do not realize that the medical profession is RESPONSIBLE for delivery of healthcare at a price all Virginians can afford; not the free market, not the government, and not insurance companies. Ultimately doctors have to see everyone one way or another.
2. There are physicians paid way too much and others paid too little especially family practice, the foundation of medical delivery.
3. The free market dictates that hospitals and doctors must earn a profit so they move towards paying patients but the preponderance of disease is in the low income patients. We have the medical profession moving away from disease! Check your community and see where the doctor’s offices and hospitals are and who they serve.
4. Finally our healthcare statistics are perhaps 3rd among civilized countries.

Desired Outcome:
Open discussion and a strategy for dealing with these problems. This is the 4th year I have brought a resolution. I suggest an entity in the state managed by physicians to place and pay doctors appropriately which includes providing and office and personnel to deal with the communities in which they are placed.
Title of Proposal:
Physician oversight of medical services in the school setting

On behalf of:
Dr. Cindy Devore

Describe the Idea or Issue:
The AMA, AAP support that all health and wellness programs within a school should be supported and overseen by a physician, ideally one trained in the care of children, such as a pediatrician or family medicine specialist. Children are in schools today with many significant health concerns that require both routine and emergent intervention as well as collaboration between the medical home and school home. Every school division should have a school medical director who is a licensed board certified physician with expertise in children overseeing all health concerns within a school division.

Desired Outcome:
Schools will have health and wellness programs for all students that are evidence based from minor issues such as infection control like head lice to major issues that can impact instruction like return to learning following concussion or anaphylaxis management and infectious disease control.

Schools will assist the medical home in implementing goals for students with complex medical conditions by facilitating rather than obstructing their smooth integration into the school through education of staff and administrators and support of school nurses.

Routine and emergent issues encountered by school nurses will be supported with appropriate standing medical orders that are regularly monitored and updated, including but not limited to safe medication delivery systems, public access defibrillation programs, naloxone, seizure, and anaphylaxis rescue, and other similar essential school issues.

A uniform gold standard of care will be established by the joint efforts of the VA Depts of Education and Health through the VA school medical directors to ensure that all school aged children, regardless of zip code, will have quality access to safe school environments overseen by board certified physicians who understand the needs of children and adolescents.

Background/Supporting Information:
Please see attached resolution proposal for background information.

Additional background materials in appendix, pgs. 139-140.
Title of Proposal:
Resolution revising health care legislation

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:
The Affordable Care Act was developed to address problems both in access to health care for our citizens and to halt the increasing cost of health care in our nation. There will continue to be legislative efforts to improve our current health care plan but whatever our political views, physicians have a major social responsibility for the patient population they serve to be sure the current health plans keeps in mind the best interests of their patients.

Desired Outcome:
That the Medical Society of Virginia assist physicians in Virginia communicate to the public and to our legislators our strong support for the 2017 American Medical Association list of guiding principles for health insurance and Health care access for any future federal or Commonwealth government health care plans.

Background/Supporting Information:
• AMA Vision on Health Reform
• “How to provide more affordable health care”, Dr. Walter Lawrence Richmond Times Dispatch Editorial

Additional background materials in appendix, pgs. 141-143.
Title of Proposal:
Mid-Level Scope of Practice Reform

On behalf of:
Virginia Academy of Family Physicians

Describe the Idea or Issue:
• Nurse Practitioner Scope of Practice
• Physician Assistant Scope of Practice

Desired Outcome:
Development of proactive legislation to establish appropriate education, training, testing, malpractice, formulary, case complexity, continuing education, discipline, and enforcement parameters for the autonomous practice of mid-level providers.

Legislative proposal should be based around team-based care model and should hold autonomous mid-levels to equivalent obligations as physicians.

Background/Supporting Information:
• Recurring NP Scope of Practice autonomous practice legislation
• Recurring PA ("Doctors of Medical Science") Scope of Practice autonomous practice legislation
• Exhaustion of political capital defending scope expansion efforts
• Need for physician-driven legislation to control autonomy parameters
Title of Proposal:
Amend 2013 Virginia Senate Bill 707

On behalf of:
Injured patients who cannot afford to use their health insurance in their PCP’s office. (Following a motor vehicle accident) / Submitted by Dr. Leon Brown

Describe the Idea or Issue:
Senate Bill 707 Mandates (with few exceptions) that persons injured in motor vehicular accidents must use their commercial health insurance, if they are seen in their PCP’s (point of care) office. If high copays and deductibles are involved this may not be to the patients advantage. An injured patient should not be forced to use their health insurance if it is not in their financial best interest. Senate Bill 707 should be amended to allow Virginians to decide what is best for them.

Desired Outcome:
(From Resolution) That the Richmond Academy of Medicine will work along with the Medical Society of Virginia to seek a legislative amendment to Senate Bill 707 to allow patients injured in motor vehicle accidents to decide how their medical bills will be paid in the primary cares office. This decision should be made by the patient in conjunction with the primary care physician and the attorney if one is involved.

Background/Supporting Information:
See copy of
#1 Senate Bill No. 707 and article from client advisory dated 3/5/13
#2 Article from client advisory dated 3/5/2013
#3 Resolution

Additional background materials in appendix, pgs. 144-150.
Title of Proposal:
Parity of telemedicine services

On behalf of:
Dr. Kurt Elward

Describe the Idea or Issue:
Insurers and some health systems are increasingly using telemedicine services to provide care for their members. These opportunities are not provided to patient's primary care physicians, however, nor specialties such as oncology where telemedicine would benefit. Physicians are limited to becoming employees of telemedicine companies in order to serve their own patients.

We should advocate for inclusion of primary care physicians and at least some selected specialties to have the ability to provide and bill for telemedicine services with a) established CPT codes and b) independent of any services provided by third party vendors of health systems or insurers.

Desired Outcome:
1. Physicians can easily provide telemedicine services to their patients independently of third party vendors and receive payment for these services. This can be secured via direct negotiation with health systems or insurers, or legislatively and through the Bureau of Insurance

2. MSV should showcase companies that can provide support needed for physicians to practice telemedicine.

Background/Supporting Information:
Telemedicine has become an increasingly significant aspect of new models of care for patients


https://www.advisory.com/research/market-innovation-center/the-growth-channel/2016/03/stanford-medicine-virtual-visits

Additional background materials in appendix, pgs. 151-168.
Title of Proposal:
Meeting appointment time requirements for opioid patients

On behalf of:
Dr. Carol Bender

Describe the Idea or Issue:
Virginia and the Board of medicine have issued mandates for visits involving the prescribing of opioids, yet physicians who are employed by others, (ie: large hospital groups) are not allowed long enough time slots for visits to fulfill these mandates. Thus these physicians would be in violation of the law. We must get legislation to allow physicians sufficient time for patient visits so that they may be in compliance with the law, have time to document their compliance during visits, and talk to the patients about how getting off opioids is better for their health. This is never a "quick" conversation.

Desired Outcome:
Longer office visits to allow physicians to obey the mandates of the law and also to practice good medicine. We cannot close our eyes to the fact that physicians are forced by employers or to continually violate this law. Perhaps we could legislate at least a 30 minute appointment for any patient on opioids. What this would achieve is allowing physicians more time to be able to truly start to deal with the opioid crises. Patients need to understand the issues not just be told "I am cutting your medicine - sorry I have no more time to talk to you!" Thank you for your consideration.

Background/Supporting Information:
Well known opioid crises. Physicians no longer in control of their own practices. Requirements by employer groups to push patients thru - deal with "one issue" per visit. Boston University Opioid CME states initial visit should take about 4 hours to cover all that is required. Certainly that is not practical but neither is 15 minutes currently allowed! Nor is 15 minutes sufficient for ongoing counseling and dealing with the "addiction" problem.
Advocacy Summit Proposal No. 19

Title of Proposal:
COPN reform legislative strategy

On behalf of:
Dr. Shiv Khandelwal

Describe the Idea or Issue:
It seems to me that COPN reform efforts could be strengthened if there were real world stories to support the issue. In my own practice, I have seen COPN as it currently exists harm patients in ways that were never intended as part of the legislation. I would like to see MSV actively seek examples from its members, providers, and patients as to how COPN as it exists might have had negative consequences for specific patients and seek patients who are willing to come testify about their own situations during the 2018 legislative session. I could provide a few examples myself.

Desired Outcome:
Reform COPN in sensible ways that benefits patients in the Commonwealth of Virginia.

Background/Supporting Information:
MSV supports COPN reform but COPN reform has failed in the last two legislative sessions. I believe this would bolster those efforts.
Title of Proposal:  
Licensure of Certified Anesthesiology Assistants

On behalf of:  
Virginia Society of Anesthesiologists

Describe the Idea or Issue:  
The Virginia Society of Anesthesiologists (VSA) requests that the Medical Society of Virginia advocate for a bill permitting the licensure of certified anesthesiologist assistants (CAAs) in the Commonwealth during the 2018 General Assembly Session.

Desired Outcome:  
The VSA requests that the Medical Society of Virginia advocate for a bill permitting the licensure of CAAs in the Commonwealth during the 2018 General Assembly Session. This is an issue that should be important to the House of Medicine, not just to anesthesiologists, because it impacts:

- Provider shortages
- Access to care
- Economic efficiencies and optimization
- Selection of mid-level practitioner to best suit patient needs

Licensure of CAAs would help alleviate all of these issues, so we are seeking the support of the entire community of medicine in this endeavor.

Background/Supporting Information:  
CAAs are highly skilled health professionals who work under the direction of licensed physician anesthesiologists to implement anesthesia care plans. All CAAs possess a premedical background, a baccalaureate degree and complete a comprehensive didactic and clinical program at the master’s level.

CAAs work exclusively within the anesthesia care team environment and, unlike nurse anesthetists; they must be supervised by a physician anesthesiologist.

Eighteen jurisdictions as well as the District of Columbia currently regulate CCAs. Virginia is surrounded by other states that have already adopted the CAA approach (North Carolina, Washington, D.C., Kentucky and Ohio).

There are 10 accredited CAA educational programs in the U.S. There are nearly 2,000 CAAs already practicing throughout the nation. Eighteen jurisdictions as well as the District of Columbia currently regulate CCAs. Virginia is surrounded by other states that have already adopted the CAA approach (North Carolina, Washington, D.C., Kentucky and Ohio).
CAA students currently rotate through Virginia hospitals, but must go elsewhere to work when they finish training. There are currently about a dozen CAAs who reside in Virginia but travel to work elsewhere (including Arlington, Alexandria, Danville, Fort Royal and Williamsburg).

Anesthesiologists are the only physicians in the Commonwealth with only one physician-extender option (nurse anesthetists). CAAs would provide an additional choice of physician-extenders for anesthesiologists who adhere to the Anesthesia Care Team model of patient care.

CAAs are recognized by CMS, Tricare and all major commercial payers. Data from the Bureau of Labor and Statics shows that the cost of nurse anesthetists decreases in the states with the highest number of CAAs:

Mean Wage
Nationwide Rank in CAA Employment
- Georgia - $137,940 - 1
- Florida - $143,870 - 2
- Ohio - $152,310 - 3
- Texas - $161,740 - 4
- Missouri - $151,330 - 5
- Virginia - $171,160 - None

*Note – Texas is likely still above average because the 130 CAAs don’t compete significantly with the 32,000 nurse anesthetists statewide.

The VSA has been studying CAAs for several years, and has watched with interest as other states have adopted CAA licensure. The VSA surveyed its members in August of 2015, and found that:
- 88% of its members thought that having CAAs as an available physician extender alternative to nurse anesthetists would be a good for anesthesiologists in Virginia.
- 74% of members said that their current practice would use at least one CAA as an alternate physician extender.
- 42% of members said that their current practice would use more than five CAAs as an alternate physician extender.

The Virginia Department of Health Professions is currently evaluating the feasibility of state licensure for CAAs. The Virginia Society of Anesthesiologists plans to pursue legislation licensing CAAs during the 2018 General Assembly Session.

Additional background materials in appendix, pgs. 169-198.