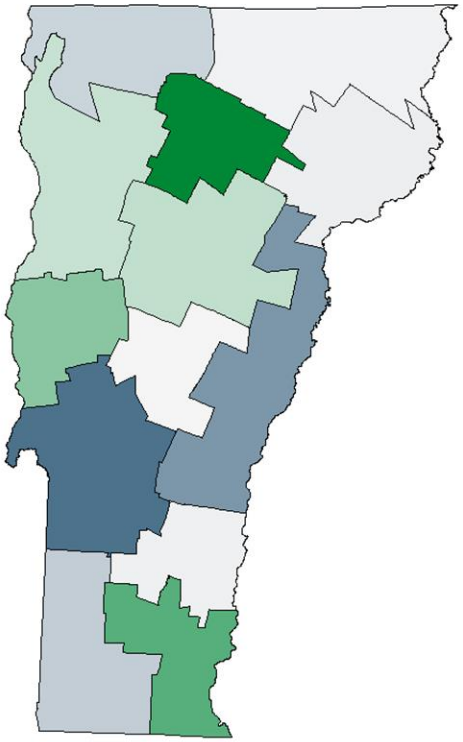

Act 54 (2015) and Act 143 (2016) Payment Differential and Provider Reimbursement Reports:

Overview of GMCB Process and Progress Update

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April 27, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Overview

- What is the issue?
- What is Vermont doing about it?
  - Goals of the Board
  - Statutory charge
  - Progress to date
- Report recommendations
  - GMCB report
  - Carrier reports
  - Medicare/MedPAC model

What is the issue?

- 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?

What is Vermont doing about it?

- Goals of the Board for fair and equitable provider reimbursement:
  - Ease consumer co-insurance and/or premiums
  - Contain total cost of care
  - Promote access to high quality care
  - Support primary care providers
  - Support independent practices within VT's regulatory framework and payment reform
  - Maintain access to critical hospital services

Act 54 (2015) and Act 143 (2016): Statutory Charge

- Insurers:
  - Implementation plan for providing fair and equitable reimbursement amounts for professional services provided by academic medical centers and other professionals [Act 54 Sec. 23(b), submitted July 15, 2016]

- GMCB:
  - Provide an update to the HROC and committees of jurisdiction on its progress toward fair and equitable reimbursement amounts for professional services provided by academic medical centers and by other professionals, without increasing health insurance premiums or public funding of health care [Act 143 Sec. 5(b), submitted December 1, 2016]

  - The GMCB "shall consider the advisability and feasibility of expanding to commercial health insurers the prohibition on any increased reimbursement rates or provider-based billing for health care providers newly transferred to or acquired by a hospital…" [Act 143 Sec. 4, submitted February 1, 2017]

Progress to date

- MVP and BCBSVT implementation plans (July 1, 2016)
- GMCB update and report (December 1, 2016 and February 1, 2017)
  - Met with MVP, BCBSVT, UVMMC, VCO, HealthFirst, Bi-State PCA, VAHHS
- MVP and BCBSVT submitted modifications (March 2017)
- On Board Meeting Agenda April 27, 2017

Recommendations
GMCB Report February 1, 2017

- Site-neutral payments for newly acquired physician practices for certain services
- For currently affiliated practices, carriers should outline plans for aligning fee schedules for site-neutral services as soon as practicable
- Carriers should include proposed effective date of each of the two reimbursement practices above, as well as analysis of impacts on 2018 plan designs, 2018 insurance rates, and implementation of All-Payer ACO Model
- GMCB will review the revised plans and begin 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

- Appears to be 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).

Next steps

- Continue Board public process to develop guidelines and criteria to be used to foster equity in payment practices
- Tap into Primary Care Advisory Group to get their input and discuss options
- Analyze impacts of site-neutrality on premiums, primary care providers and All-Payer Model requirements
- Explore additional longer term recommendation for measuring and aligning payment across providers and care settings – part of the Board's evaluation of its regulatory processes to align with implementation of the All-Payer ACO Model Agreement