

Payment Differential and Provider Reimbursement Reports: Update and Discussion

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August 28, 2017

Overview

- Academic medical center practices are generally reimbursed higher professional rates than community hospitals and independent practices by commercial payers for the same services.
- The Legislature's concern over the reimbursement differential
 - Independent providers' practice solvency
 - Contributes to health system consolidation – loss of independent practices
 - Impacts consumers and health spending
- Concerns led to a series of mandates since 2014.

Passed	Legislation	Report/Activity	Recommendation
2014	Act 144, § 19 – Independent Physician Practices Report (Administration)	Variation in commercial payment rates based on affiliation with AMC, not hospital ownership, November 2014 <i>Stakeholder process</i>	Continue to pursue payment and delivery system reform and ensure this issue remains an important part of the discussion
2015	Act 54, § 23 – Payment Reform and Differential Payments to Providers (BCBS and MVP)	Implementation plans for providing fair and equitable reimbursement, July 2016	Reduce AMC differential by reducing rates based on a factor calculated by insurers; each carrier proposed different ways of achieving reduction
2016	Act 143, §§ 4-5 – Provider Reimbursement Report (GMCB)	GMCB reports December 1, 2016 and February 1, 2017 Board Meeting 4/27/17 <i>Stakeholder process</i>	Site-neutral payments (medpac), newly acquired practices remain on community fee schedule, work group, clinician landscape
2017	Act 85, § E.345.1 – Fair Reimbursement Report (GMCB)	Report to Health Reform Oversight Committee by October 1, 2017 <i>Stakeholder process</i>	Present options to GMCB 8/28/17

Recommendations

GMCB Report February 1, 2017

- Implement site-neutral payments for newly acquired physician practices for certain services
- For currently affiliated practices, carriers directed to formulate plans to align fee schedules for site-neutral services
- Carriers should propose effective date for implementing site-neutral reimbursement plan, and provide analysis of plan impacts on 2018 insurance rates and plan design, and implementation of All-Payer ACO Model
- GMCB will review the revised plans in a public process
- GMCB will explore additional longer term recommendations for measuring and aligning payments across providers and care settings

Modified carrier plans March 2017

- There is agreement that the Medicare site-neutral approach is a rational approach for Medicare; however, there are complexities for the commercial market
- Unlike Medicare, commercial insurers have multiple fee schedules and negotiated contracts, so there are contractual and administrative consequences

Medicare and MedPAC as a Model

- MedPAC (March 2014) identified service categories that could have their hospital payment rates aligned with physician office rates
- MedPAC recommended applying site-neutral rates to E/M codes and 66 ambulatory services that:
 - Do not require emergency standby capacity
 - Do not have extra costs associated with higher patient complexity in the hospital
 - Do not need the additional overhead associated with services that must be provided in a hospital setting
- January 1, 2017 (Section 603 Bipartisan Budget Act of 2015) – Newly acquired off-campus physician practices no longer eligible for reimbursement under Medicare Outpatient Prospective Payment System (OPPS). These providers now paid under Physician Fee Schedule (PFS).

Where are we now?

- **Provider payment stakeholder work group**
 - May 24 and June 20, plus additional sub-group meetings
 - Participants included MVP, BCBSVT, UVMHC, RRMC, VAHHS, OneCare, VMS, HealthFirst, independent primary care and specialty providers, Bi-State Primary Care, VPQHC, legislators
- **Vermont clinician landscape survey and focus groups**
 - Clinician survey, medical student survey, focus groups
- **Literature review**
 - National trends
- **Vermont specific reimbursement analysis**
 - Carrier reports
 - Blueprint primary care analysis

Key Point #1

- 1. There is a significant fee-for-service rate differential between the academic medical center and other providers for professional services.**
2. The trend in Vermont and nationally is toward greater consolidation in health care; commercial reimbursement rates are not the only reason physicians are joining up with larger practices and health systems.
3. Adjusting fee-for-service rates through regulation is complex and will have impacts on consumer premiums and out-of-pocket costs, hospital budgets, as well as access and quality of care.

Literature Review: national trends

- Metropolitan areas with greater vertical integration experienced faster growth in prices and spending for outpatient services, little impact on inpatient (Neprash et al, 2015)
- Hospital acquisition is associated with an overall increase in physician prices of 14% and an increase in primary care spending of about 5% (Capps et al, 2017)

Carrier reports, July 2016

- MVP:
 - UVMHC reimbursed above other tertiary care providers in MVP network
 - MVP is “certain” that its current reimbursements for professional services provided by Vermont’s independent physicians are “fair and equitable.”
 - Can reduce AMC/independent differential 23% in each of the next two years
- BCBSVT:
 - Produce fair and equitable reimbursement through adjustment to AMC reimbursement
 - Align with Medicaid/Medicare AMC benchmark methodology
 - Will take into account Graduate Medical Education, Disproportionate share hospital payments
 - Reduce rate over 3 years for E/M codes only; revenue shift to inpatient

Average allowed amount per primary care service*, Vermont Blueprint practices, 2015

	Blueprint practices	Avg. allowed amount Commercial	Avg. allowed amount Combined public/private
FQHC/RHC	41	\$95.66	\$120.39
Academic Medical Center	10	\$167.58	\$112.51
Independent	47	\$99.72	\$91.57
Community Hospital	34	\$103.31	\$80.34

Source: Blueprint practice roster and VHCURES claims data, CY2015

*Primary care services as defined by primary care work group in 2015.

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Key Point #2

1. There is a significant fee-for-service rate differential between the academic medical center and other providers for professional services.
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Literature Review: national trends

- Overall market concentration in U.S. hospital sector has increased 40% since mid-1980s, both vertical and horizontal consolidation (Cutler and Morton, 2013)
- Hospital ownership of physician practices increased from 24% of practices to 49% from 2004-2011 (Cutler and Morton, 2013)
- 37% of practices were physician owned in 2013, down from 57% in 2000, projected to drop to 33% in 2016 (Accenture, 2015)

Literature Review: national trends

- Literature describes additional reasons physicians are joining up with larger practices and health systems. (Accenture, 2015; Jackson Healthcare)
 - EMR implementation
 - Challenge and risk of running a complex business
 - Income security
 - ACA and ACO incentives to integrate health care systems
 - Lifestyle preference

2017 Medscape physician compensation report

Who Earns More: Employed or Self-employed Physicians?



Medscape Physician Compensation Report, 2017. <http://www.medscape.com/slideshow/compensation-2017-overview-6008547>. Survey recruitment period 12/20/2016-3/7/2017.

VT Clinician Landscape Survey

When:

Fielded an electronic survey (SurveyMonkey)
between
8/10/2017 – 8/22/2017

How:

We requested distribution of survey link via:
Vermont Medical Society
Hospital Systems
Bi-State Primary Care
VT HealthFirst

Completed Responses:

404 clinicians

91 clinicians (23%) practicing independently

313 clinicians (77%) are employed by AMC,
community hospital, FQHC/rural health clinic

Demographics:

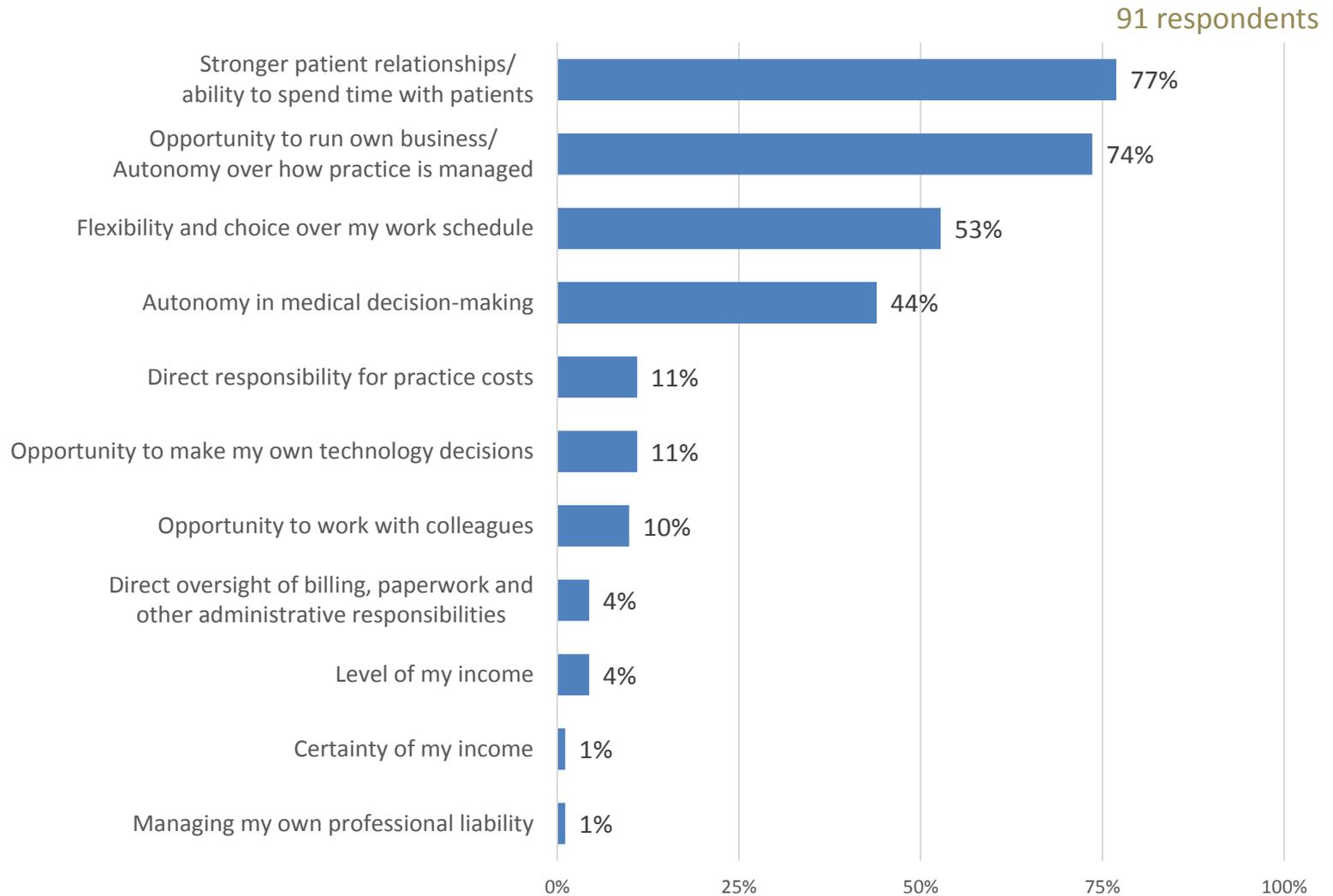
Primary care (30%)

Pediatrics (9%)

Specialty (61%)

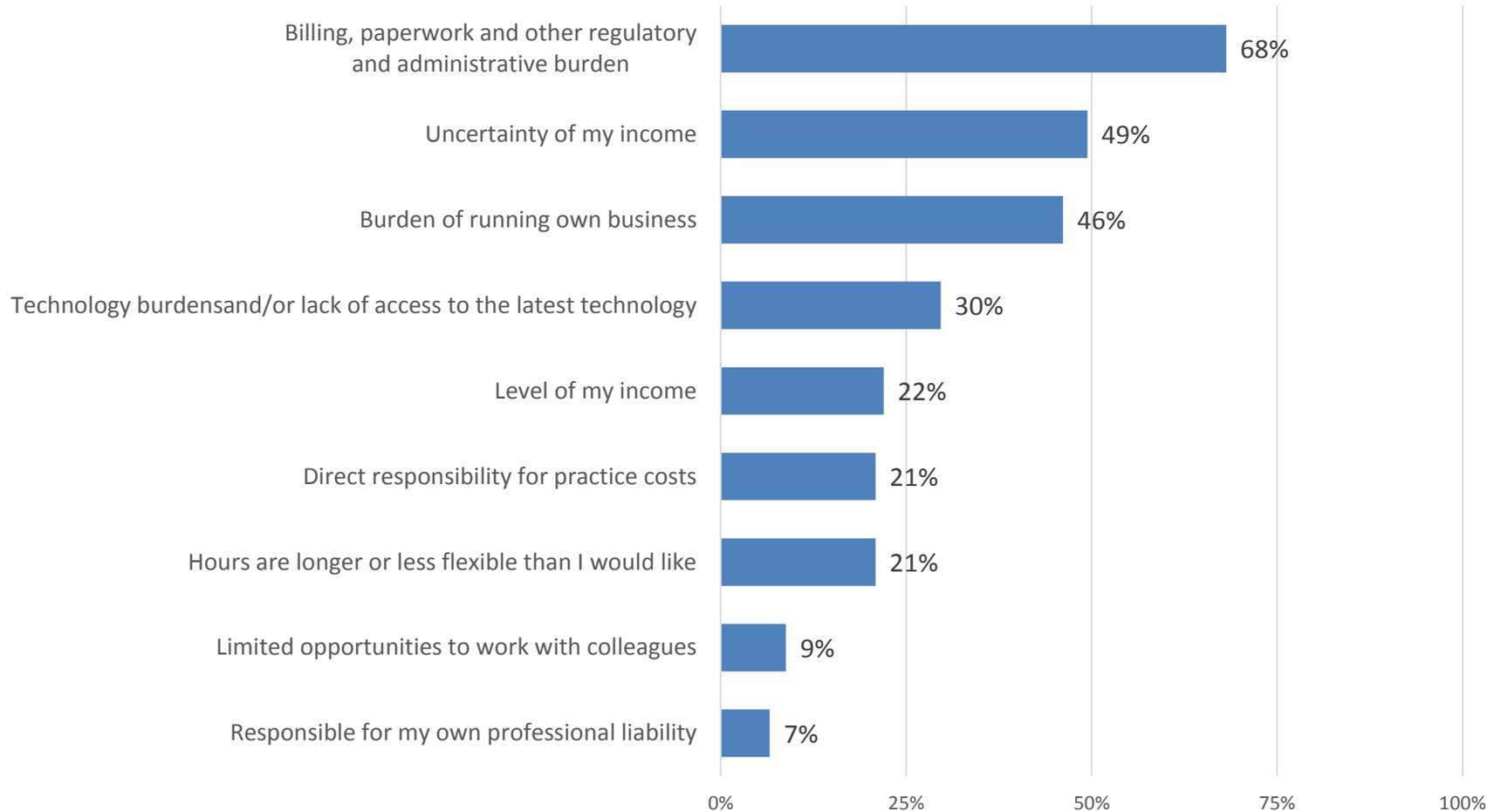
HSA: all represented

Satisfying Factors: Independent Clinicians

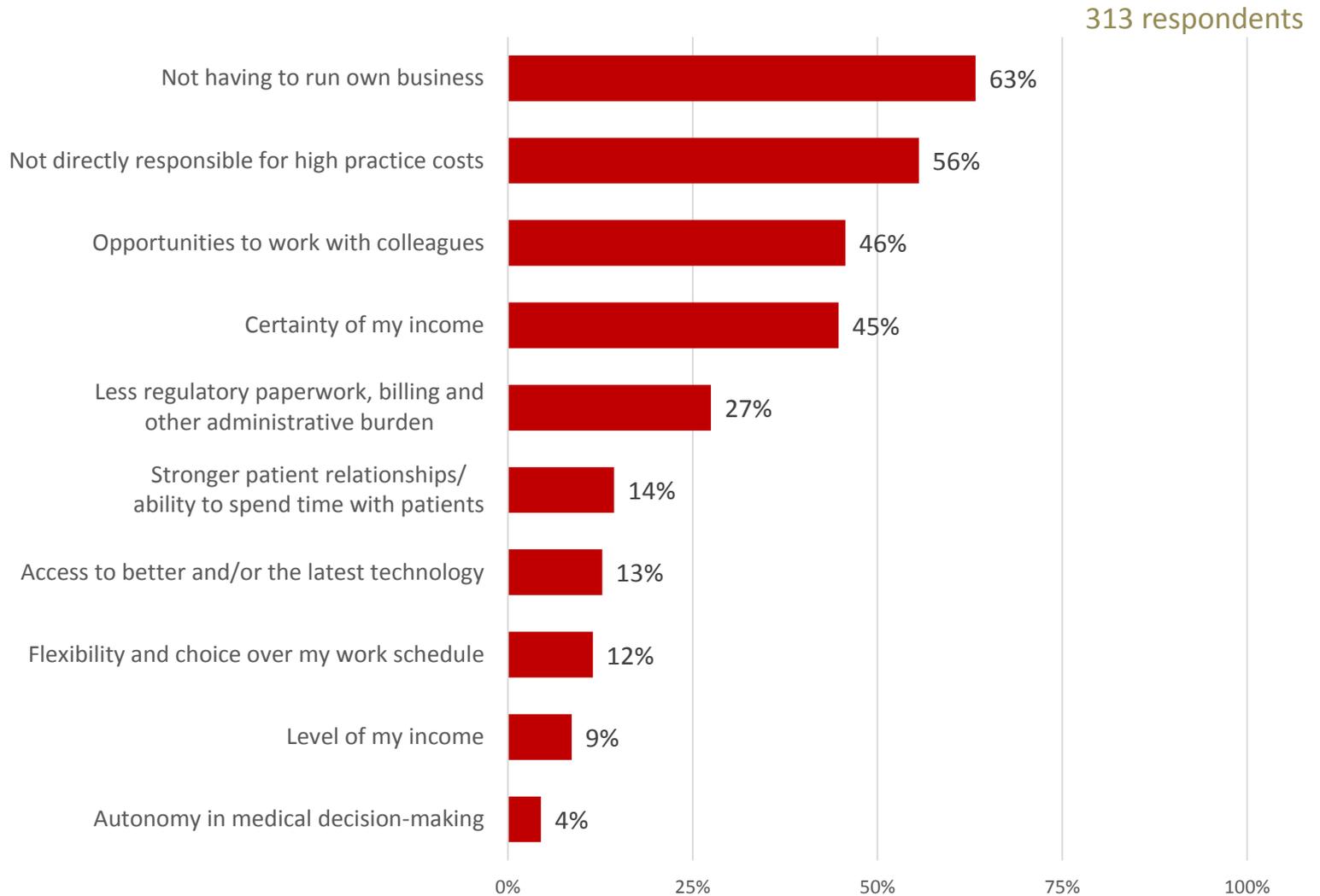


Frustrating Factors: Independent Clinicians

91 respondents



Satisfying Factors: Employed Clinicians



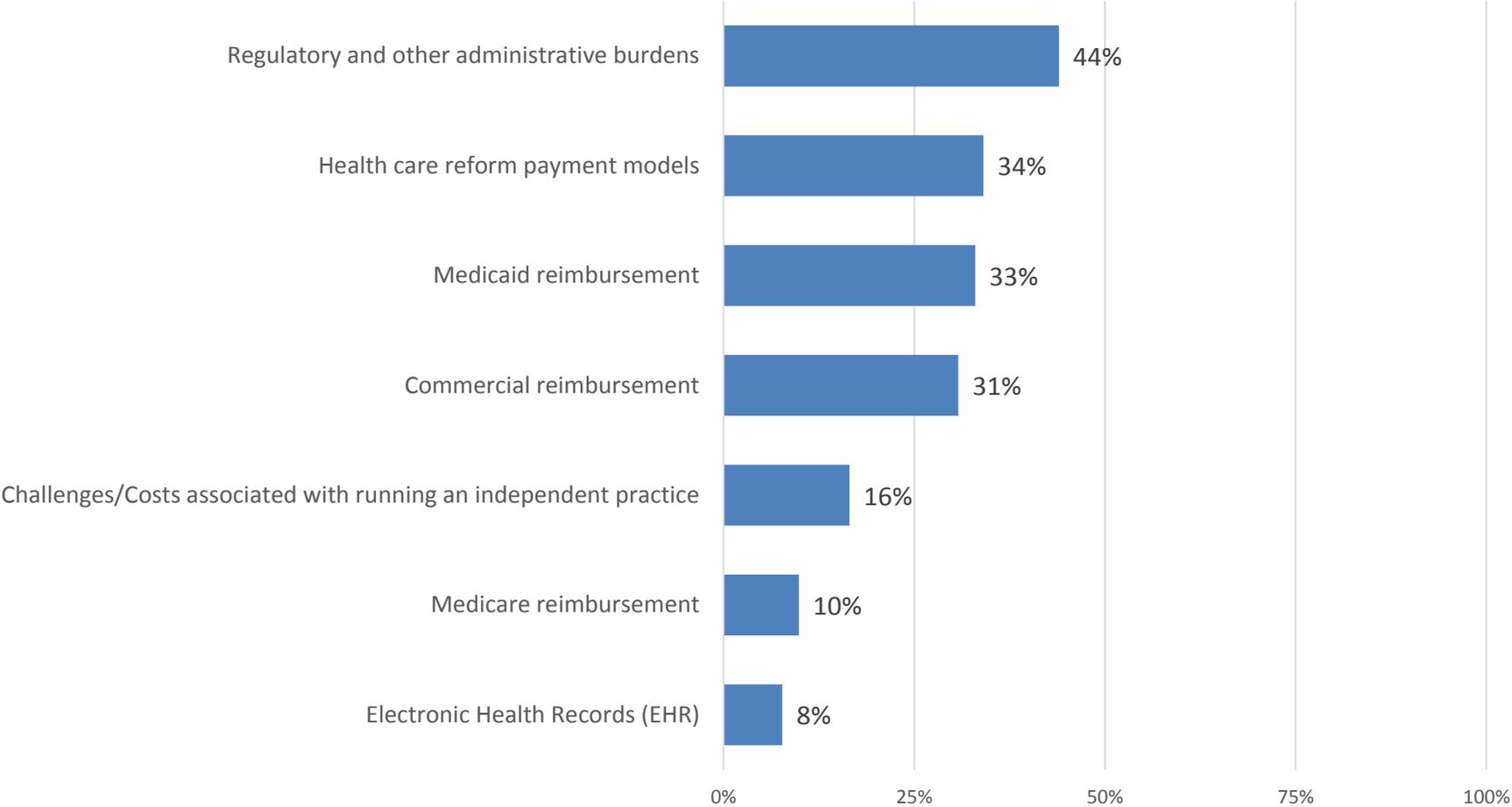
Frustrating Factors: Employed Clinicians

313 respondents



Greatest Threats: Independent Clinicians

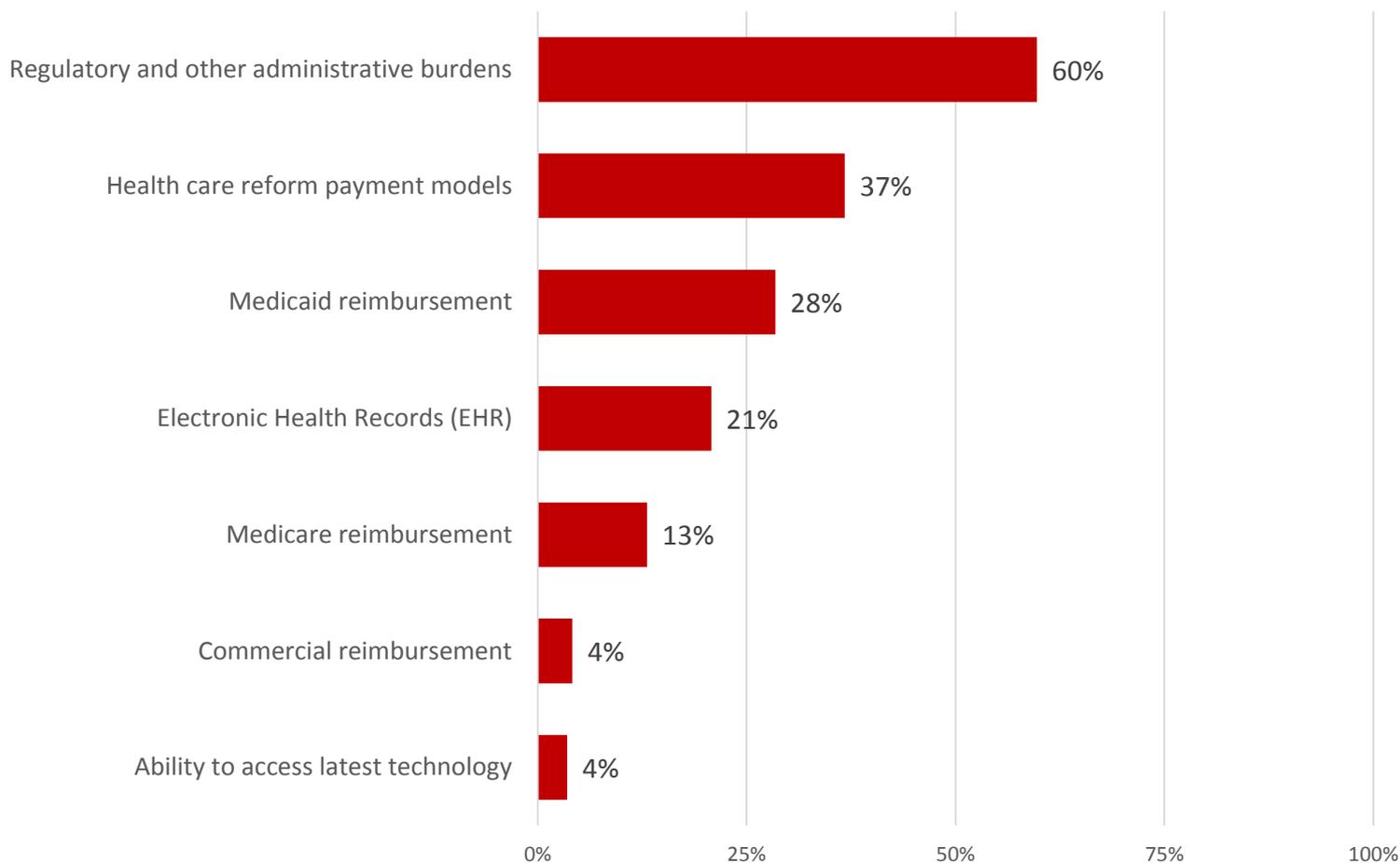
91 respondents



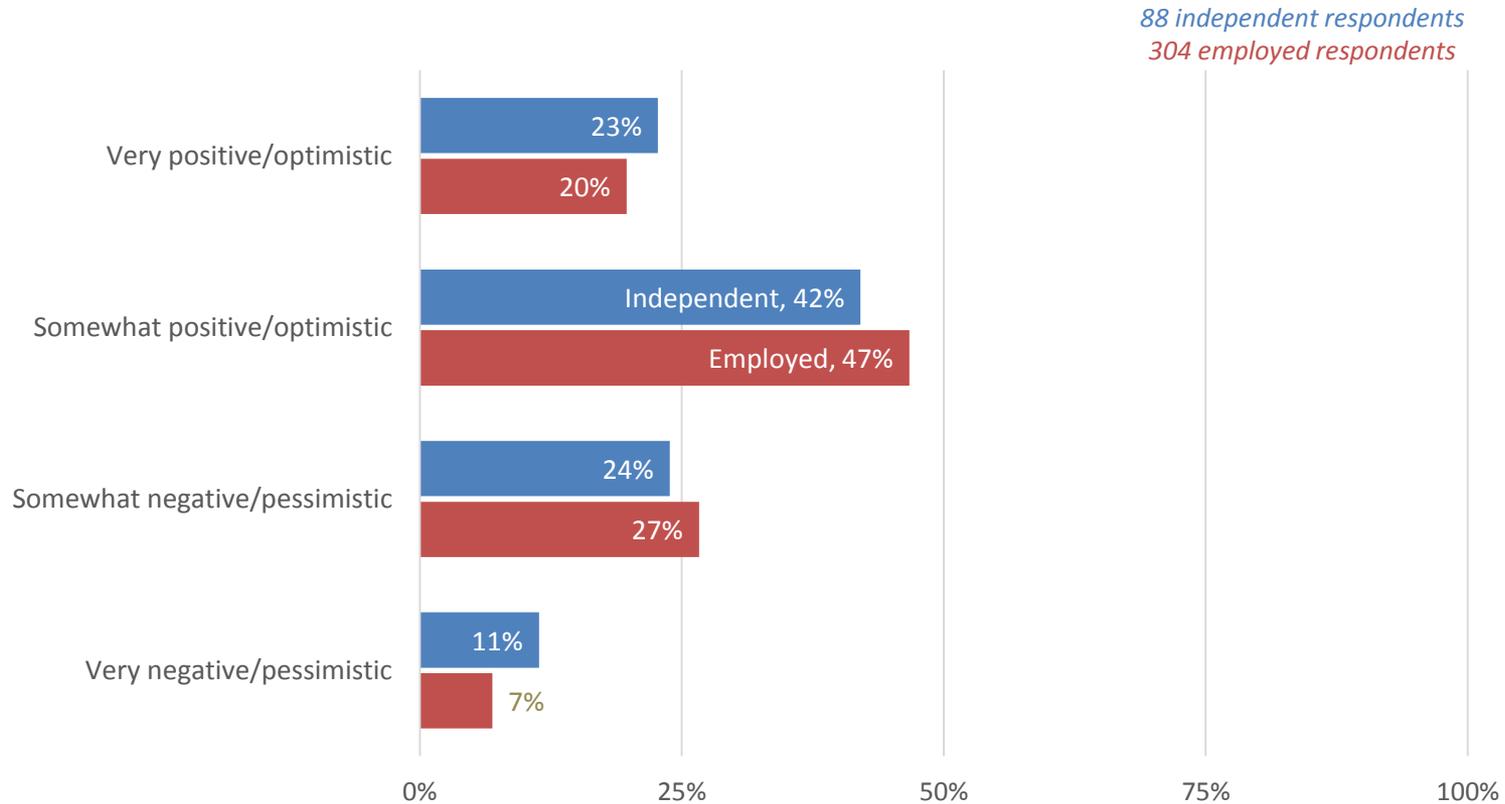
Source: GMCB Provider Landscape Survey, 2017

Greatest Threats: Employed Clinicians

313 respondents

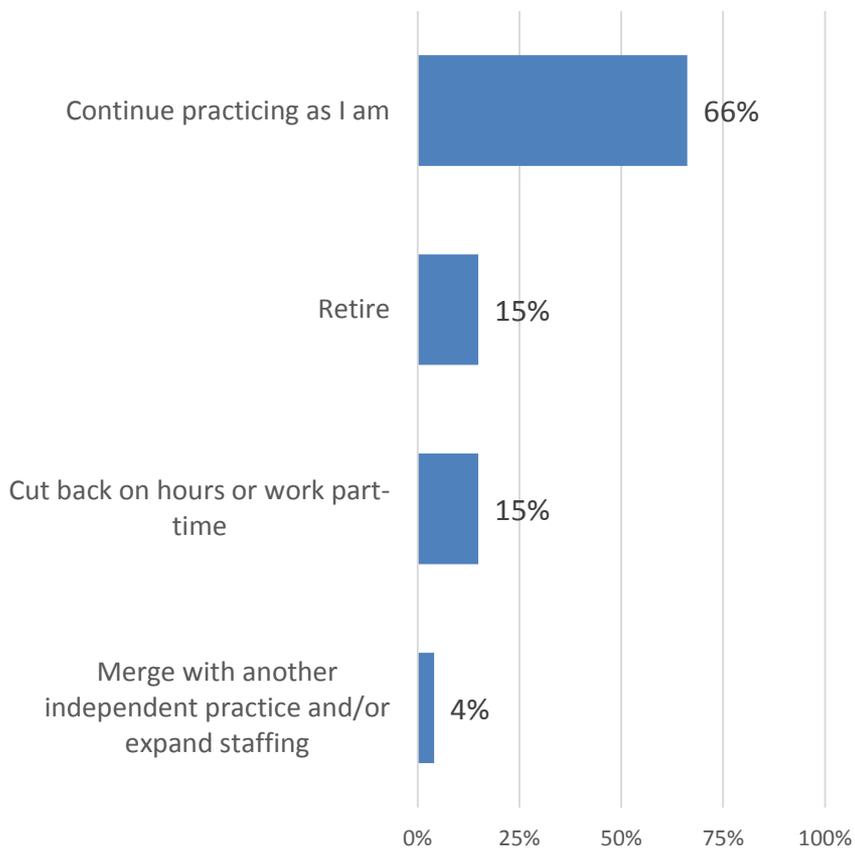


Which best describes your professional morale and your feelings about your current employment?



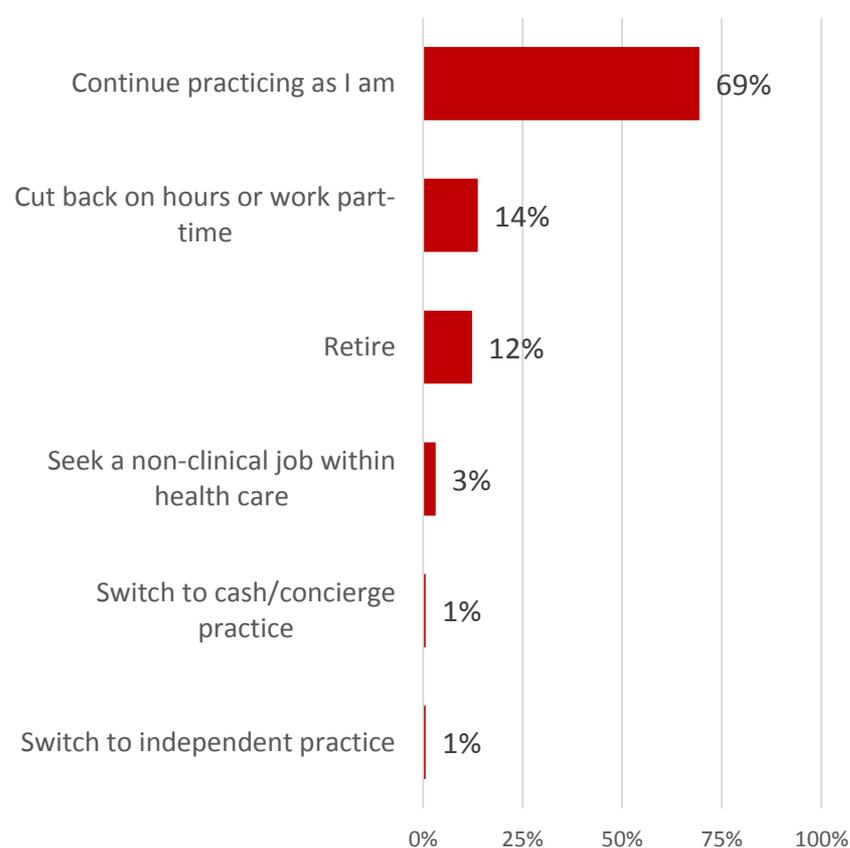
Next Three Years

Independent Clinicians



74 respondents

Employed Clinicians



284 respondents

Takeaways

- Independent clinicians like the autonomy and flexibility that running their own practice provides while employed clinicians like not having to deal with the burdens and high costs of running their own practice.
- Both independent and employed clinicians are frustrated by the administrative burdens.
- Independent clinicians identify the uncertainty of their income as a frustration whereas employed clinicians identify the level of their income as a frustration.
- Whether independent or employed, the greatest threats to practicing in Vermont are seen to be regulatory/administrative burden, health care reform payment models and Medicaid reimbursement.
- Even with these frustrations, most clinicians plan to continue practicing in the coming years as they are today.

Continuing to Study the Issues

- Additional sub-analyses to understand differences, if any, by HSA and by specialty.
- Focus Groups to take a deeper dive into the issues facing Vermont clinicians.
- Survey of UVM medical students.

Key Point #3

1. There is a significant fee-for-service rate differential between the academic medical center and other providers for professional services.
2. The trend in Vermont and nationally is toward greater consolidation in health care; commercial reimbursement rates are not the only reason physicians are joining up with larger practices and health systems.
3. Adjusting fee-for-service rates through regulation is complex and will have impacts on consumer premiums and out-of-pocket costs, hospital budgets, as well as access and quality of care.

A path toward “fair and equitable” reimbursement...

The challenge for the work group:

How might we move to a consistent, transparent, and easily operationalized reimbursement system based on the resource costs of delivering high quality care in the least cost setting?

Consequences that need to be addressed in any proposed approach:

- Impact on independent practices
- Impact on hospitals
- Impact on premiums and out of pocket costs for consumers
- Impact on access and quality of care
- Operational implications for payers
- Regulatory impact

Where are we now?

- A reduction in academic medical center rates and increase in professional fees to other providers for some services
- UVMHC has proposed a 10% reduction for professional service fees in its FY2018 budget

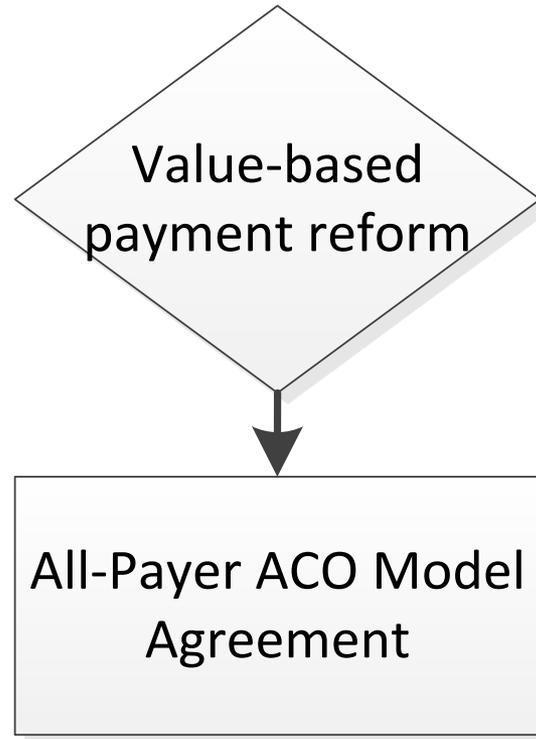
A path toward “fair and equitable” reimbursement...

- Vermont is moving away from fee-for-service payments toward system-wide value-based payment reform
- The incentives of value-based payments are designed to address reimbursement differentials for providers participating in the model
- A short term fix to fee-for-service price differentials could have implications on moving toward new payment models

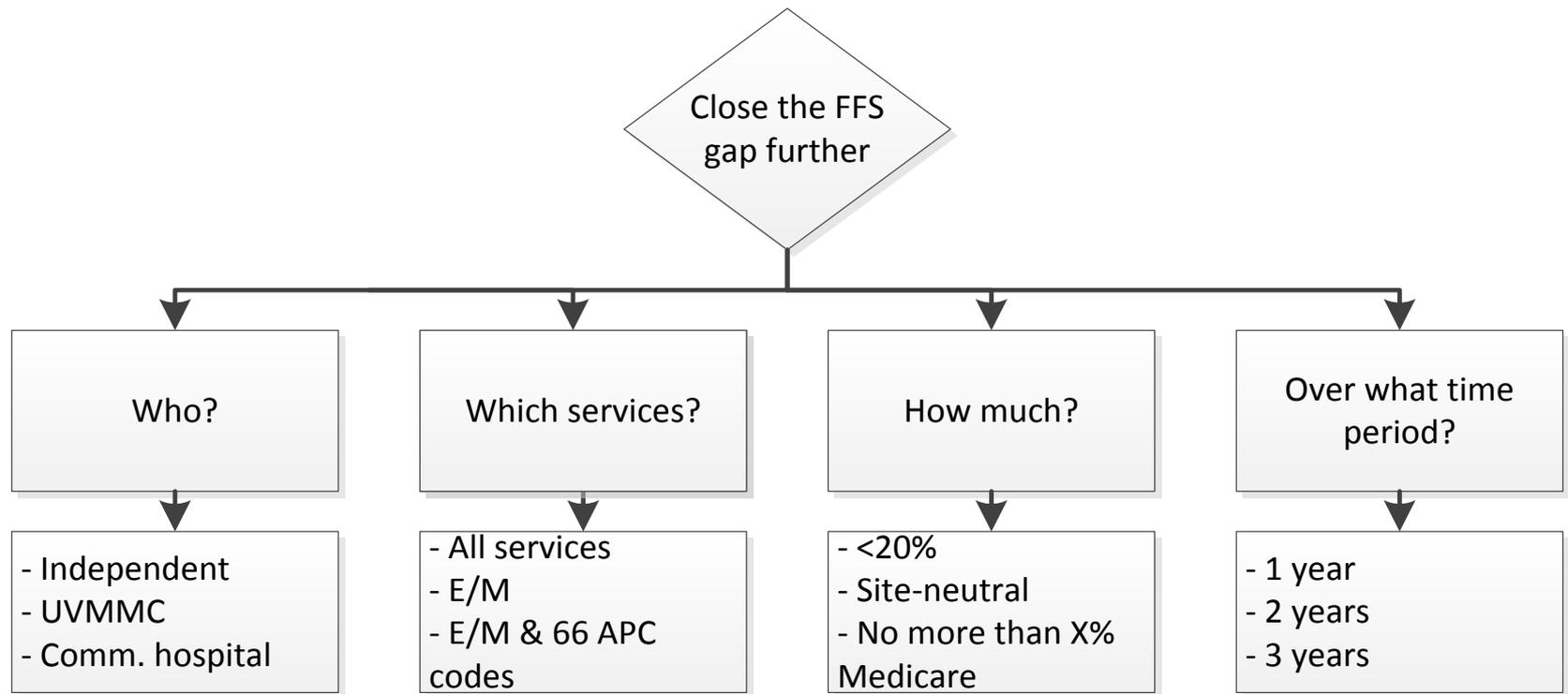
Vermont All-Payer Accountable Care Organization (ACO) Model

- Moves from fee-for-service reimbursement to a value-based payment model.
- Provides Vermont ACOs an opportunity to participate in a state tailored Medicare ACO Initiative, aligned with Medicaid and Commercial programs for ACOs.
 - Offers **prospective, population-based payments**, calculated using the historical expenditures of attributed members from all participating payers.
 - Gives flexibility to **redirect** pool of dollars to better support preventive, primary care and improve health care outcomes.

A path toward “fair and equitable” reimbursement...



A path toward “fair and equitable” reimbursement...



Considerations

- National and Vermont trends toward greater consolidation in health care
- Consolidation can lead to greater efficiencies and care integration, but also to higher prices
- What is the appropriate price differential for services provided at an academic medical center in comparison to the same services provided at an independent community provider?
- For which services is it appropriate to have parity (“site-neutrality”) between different types of providers?

References

1. Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. JAMA Intern Med 2015;**175**(12):1932-9 doi: 10.1001/jamainternmed.2015.4610published Online First.
2. Capps, C., Dranove, D. & Ody, C. (2017). The effect of hospital acquisitions of physician practices on prices and spending. Retrieved from <http://economics.mit.edu/files/12747>
3. Cutler DM, Scott Morton F. Hospitals, market share, and consolidation. JAMA 2013;**310**(18):1964-70 doi: 10.1001/jama.2013.281675published Online First.
4. Accenture. (2015) Independent Physicians: A Swiftly Shrinking Segment. Available: <https://www.accenture.com/us-en/insight-clinical-care-independent-doctor-will-not-see-you-now>.
5. Medscape Physician Compensation Report, 2017. <http://www.medscape.com/slideshow/compensation-2017-overview-6008547>. Survey recruitment period 12/20/2016-3/7/2017.

References

- Provider reimbursement report materials are available on the GMCB website:
 - <http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports>
- April 27, 2017 Board meeting materials:
 - [UVMHN Presentation - Act 54 and Act 143: "Fair and Equitable Payments" and Site Neutrality](#)
 - [GMCB Presentation - Act 54 \(2015\) and Act 143 \(2016\) Payment Differential and Provider Reimbursement Reports: Overview of GMCB Process and Progress Update](#)
 - [GMCB Act 143 Update](#)