Price Variation

VERMONT
GREEN MOUNTAIN CARE BOARD

Summary

Price transparency in health care is an effort to describe and provide comparison for the cost of health care. Many states have invested substantial resources to build dedicated tools so that consumers are able to investigate the expected costs at the procedure level. These tools vary in their complexity, format, and the authoring entities. Vermont statute[1] requires commercial health insurers in Vermont to provide their customers with a means to compare costs and expected member responsibility based on their health plan. One example of a price and quality tool is on the BlueCross BlueShield of Vermont website.[2]

Background Information

In April 2019, the Board, through its Data Governance Council, adopted Data Stewardship Principles and Policies, which include timely, consistent, and actionable analyses that support the Board's analytic priorities.[3]

In October 2019, the Board requested a comprehensive report on price variation to inform their regulatory decision-making. To support that request, the GMCB Analytics Team started a project to produce a report dashboard that will allow public exploration of how prices vary for a variety of medical services and procedures, as well as some factors that help explain that variation.

The primary source of relevant information available to GMCB staff is the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's All-Payer Claims Database (APCD). This is a large database containing eligibility, provider, and medical/pharmaceutical claim data for most Vermonters. Data are submitted by the entities who pay the claims, both governmental (i.e. Medicare and Medicaid) and commercial payers (e.g. BlueCross BlueShield of Vermont, MVP). The data set has limitations as it does not include all Vermont residents and is not tied to sworn financial statements. Therefore, the project will include an initial validation phase to better estimate the magnitude of expected differences from the actual amounts exchanged for medical care.

Green Mountain Care Board

The purpose of the Green Mountain Care Board is to promote the general good of the State by:

1. Improving the health of the population;
2. Reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
3. Enhancing the patient and health care professional experience of care;
4. Recruiting and retaining high-quality health care professionals; and
5. Achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

The GMCB Analytics Team has begun researching claims pricing using the publicly available methodologies from Medicare and Medicaid. The following outlines factors have historically influenced pricing and are expected to have measurable variables in the VHCURES database.

Definition of Price for a Medical Service

Discussions around the prices of medical services mostly refer to the negotiated price between providers and insurers. Providers who have negotiated prices for services with an insurer are often referred to as "in-network," whereas providers who do not have negotiated prices with an insurer are "out-of-network." However, the negotiated prices are not always available nor is it included on the claims stored in VHCURES. Instead we approximate the negotiated price using what we know from the claims payments. The GMCB's

analysis defines "price" as the sum of (1) the price paid by insurance and (2) the expected member share (also known as "out-of-pocket amount"), and we call this the "total allowed amount" for a service.

$$Price = Total\ Allowed\ Amount = Insurance\ Paid\ Amount + Expected\ Member\ Share$$

An analysis of price variation will be based on the above definition of price, and consequently will provide insight into both the differences between what insurances pay and the differences between what the insured populations pay.

Insurance (also known as "Payer")

The insurer (Medicaid, Medicare, MVP, etc.) is an important factor when calculating price variation, for several reasons, including the following:

Primary Insurance vs. Secondary Insurance

It is common for an individual to have more than one medical or pharmacy insurance. For example, an individual may have medical insurance through their employer and also be eligible for government insurance (Medicare or Medicaid), or be covered by both Medicare and Medicaid. It is important to identify the individual's primary insurance (or "primary payer") because the primary payer will generally pay a larger portion—if not all—of the insurer's share of the price of a covered procedure.

Annual Pricing Increases

Prices generally increase quarterly and/or annually for every insurer. Each insurer has their own definition for their 12-month year. For Medicaid, many price changes occur on the state fiscal year (July 1-June 30). Medicare updates their fee-for-service rates on the calendar year basis. Commercial insurers' prices change based on their plan year, which varies across insurers and employer groups.

Patient Program Affiliation or Other Patient Attributes

Depending on the individual's insurer, aspects such as their age or their enrollment in an Accountable Care Organization (ACO) can impact the claims-based price of the medical procedures. As an example, individuals under 21 years of age enrolled with Medicaid may be covered for different services than those 21 and older. Also, some Medicaid patients attributed to the ACO have covered medical procedures paid in advance outside of the claims system; claims are still submitted to reflect services provided, but they are "shadow claims" with a price of $0. These must be considered in a different way than a claim paid in a more conventional, fee-for-service arrangement.

Billing Practices

Some payers may divide their payments between two different type of claims; facility claims and professional claims. These "split billing" practices should be accounted for when trying to compare the prices for the same procedure.

Facility and Professional Claims

There are two main types of medical claims:

1) Facility claims are used for billing by institutional providers, such as hospitals or nursing homes.
2) Professional claims are used for non-institutional providers, such as therapists, individual doctors, chiropractors, and suppliers.

Facility claims are usually associated with treatment provided at an institution or facility. Payments are tied to the institutional resources used to treat a patient, whereas professional claims are associated with the procedures conducted by healthcare providers to treat a patient. The professional claims payments are tied

to the service delivered to the patient based on standard procedure codes (e.g. Current Procedural Terminology [CPT] or Healthcare Common Procedural Coding System [HCPCS] codes).

When providers deliver care in an institutional setting, the medical claims may be divided between professional and facility claims, which can make it challenging to meaningfully compare similar services delivered in an institutional setting to those delivered in a non-institutional setting.

Care Setting

Site of care can influence reimbursement and must be considered in any price variation analysis. For example, a procedure at an independent practice is billed differently than the same procedure performed at a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC); more specifically, the FQHC/RHCs bill is based on an "encounter payment" for the price for a service, but shows a price of $0 for other services on the same claim. Therefore, in the GMCB's analyses, claims which take place at FQHC/RHCs will be flagged and considered separately in an analysis of price variation.

Provider Type

Different provider types are authorized to charge different reimbursement amounts for the same service, largely based on the Medicare Relative Value Unit methodology.[4] For some codes, the difference will not be large, but for other codes it may be material.

Adjusted Claims

The claims in VHCURES are aggregated to represent the most recent version of insurance transactions. Consequently, adjusted claims or denied claims must be reviewed to ensure they represent accurate prices.

Modifiers

Procedure code modifiers can also change the paid amount for a certain procedure if they are functional modifiers. Some modifiers are only informational and do not affect pricing. For example, a procedure code could be used for to indicate that a procedure was performed on both sides of the body and would adjust the payment accordingly. On the other hand, a modifier may be used to indicate which side of the body an operation was performed and would not change the payment amount. Therefore, modifiers should be carefully accounted for to make accurate comparisons.

Key Dates & Timeline

Validation of VHCURES and Vermont's hospital discharge data (VUHDDS[5]) is anticipated by fall of 2020. Comprehensive analysis of price variation will take approximately one year to complete, and the price variation report dashboard is anticipated to be completed by the end of calendar year 2021.

Last Updated: May 2020

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[1] 18 V.S.A. § 9413; Quality, Resource Allocation, And Cost Containment; https://legislature.vermont.gov/statutes/section/18/221/09413

[2] https://www.bcbsvt.com/member/price-tools-and-quality-tools-for-health-coverage

[3] GMCB Data Governance and Stewardship Principles and Policies; version 2.0 as adopted April 2019; https://gmcboard.vermont.gov/data-and-analytics/data-governance

[4] Medicare Fee Schedule RVU Summary, Accessed April 2020: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrephysFeeSchedfctsht.pdf

[5] Vermont Uniform Hospital Discharge Data System; https://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-discharge-data