



Rutland Regional Medical Center

An Affiliate of Rutland Regional Health Services

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April 17, 2017

Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

Dear Board Members:

We are writing in regards to two related issues; the potential action on rates based upon the FY16 operating results and the Provider-Based Billing issue.

First, on the FY16 results, you are aware that RRMC has or will have decreased rates three times since April of 2016. The annual reduction totals over \$30 million in gross charges and \$7.5 million in net revenue. The result of these rate changes has brought net revenue down and in FY17 we are on budget. GMCB staff has recommended that we be allowed to move forward with our plan. We urge you to accept this recommendation.

In addition to the three rate reductions there were also payer reimbursement reductions that impacted net revenue. On July 1, 2016 the Department for Vermont Health Access (DVHA) changed the manner in which they reimbursed Evaluation and Management (E&M) services for hospital based physicians. The change reduced our Medicaid reimbursement by \$1.5 million a year.

In addition, we have reviewed the GMCB report on Provider Based billing as well as the responses by the insurers. As we interpret the recommendations, we estimate that the change in payment would reduce RRMC's net revenue by \$4 million. The recommendations do not change our payment for physician E&M codes as we are already paid on physician schedules for these services. However, we would face significant reductions in net revenue for various types of testing. This is related to changes in reimbursement for 66 "ambulatory services." that are delivered across both clinical and hospital ancillary departments. More than half of these changes are for services performed in the hospital. Of the 66 services listed there are 10 services that represent 60% of the estimated reduction. As shown on the "Top 10" list below you can see that the largest decrease is for MRI testing.

| Service Description | Estimated Loss |
|---|-----------------------|
| MRI any Joint Lower Extremity | (433,751) |
| MRI Spinal Canal, Lumbar W/ contrast | (350,716) |
| Sleep Study | (294,087) |
| Nuclear Med Study of Vessels of Heart, exercise/drug induced. | (267,928) |
| Sleep Study with Mask | (224,840) |
| MRI Spinal Canal W/O contrast | (204,457) |
| MRI Upper Extremity W/O contrast | (201,541) |
| Chemotherapy IV infusion up to 1 Hour, Single Drug | (147,622) |
| MRI Brain W/O contrast | (144,972) |
| Aspiration of joint or injection of joint | (114,405) |

A \$4 million reduction is not possible while we reduce prices, plan to accept risk and continue services for our community. RRMC's voluntary rate reductions represent only one of several reasons that the GMCB should not apply MedPac's site-neutral payment recommendation. MedPac's purpose and analysis does not apply to the Vermont health care system. MedPac's responsibility is to recommend policies to maintain aggregate payment adequacy across the entire Medicare program to ensure patients' access to care, quality of care, and providers' access to capital.¹ Obviously the Medicare reimbursement system does not contemplate providers proactively adjusting rates to balance adequacy and affordability. As MedPac notes, their recommendations apply to entire system that includes high margin for profit hospitals and low and negative margin rural community hospitals.² MedPac's analysis notes that site-neutral payment policy would subject rural hospitals like Rutland Regional to a disproportionately negative impact.³ MedPac describes hospitals like Rutland as "primary sources of access to ambulatory services for low-income patients [that would] experience significant reductions in Medicare revenue as a result of [a site neutral payment policy.]" MedPac further recommended a cap on revenue losses for hospitals like Rutland that serve a large share of low income patients.⁴ RRMC has demonstrated its responsibility in balancing costs and revenue. Blindly applying MedPac's recommendation would produce an outcome that is inconsistent with MedPac's purpose of ensuring patients' access to care, quality of care, and providers' access to capital.

¹ Medicare Payment Advisory Commission (MedPAC), Report to the Congress: *Medicare Payment Policy* (March 2014) at 51-52.

² Id. at 67.

³ Id. at 78.

⁴ Medicare Payment Advisory Commission (MedPAC), Report to the Congress: *Medicare Payment Policy* (March 2012) at 77. MedPac also stated that hospitals could reduce their revenue loss associated with site-neutral payment by converting outpatient clinical to federally qualified health centers. RRMC

RRMC did not engage in the practices that MedPac and other governmental entities are seeking to address. MedPac's site-neutral payment recommendations are intended to reverse the practice of reimbursement arbitrage where large hospital systems strategically purchase standalone physician practices for the sole purpose of converting them to off campus hospital outpatient departments to increase reimbursement for the same service. MedPac recommendation seeks to correct a market distortion that led to the practice of reimbursement arbitrage, which adversely affected competition between providers that provide the same service. RRMC's gradual employment of physician specialists was based on the need to retain specialty practices in a community where it was no longer economically feasible to operate independent practices for most specialties. RRMC did not pursue a strategy of reimbursement arbitrage. Rather we did whatever we could to maintain basic health care services in our community. MedPac's recommendations are intended to address a problem that is inapplicable to RRMC, but the consequences of imposing MedPac's policy recommendation would adversely affect RRMC's ability to maintain basic health care services in our community. Finally, it is important to note that Congress did not accept many of MedPac's recommendations.

The GMCCB correctly notes on page 5 of its Report to the Legislature that the "concerns" that inform MedPac's recommendations and Medicare policy for site-neutral payment are not directed at physician practices located in a hospital campus as defined by federal regulation, and therefore community hospitals like Rutland Regional. This primary concern of reimbursement arbitrage at off-campus practices led Medicare to develop the off-campus modifier (modifier PO) and Congress to enact section 603 of the Bipartisan Budget Act of 2015, which imposed a site-neutral payment policy for all new off-campus departments. Again, RRMC is not a cause of the problem that federal policies are seeking to address, almost all of RRMC's operations are located on our hospital campus including ninety-four percent of our services that are associated with the sixty-six APCs.

Changes to the reimbursement methodology for the 66 ambulatory services would increase administrative costs to both payers and providers. The change would be administratively challenging to implement as not all services in a department are included. The implementation would require significant software programming time, testing and money to develop and implement. The responses by both MVP and Blue Cross speak to the challenge in implementing such a change. In addition to billing system changes there would also be legal challenges that would need to be addressed as each of the hospitals have individual contracts in place with the insurers that would need to be considered.

If we had not taken over the specialty practices in Rutland, there would be very few physicians in the Rutland area. Given our demographics and payer mix it is not possible to sustain private practices in most specialties. Without the financial support of services like those in the 66 ambulatory services group, we will not be able to support the array of services either.

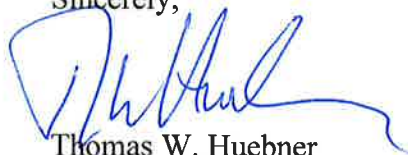
RRMC-GMCB

April 17, 2017

4

Attached is a full list of the services impacted on an item by item basis. We will be happy to discuss at the hearing on April 19.

Sincerely,



Thomas W. Huebner
President and CEO

TWH/jsb

Enclosure

RRMC
66 APC list by CPT code
@ 4/17/2017

| Service | Incr (Decr) in Reimb |
|------------------------------|---------------------------------|
| Mri jnt of lwr extre w/o dye | \$ (433,751) |
| Mri lumbar spine w/o dye | \$ (350,716) |
| Polysomnography, 4 or more | \$ (294,087) |
| Ht muscle image spect, mult | \$ (267,928) |
| Polysomnography w/cpap | \$ (224,840) |
| Mri neck spine w/o dye | \$ (204,457) |
| Mri joint upr extrem w/o dye | \$ (201,541) |
| Chemo, iv infusion, 1 hr | \$ (147,622) |
| Mri brain w/o dye | \$ (144,972) |
| Drain/inject, joint/bursa | \$ (114,405) |
| N block, other peripheral | \$ (94,498) |
| Fetal non-stress test | \$ (86,396) |
| Vascular study | \$ (83,060) |
| Mri lower extremity w/o dye | \$ (69,369) |
| Dxa bone density, axial | \$ (64,829) |
| Mri chest spine w/o dye | \$ (60,775) |
| Evaluation of wheezing | \$ (57,172) |
| Extracranial study | \$ (52,549) |
| Percut allergy skin tests | \$ (52,224) |
| Comprehensive hearing test | \$ (47,861) |
| Stress tte complete | \$ (46,549) |
| Icm/ilr remote tech serv | \$ (41,864) |
| Mr angiography head w/o dye | \$ (38,809) |
| Echo transesophageal | \$ (35,185) |
| Extremity study | \$ (30,754) |
| Pos airway pressure, CPAP | \$ (29,445) |
| Biopsy of uterus lining | \$ (29,098) |
| Ht muscle image spect, sing | \$ (27,742) |
| Ob us, follow-up, per fetus | \$ (27,016) |
| Tissue exam by pathologist | \$ (24,744) |
| Cystoscopy | \$ (22,886) |
| Apply short leg cast | \$ (21,089) |
| N block inj, brachial plexus | \$ (20,591) |
| Mri pelvis w/o dye | \$ (19,917) |
| Tympanometry | \$ (19,021) |
| Ther injection, carp tunnel | \$ (17,980) |
| Multiple sleep latency test | \$ (17,678) |
| Biopsy of cervix | \$ (17,556) |
| Inj tendon sheath/ligament | \$ (16,682) |

| | | |
|------------------------------|----|----------|
| Transvaginal us, obstetric | \$ | (16,577) |
| Inj foramen epidural l/s | \$ | (14,910) |
| N block inj, sciatic, sng | \$ | (14,314) |
| Audiometry, air & bone | \$ | (13,315) |
| Drain/inject, joint/bursa | \$ | (13,072) |
| Application of forearm cast | \$ | (12,939) |
| Remove intrauterine device | \$ | (12,568) |
| Basic vestibular evaluation | \$ | (12,386) |
| Inj paravert f jnt c/t 1 lev | \$ | (11,513) |
| Us facet jt inj ls 3 level | \$ | (11,212) |
| Visual field examination(s) | \$ | (10,984) |
| Mri upper extremity w/o dye | \$ | (10,213) |
| Nasal/sinus endoscopy, surg | \$ | (10,148) |
| Inj paravert f jnt l/s 1 lev | \$ | (9,989) |
| Tympanometry & reflex thresh | \$ | (9,789) |
| Drain/inject, joint/bursa | \$ | (9,574) |
| Evaluation of wheezing | \$ | (9,399) |
| Us facet jt inj ls 3 level | \$ | (8,690) |
| EEG monitoring/computer | \$ | (8,443) |
| Inject spine l/s (cd) | \$ | (8,359) |
| Extremity study | \$ | (7,750) |
| Conditioning play audiometry | \$ | (7,060) |
| Spinal fluid tap, diagnostic | \$ | (7,032) |
| N block inj, trigeminal | \$ | (6,867) |
| Pure tone audiometry, air | \$ | (6,532) |
| Inj paravert f jnt l/s 2 lev | \$ | (5,921) |
| Speech threshold audiometry | \$ | (5,732) |
| Ent procedure/service | \$ | (5,704) |
| Nervous system surgery | \$ | (5,183) |
| Visual audiometry (vra) | \$ | (5,089) |
| Auditor evoke potent, limit | \$ | (4,683) |
| Inject spine c/t | \$ | (4,589) |
| Us facet jt inj ls 3 level | \$ | (4,304) |
| Mri abdomen w/o dye | \$ | (4,260) |
| Pm device progr eval, dual | \$ | (4,227) |
| Ophthalmic biometry | \$ | (3,959) |
| Icd device progr eval, mult | \$ | (3,788) |
| Exc h-f-nk-sp b9+marg 0.6-1 | \$ | (3,639) |
| Diagnostic laryngoscopy | \$ | (3,581) |
| Ob us, limited, fetus(s) | \$ | (3,322) |
| Breathing capacity test | \$ | (3,060) |
| Us facet jt inj ls 3 level | \$ | (2,656) |
| Tinnitus assessment | \$ | (2,570) |
| Evoked auditory test | \$ | (2,383) |
| Aspirate/inj ganglion cyst | \$ | (2,207) |
| Nasal/sinus endoscopy, surg | \$ | (2,199) |
| Speech audiometry, complete | \$ | (2,141) |

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|-------------------------------|----|---------|
| Inj trigger point, 1/2 muscl | \$ | (2,114) |
| N block inj, plantar digit | \$ | (2,087) |
| Biopsy, skin lesion | \$ | (1,983) |
| Apply rigid leg cast | \$ | (1,928) |
| Icd device prog eval, 1 sngl | \$ | (1,897) |
| Eye exam with photos | \$ | (1,788) |
| Transvaginal us, obstetric | \$ | (1,662) |
| Auditor evoke potent, compre | \$ | (1,641) |
| Change of windpipe airway | \$ | (1,608) |
| Nasal function studies | \$ | (1,575) |
| Insert pessary/other device | \$ | (1,523) |
| Dilate urethra stricture | \$ | (1,469) |
| Exc tr-ext mlg+marg 0.6-1 cm | \$ | (1,389) |
| Application of long arm cast | \$ | (1,336) |
| Injection(s), spider veins | \$ | (1,281) |
| Us exam infant hips, dynamic | \$ | (1,227) |
| Chemo prolong infuse w/pump | \$ | (1,196) |
| Icd device progr eval, dual | \$ | (1,063) |
| Evoked auditory test | \$ | (1,018) |
| Debride skin/muscle, fx | \$ | (898) |
| Pm/icd remote tech serv | \$ | (862) |
| Larynscoep w/tumr exc + scope | \$ | (837) |
| Drain blood from under nail | \$ | (821) |
| Exc tr-ext b9+marg 1.1-2 cm | \$ | (797) |
| Exc tr-ext b9+marg 2.1-3 cm | \$ | (793) |
| Exc tr-ext mlg+marg 2.1-3 cm | \$ | (728) |
| Exc face-mm b9+marg 1.1-2 cm | \$ | (715) |
| Us exam, chest | \$ | (715) |
| Icd device interrogate | \$ | (710) |
| Us exam, pelvic, limited | \$ | (688) |
| Debride infected skin | \$ | (686) |
| Removal of nail bed | \$ | (677) |
| Us facet jt inj ls 3 level | \$ | (634) |
| Tissue exam by pathologist | \$ | (590) |
| Exam of cervix w/scope | \$ | (586) |
| Exc h-f-nk-sp b9+marg 0.5 < | \$ | (527) |
| Exc tr-ext mlg+marg 1.1-2 cm | \$ | (527) |
| Ilr device interrogate | \$ | (485) |
| Exc face-mm b9+marg 0.5 < cm | \$ | (479) |
| Exc tr-ext b9+marg 0.6-1 cm | \$ | (473) |
| Injection therapy of vein | \$ | (462) |
| Remove foreign body from eye | \$ | (440) |
| Inj foramen epidural add-on | \$ | (419) |
| Apply short leg cast | \$ | (419) |
| Exc h-f-nk-sp b9+marg 1.1-2 | \$ | (339) |
| Dilation of urethra | \$ | (329) |
| Clean out mastoid cavity | \$ | (321) |

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|------------------------------|-----------|--------------------|
| Spontaneous nystagmus test | \$ | (321) |
| Shave skin lesion | \$ | (267) |
| Trim skin lesion | \$ | (245) |
| Dilate tear duct opening | \$ | (213) |
| Us facet jt inj ls 3 level | \$ | (205) |
| Stenger test, pure tone | \$ | (178) |
| Positional nystagmus test | \$ | (164) |
| Diagnostic sigmoidoscopy | \$ | (156) |
| Dress/debrid p-thick burn, s | \$ | (151) |
| Psycho testing by psych/phys | \$ | (143) |
| Visual evoked potential test | \$ | (136) |
| Tensilon test | \$ | (122) |
| Trim skin lesions, 2 to 4 | \$ | (103) |
| Pm device progr eval, sngl | \$ | (87) |
| Sigmoidoscopy and biopsy | \$ | (53) |
| Acne surgery | \$ | - |
| Dx laryngoscopy excl nb | \$ | - |
| Obtaining screen pap smear | \$ | - |
| Injection therapy of veins | \$ | 60 |
| Fna w/o image | \$ | 137 |
| Remove foreign body from eye | \$ | 189 |
| Actigraphy testing | \$ | 261 |
| Drainage of eyelid abscess | \$ | 746 |
| Grand Total Loss | \$ | (3,954,382) |