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UVMHealth.org

Act 54 and Act 143:

“Fair and Equitable Payments” and Site Neutrality

Green Mountain Care Board

April 27, 2017

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Overview

- What problems are we trying to solve?
- Will what has been proposed solve those problems?
- Where do we go from here?

Problems

- “Independent physicians are paid less than hospital-employed physicians”
  - Act 54: insurers to develop plans “for providing ***fair and equitable reimbursement***”
- “Hospitals are buying physician practices to increase their revenues”
  - Act 143: GMCB to recommend whether to prohibit “provider-based billing” for practices newly transferred or acquired by hospitals

Fair and Equitable Reimbursement

- As Vermont's academic medical center, UVM Medical Center has a completely different cost structure than community-practice physicians
  - Highly-specialized services (like pediatric specialties, transplant) not otherwise available in Vermont
  - Level 1 Trauma Center
  - NICU
  - Education and research
  - 6% provider tax on physician reimbursements
  - Higher proportion of Medicaid, charity care and uninsured patients

Physician Salaries

- Professional fees do not equate to physician salaries
  - We use several benchmarks in looking at salaries, including those for other academic medical centers as well as the Medical Group Management Association (MGMA)
  - Academic salaries are generally lower than non-AMC salaries
  - Looking just at the MGMA survey, average compensation for a UVM Medical Center-employed physician is at 30th percentile
- Professional fees support the overall mission and services of the UVM Medical Center, as do all other revenues

“Site-Neutral Payments”

- UVM Medical Center does not “buy practices” to build a larger power base
  - Three practices have come into the UVM Medical Center in the past 5 years
  - In each case, they have approached us
    - Why? Because practicing independently is becoming more difficult and complicated and expensive (*e.g.*, needed investments in EHRs, cost of NCQA accreditation in order to be a Blueprint practice, Medicare’s new MACRA/MIPS reporting requirements)
- The ***only*** payer in Vermont that uses provider-based billing is Medicare

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We Need Facts

- We continue to call on the GMCB to use the data it collects to analyze and publish meaningful and actionable facts

Arrowhead Health Analytics Report

Table 2. Vermont Commercial Claims, 2008
Ratio of Per-Member Per-Month Cost to State Average by Hospital Service Area

		Hospital Service Area				
	Total	Inpatient Hospital	Outpatient Hospital	Outpatient Radiology	Emergency Department	Physician Office
Central Vermont	0.99	0.94	1.06	1.06	1.00	1.00
Southwestern	1.16	1.43	1.19	1.06	1.50	1.17
Brattleboro	1.00	1.02	1.08	1.28	0.79	0.93
FAHC	0.89	0.76	0.74	0.78	0.79	1.07
Porter	0.96	1.10	0.83	0.72	0.86	1.15
Copley	1.01	1.18	1.05	0.89	0.71	0.90
North Country	1.10	1.14	1.44	1.08	1.57	0.71
Gifford	1.05	1.12	1.31	1.28	0.93	0.85
Rutland	1.18	1.47	1.26	1.39	1.14	1.02
Springfield	1.09	1.08	1.26	1.42	1.36	0.83
Northwestern	0.95	0.86	0.98	0.86	1.29	1.02
Northeastern	1.03	1.14	1.19	1.08	0.79	0.66
White River Jct.	1.12	1.02	1.21	1.36	0.93	0.85

Source: OnPoint, Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) data, Policy Integrity analysis.

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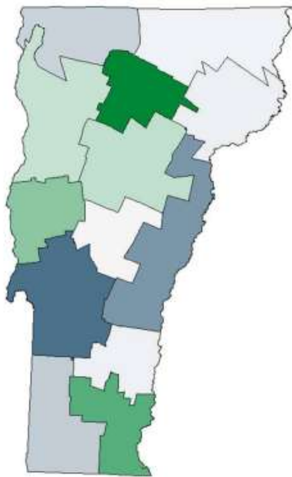
Source: "Health Care Costs and Cost Growth in Vermont: An Analysis of Recent Trends and Explanatory Factors," Arrowhead Health Analytics, Sept. 2010, p.7

Optumus Report



Vermont All-Payer Model Agreement

Development of Projection Model and Agreement Hospital Service Area Analysis

February 2, 2017

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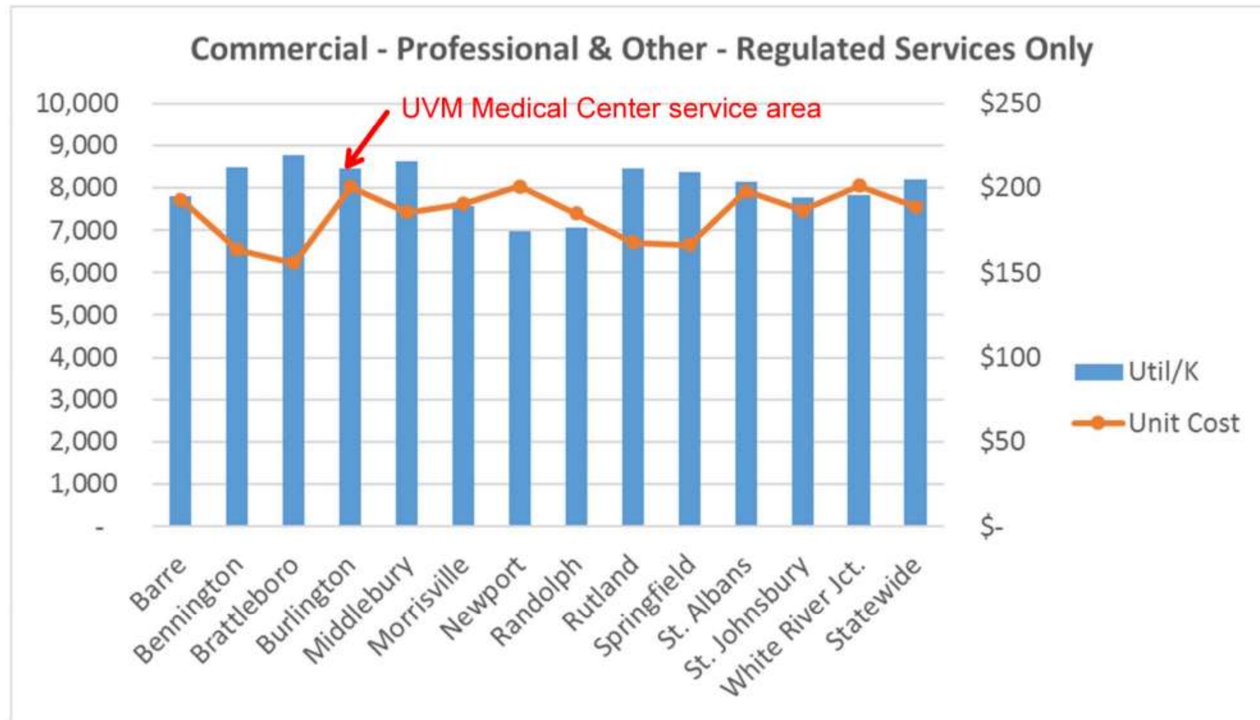
Optumus Report



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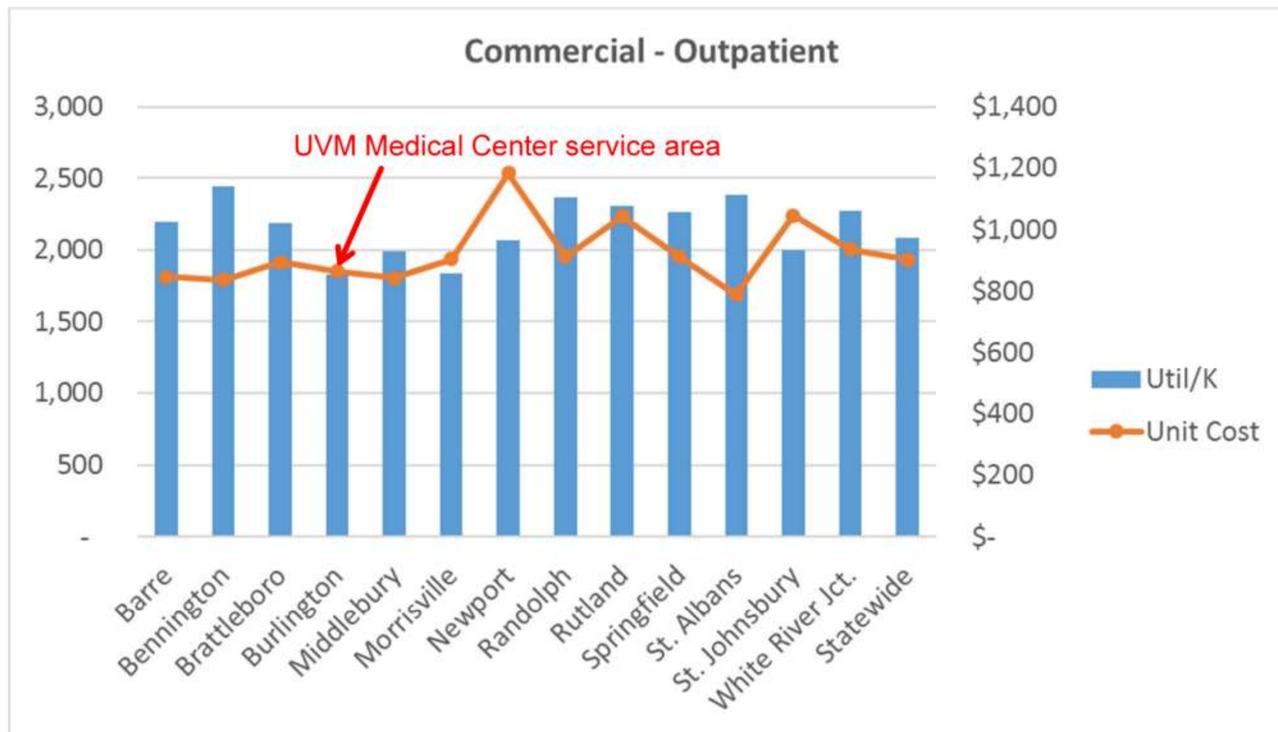

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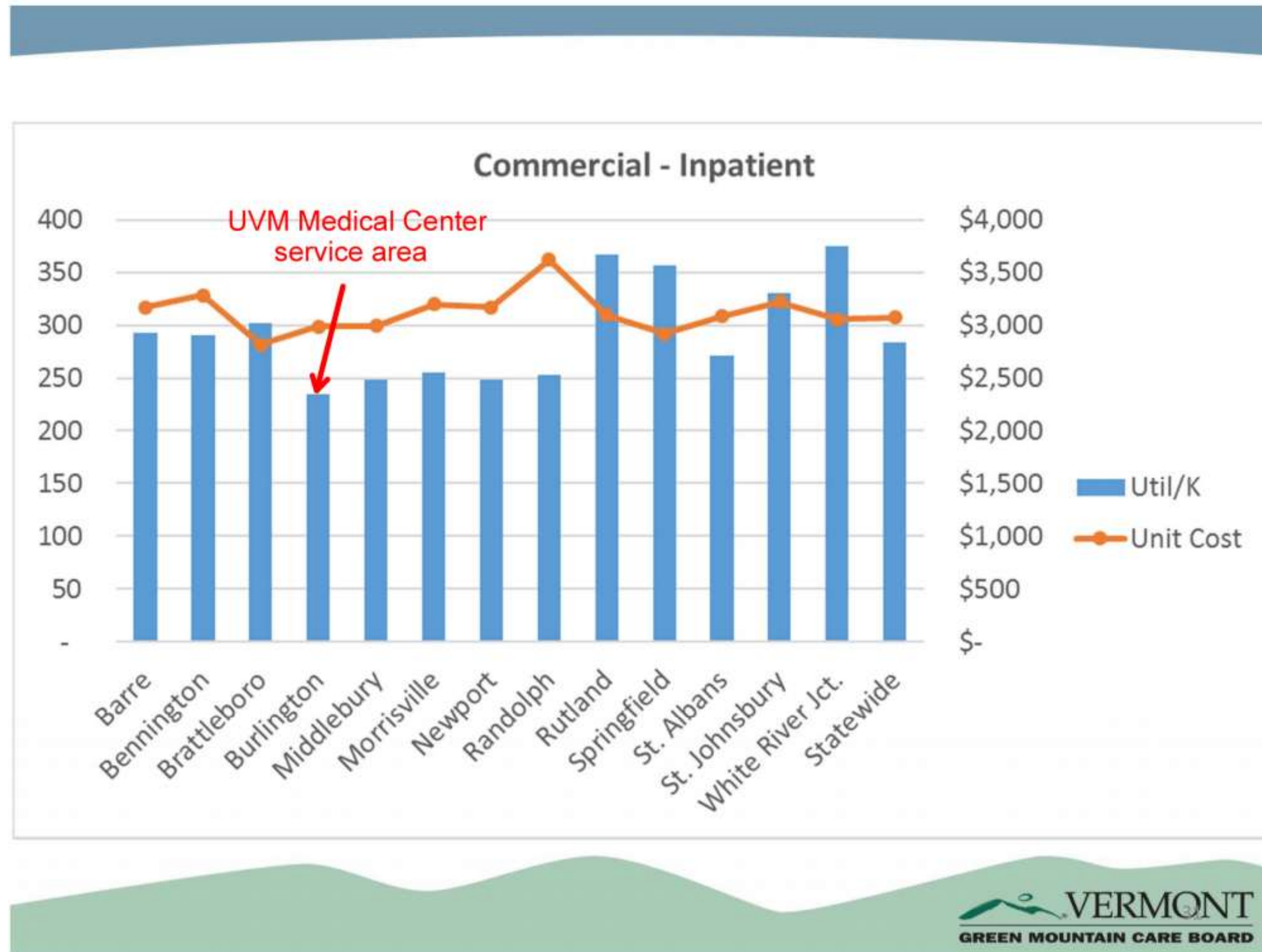

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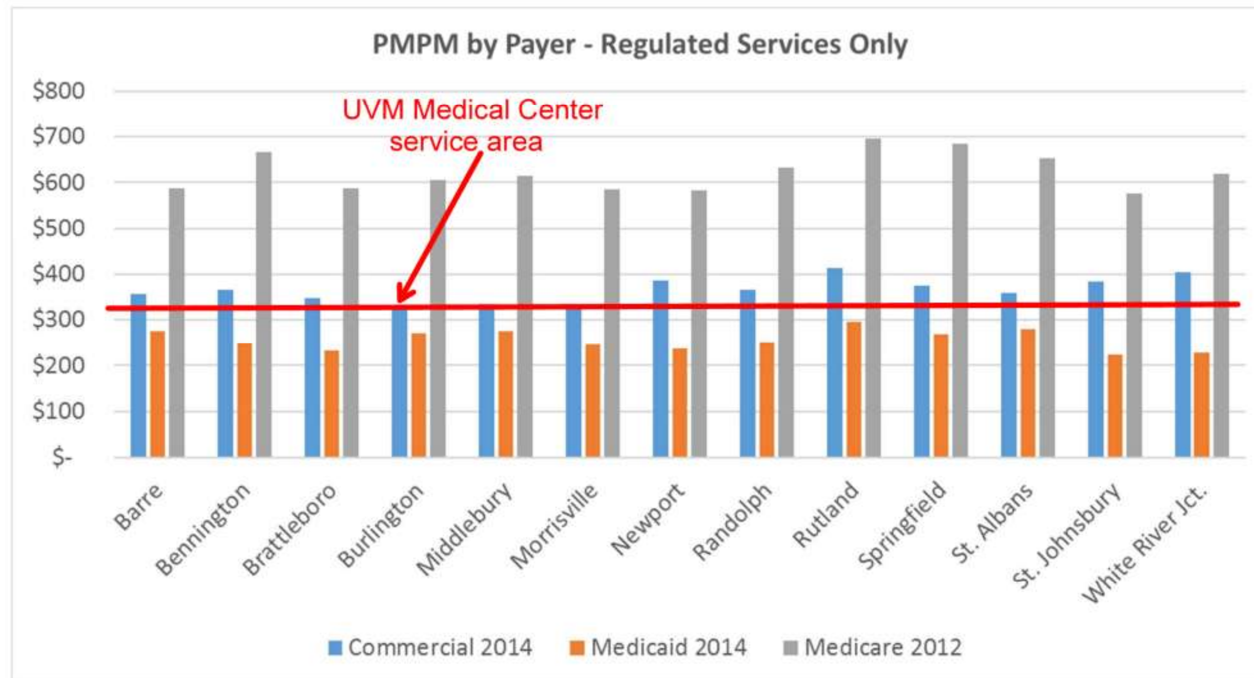

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Blueprint Data

Practice Type	Payer Type	Count of Total Attributed Members	Average Age of Members	Primary Care Services PMPM (Allowed = Plan and Member Payments to Practice)
AMC (Academic Medical Center)	COMBINED Medicare, Medicaid, Commercial	47,032	46	$26.27
FQHC (Federally Qualified Health Center)	COMBINED Medicare, Medicaid, Commercial	102,798	41	$25.62
Hospital-Owned	COMBINED Medicare, Medicaid, Commercial	82,705	42	$19.41
Independent Multi-Site	COMBINED Medicare, Medicaid, Commercial	23,127	24	$26.88
Independent Single-Site	COMBINED Medicare, Medicaid, Commercial	76,724	40	$22.86
RHC (Rural Health Clinic)	COMBINED Medicare, Medicaid, Commercial	30,594	42	$20.79

Source: Derived from "Primary Care Analysis Report – Updated 2016-12-29," provided by GMCB to OneCare Vermont

Proposals

- GMCB: Use MedPAC's March 2014 recommendations for site-neutral payments
  - No increase in payments to newly-integrated practices for E&M codes and 66 APCs
  - No use of provider-based billing for those services
  - Make all physician practice payments consistent with MedPAC recommendations "as soon as is practicable"

- Insurers: And do not let hospitals increase other revenues to offset lost revenues associated with making MedPAC-recommended changes

Issues

- The GMCB regulates hospitals at a global level
  - Revenue reductions in one area will require revenue increases elsewhere
- The MedPAC recommendations from 2014 were not adopted by Medicare, and are out of sync with how Medicare currently pays for those APCs
  - The APCs as defined in the report no longer exist (completely reconfigured in 2016)
  - A single APC is not a unique "service" but a group of services/CPT codes
  - In the last 7 years, CMS has altered the APC payment system to incorporate a significant amount of bundling/packaging methodologies, many of which would now fall under the "Group 2" category (APCs that did ***not*** meet criteria for equal payment across settings)

Issues

- UVM Medical Center faces significantly reduced revenues should the MedPAC recommendations be implemented (if they can be)
  - Estimated at $13.8 million across all sites
- Unless GMCB can draw a straight line between hospital revenue reductions and premium reductions – which has so far proved impossible – these changes only benefit the insurers
  - Hospitals' historically-low rate increases over the past few years (1.8% in FY 2017) have not materially impacted insurance premiums (BCBSVT 2017 premium increase for VHC plans was 7.3%, MVP premium increase was 3.7%)

UVM Medical Center Proposals

- UVM Medical Center has been lowering professional rates over the last three years
- Propose to further reduce them in FY 2018
  – Although will still be higher, reflecting differences in services being supported
- No change in rates for any new practices integrated into UVM Medical Center starting now (site-neutrality issue)

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How Does This Fit Into the APM?

- UVM Medical Center is all-in with health care reform in Vermont
  - Investments in the statewide ACO that underpins the All-Payer ACO Model Agreement with CMS
  - Already accepting capitated payments for Medicaid lives under the Medicaid NextGen ACO Program
  - Ready to expand that to include Medicare and willing insurer partners in 2018
- We should be focusing on the future, and how a reformed payment system can support all providers

Questions?