VERMONT

Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

[phone] 802-828-2177
www.gmcboard.vermont.gov

To: Health Reform Oversight Committee
From: Green Mountain Care Board
Date: October 1, 2017
Re: Payment Differential and Provider Reimbursement Report, Act 85 (2017) § E.345.1

Introduction

The Green Mountain Care Board respectfully submits this memorandum to the Heath Reform Oversight Committee in response to the charge in Act 85 of 2017, Section E.345.1.

> Act 85 (2017) Sec. E.345.1 FAIR REIMBURSEMENT REPORT
> Utilizing funds appropriated in Section B.345 of this act, the Green Mountain Care Board shall report to the Health Reform Oversight Committee by October 1, 2017 describing what substantial changes have been put into effect to achieve the site-neutral, fair reimbursements for medical services as envisioned in 2014 Acts and Resolves No. 144, Sec. 19, 2015 Acts and Resolves No. 54, Sec. 23, and 2016 Acts and Resolves No. 143, Sec. 5.

Overview

In a series of mandates since 2014, the Legislature has highlighted the payment differential between hospital-acquired practices and independent practices as a target for policy intervention.[1] The primary concern has been that the payment differential between hospital-owned practices (most specifically, the academic medical center) and their independent counterparts has led to the decline of independent providers in the state and to increased consolidation of the state's health care system. Board actions to achieve site neutral, fair reimbursement for medical services can be found on page 14 of this report.

Relevant legislation, 2014-2016

In 2014, the legislature first mandated that the Agency of Administration evaluate whether the State should prohibit reimbursement differentials based on practice setting and/or ownership type. In its "Independent Physician Practices Report," the Agency found that differentials in commercial payment rates largely existed between the academic medical center and other practice settings.[2] The Agency recommended that the State continue to pursue payment and delivery system reform while ensuring the pay differential remains an important part of the discussion.

[1] The issue of payment differentials among providers by practice ownership is often referred to as "pay parity" or "fair and equitable reimbursement."
[2] Other practice settings include community hospitals and independent providers, who are reimbursed at roughly the same levels.

In 2015, the Legislature mandated that Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Healthcare (MVP) submit implementation plans to ensure "fair and equitable reimbursement amounts for professional services provided by academic medical centers and other professionals." In July 2016, the carriers submitted plans to the Green Mountain Care Board for review.[3] Although each carrier proposed a different methodology reducing the differential between the academic medical center and other practice settings, it is important to note that neither carrier proposed an increase in rates to independent providers. The Board reviewed the carriers' plans but concluded that neither plan offered a sufficient analysis of the consequences—whether intended or unintended—of changing how they reimburse providers. On February 1, 2017, the Board submitted a comprehensive report to the Legislature with its own set of recommendations for "fair and equitable reimbursement."[4]

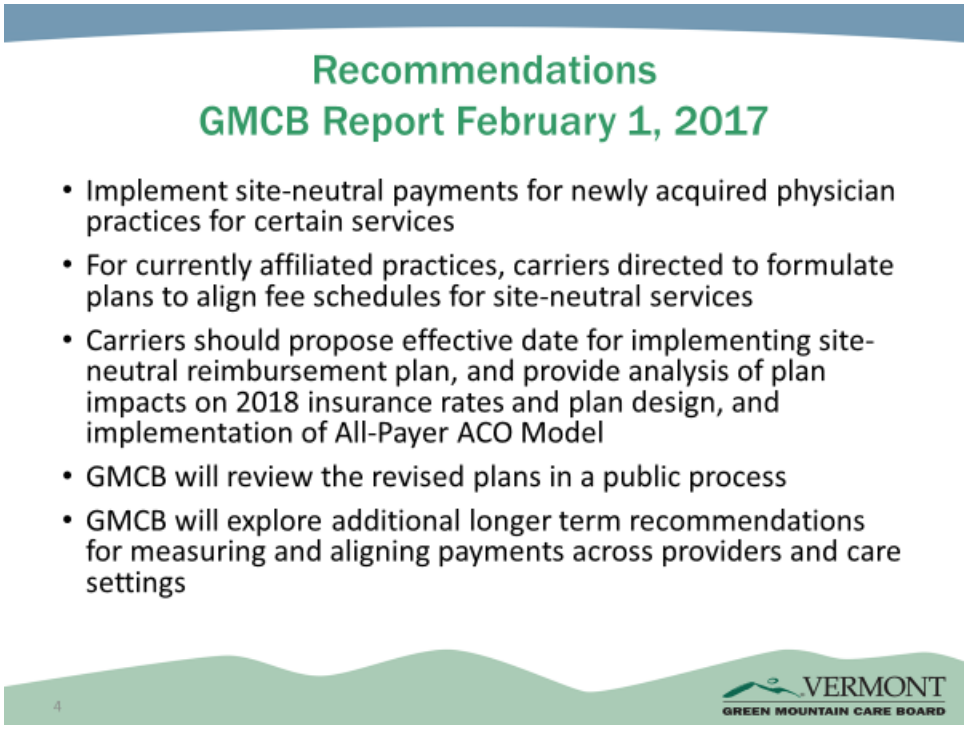
February 2017 Board recommendations and insurer responses

In the February 1, 2017 report, the Board first recognized that the payment reform efforts outlined in the All-Payer Accountable Care Organization Model Agreement (All-Payer Model or APM) transition the State from a fee-for-service reimbursement model toward value-based payments, and that such a transition should alleviate concerns about payment differentials. However, the Board recognized that the transition would take time and recommended several steps to narrow the gap in the short term.

Noting that there are cost-related justifications for differential reimbursements between the academic medical center and other settings for some services, the Board decided to focus its attention on those services deemed to be "site-neutral"; that is, services for which there is no underlying difference in the cost required to deliver the care, no matter the setting. The Board looked to work performed by the Medicare Payment Advisory Commission (MedPAC), which had recently examined the issue of disparities in provider reimbursements and issued recommendations on site-neutral services and payment methodologies.[5] The Board recommended that physician practices newly acquired by the academic medical center should not be allowed to switch to the (generally higher) academic medical center fee schedule, but must remain on the (generally lower) community fee schedule upon their acquisition. This recommendation aligns with 2017 adjustments to Medicare provider reimbursements, and was supported by the University of Vermont Medical Center (UVMMC).[6] For existing hospital-affiliated practices, the Board asked the carriers to outline a plan for achieving greater equity in reimbursements for E/M codes and for procedures MedPAC had identified as site-neutral.

[3] All reports are available on the Green Mountain Care Board website at: http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports.
[4] Ibid.
[5] Site-neutral services are defined by the MedPAC as services that 1) do not require emergency stand-by capacity 2) do not have extra costs associated with higher patient complexity in the hospital, and 3) do not need the additional overhead associated with services that must be provided in a hospital setting. MedPAC identified Evaluation and Management (E/M) codes and a set of ambulatory services as site-neutral. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2014) at 75-78, *available at* http://www.medpac.gov/docs/default-source/reports/mar14_entirereport.pdf?sfvrsn=0. Due to the complexity of adjusting fee-for-service rates and with input from stakeholders, the Board focused its actions on E/M codes only.
[6] Presentation to the Board by the University of Vermont Health Network, *Act 54 and Act 143: Fair and Equitable Payments and Site Neutrality* (April 27, 2017), *available at* http://gmcboard.vermont.gov/sites/gmcb/files/UVMHN%20presentation%20on%20fair%20and%20equitable%20payments%20%204-27-17.pdf.

The Board's February 1, 2017 recommendations are summarized below:



Both carriers were asked to submit responses to the Board's report no later than March 15, 2017. In its response, BCBSVT stated that the recommendation to keep newly acquired practices on the same fee schedule would have little impact on premiums and could "be done with moderate administration modifications to BCBSVT processes;" however, the recommendation to lower reimbursements for existing hospital-based practices had the potential to lead to higher premiums if hospitals shifted costs to inpatient services.[7] MVP's response included a request that the Board "issue a regulatory requirement governing the appropriate billing practice for services provided by hospital owned physicians" and require that newly acquired and currently owned practices convert to a Medicare fee schedule, regionally adjusted for Vermont. MVP also anticipated hospital cost-shifting to other services to offset the reduction.[8]

In the end, both carriers agreed that the Medicare site-neutral approach is a rational strategy for that specific payer, but raised concerns about implementing site neutrality in the commercial market with its complex array of fee schedules and negotiated contracts.

[7] *Blue Cross and Blue Shield of Vermont Implementation Plan for Providing Fair and Equitable Reimbursement Amounts for Professional Services Provided by Academic Medical Centers and Other Professionals* (March 2017) *available at* http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/BCBSVT%20Act%20143%20revised%20Reimbursement%20Plan%20Final%203-15-17.pdf.

[8] *Addendum to MVP's July 1, 2016 Report to the GMCB Regarding Fair and Equitable Physician Reimbursement* (March 2017) *available at* http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/GMCB%20March%2031%202017-MVP%20submission%20merged.pdf.

Board Review, March 2017-present

Since its February report and the submission of carrier responses, the Board took a step back to more thoroughly understand the issues driving the legislative charge and consider new avenues towards fair and equitable reimbursement.

First, in an effort to better understand the pressures facing physicians and the factors affecting health care consolidation, the Board embarked on a "clinician landscape" study. In addition to reviewing national trends in vertical consolidation (independent physicians joining with larger hospital systems), the Board analyzed data on provider employment trends in Vermont and conducted both a state-wide survey and a series of focus groups with Vermont clinicians.

Second, in order to evaluate the reimbursement differential, its implications and potential solutions, the Board reviewed a claims-based analysis performed by Onpoint Health Data, analyzed all plans and responses provided by the insurers, and convened a stakeholder workgroup to define and outline how to achieve a more "fair and equitable reimbursement" system. The workgroup included representatives from MVP, BCBSVT, UVMMC, Rutland Regional Medical Center, the Vermont Association for Hospitals and Health Systems, OneCare Vermont, Vermont Medical Society, HealthFirst, individual independent primary care and specialty providers, Bi-State Primary Care Association, Vermont Program for Quality in Health Care, and legislators. The workgroup met on May 24 and June 20, 2017, and additional sub-group meetings were held in between the workgroup sessions. Having all stakeholders in the room allowed for a robust discussion on the complexity of the issues. The workgroup did not come to consensus on a path forward, but the discussions helped to frame the options before the Board.

Several key points emerged:

> **Key Point #1:** Both nationally and in Vermont, more providers are choosing employment in hospitals and health systems rather than practicing independently. This has led to greater consolidation in healthcare.

> **Key Point #2:** Multiple factors explain the trend toward more hospital-based employment including the growing costs, challenges and risks associated with running a business, Affordable Care Act (ACA) incentives to integrate, and provider preferences for consistent schedules and predictable salaries. Commercial reimbursement rates do not appear to be a primary reason that physicians are choosing employment in hospital and health systems. Salaries are also not likely to be higher in hospital-based settings.

Timeline

2016

July – BCBSVT and MVP implementation plans for fair and equitable reimbursement
November – GMCB stakeholder meetings
December 1 – GMCB update to legislature

2017

February 1 – GMCB report to legislature
March – BCBSVT and MVP modified reports submitted to GMCB
April 27 – GMCB public meeting
May – GMCB legislative testimony
May 24 – Work group meeting
June 20 – Work group meeting
August/September – GMCB clinician landscape survey and focus groups
August 28 – GMCB public meeting
September 14 – Hospital budget vote on UVMMC "pay parity" adjustment
October 1 – Report to Health Reform Oversight Committee

Key Point #3: Fee-for-service rate differentials exist between hospital-based practices and independent settings for professional services. In Vermont, the greatest differential is between the academic medical center and other providers.

Key Point #4: 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.

This memorandum addresses each point in turn.

Key Point #1: Both nationally and in Vermont, more providers are choosing employment in hospitals and health systems rather than practicing independently. This has led to greater consolidation in healthcare.

Our review of the literature makes clear that many of the trends facing Vermont are not unique. Over the past decade, our national healthcare system has transformed from one characterized by a diverse network of largely independent hospitals, clinics and physician practices, to a more concentrated system with one or more academic medical centers in full or partial control of surrounding community hospitals, physician practices and post-acute care facilities. Evidence indicates that overall market concentration in the U.S. hospital sector has increased 40 percent since the mid-1980s, and that consolidation has been both horizontal (e.g., hospitals buying other hospitals) and vertical (e.g., hospitals buying physician practices and post-acute facilities). Nationally, hospital ownership of physician practices increased from 24 percent of practices to 49 percent from 2004-2011.[9] A more recent analysis suggests that 37 percent of practices were independent in 2013, down from 57 percent in 2000, and the number was projected to drop to 33 percent for 2016.[10] The 2016 Survey of America's Physicians also reports that "only 33% of physicians identify as independent practice owners or partners, down from 48.5% in 2012."[11]

In Vermont, identifying trends in vertical consolidation has been hampered by the lack of a complete and historical database tracking the employment status of clinicians. The Board has heard anecdotal claims that as few as 15 percent of Vermont clinicians now practice independently, but such claims have not been verified with data. Nor have there been any attempts to quantify the degree to which this has changed over time. The Board supports efforts to include employment status information in Vermont Department of Health's physician census data collection.

The Board acquired data from SK&A, a third-party market research firm whose dataset and extensive physician database is used by federal agencies and academic researchers to analyze hospital and provider

[9] Cutler and Morton, *Hospitals, Market Share, and Consolidation*, Vol. 310, No. 18, Journal of the American Medical Association (Nov. 13, 2013).
[10] Accenture, *The (Independent) Doctor Will NOT See You Now* (May 2015), *available at* https://www.accenture.com/t20160601T222041Z__w__/us-en/_acnmedia/PDF-2/Accenture-The-Doctor-Will-Not-See-You.pdf#zoom=50.
[11] *2016 Survey of America's Physicians: Practice Patterns & Perspectives*, conducted on behalf of The Physicians Foundation by Merritt Hawkins (September 2016) at 8, *available at* http://www.physiciansfoundation.org/uploads/default/Biennial_Physician_Survey_2016.pdf.

market conditions.[12] Although the data may not be all-inclusive, it provides one estimate of the trends in physician consolidation over time. The data in Table 1, below, suggests that overall, 31 percent of Vermont physicians are practicing independently in 2017, down from 47 percent in 2011, in alignment with the national data discussed above. The data also suggests that more Vermont specialists than primary care providers moved from independent to hospital-employed status between 2011-2017; 46 percent of primary care providers in Vermont are still independent, compared to only 23 percent of specialists.

Table 1: Number of primary care providers and specialists in Vermont, % employed and independent (SK&A data set, 2017)

	2011	***2013***	***2015***	***2017***
Primary Care (No.)	481	517	521	528
% Employed	*46%*	*46%*	*51%*	*54%*
% Independent	*54%*	*54%*	*49%*	*46%*
Specialist (No.)	1,033	1,072	1,080	1,006
% Employed	*56%*	*64%*	*75%*	*77%*
% Independent	*44%*	*36%*	*25%*	*23%*
TOTAL (No.)	1514	1589	1601	1,534
% Employed	53%	58%	67%	69%
% Independent	47%	42%	33%	31%

It should be noted that there are advantages and disadvantages associated with increased consolidation of the health care system.[13] While there is the potential for higher prices in a more concentrated market, there is also the potential for greater care coordination and cost savings through economies of scale. As Vermont moves towards value-based payment reform and greater care coordination, a more integrated market—with state regulatory oversight—may help achieve the health reform goals outlined in the All-Payer ACO Model.

[12] The SK&A data set, originally compiled for commercial purposes, is highly regarded and has been used in several health services research studies, including MedPAC's June 2017 Report to the Congress (Chapter 10: Provider consolidation: The Role of Medicare policy). The MedPAC Report is available at http://medpac.gov/docs/default-source/reports/jun17_reporttocongress_sec.pdf?sfvrsn=0. The SK&A physician database is updated semi-annually. *See SK&A Data: How We Acquire It*, http://www.skainfo.com/about/data-collection.

[13] Cutler and Morton, note 8, *supra*.

Key Point #2: Multiple factors explain the trend toward more hospital-based employment including the growing costs, challenges and risks associated with running a business, ACA incentives to integrate, and provider preferences for consistent schedules and predictable salaries. Commercial reimbursement rates are not the primary reason that physicians are choosing employment in hospital and health systems. Salaries are also not likely to be higher in hospital-based settings.

Although the legislative charge puts the focus on commercial reimbursement rates, the national literature highlights many other factors driving providers to seek employment or affiliation with larger institutions: the high costs associated with EMR implementation, increasing measurement and payment driven reporting requirements, the growing costs, challenges and risks associated with running a business, ACA incentives to integrate, and provider preferences for consistent schedules and predictable salaries. A survey conducted by the Board, described in more detail below, shows consistent findings for Vermont clinicians.

GMCB Clinician Landscape Survey

During August and September 2017, the Green Mountain Care Board fielded an electronic survey of Vermont clinicians and conducted three focus groups to launch discussion around experiences with being independent or employed practitioners, how practices have changed over time, the impact of healthcare reform initiatives on practices, and thoughts about the future of healthcare in Vermont. Specifically, we were interested in learning what clinicians find most rewarding, the stressors they face in their practices, the factors that drive their employment choices, and their outlook on the profession in Vermont. The full Vermont Clinician Landscape Study Report accompanies this Report (Attachment A).

After reviewing over 400 survey respondents, we identified the following key takeaways:

- Independently practicing clinicians cite strong patient relationships, the opportunity to run their own practice as well as flexibility and choice over work schedules as the factors most satisfying about their work.

- Independent clinicians are most frustrated by billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice and accessing costly technology.

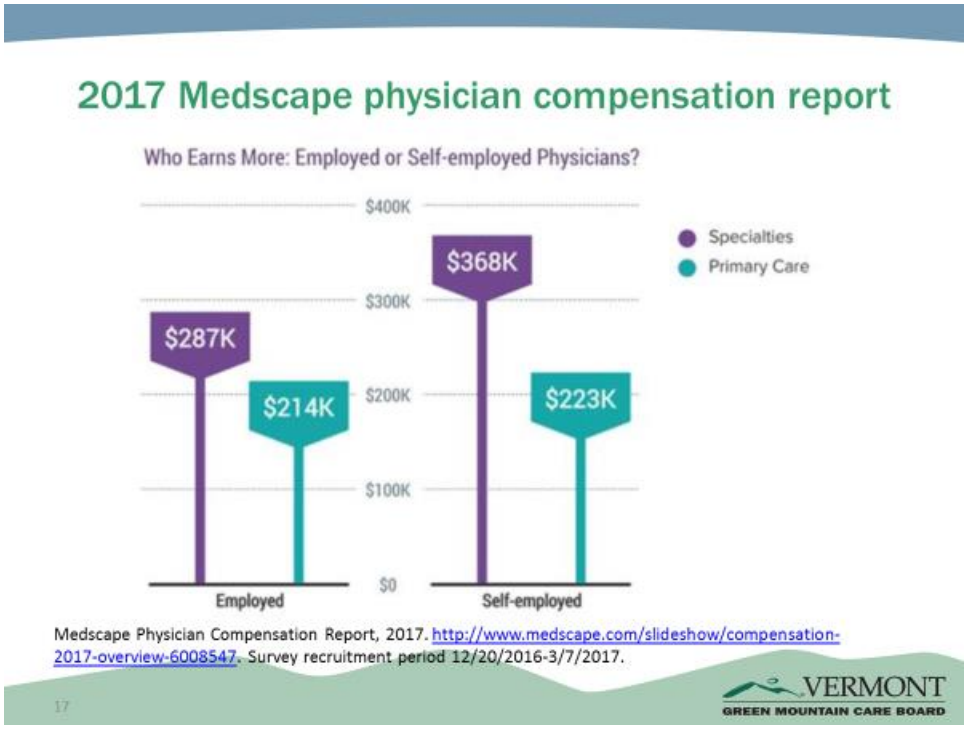
- Employed clinicians are most satisfied about not having to run their own business, not being responsible for high practice costs, the opportunities to work with colleagues, and the **certainty** of their income in an employed setting.

- Like independent clinicians, employed clinicians find administrative burdens frustrating. They also identify as frustrations the limited control they have over practice management, lack of control over their work schedule, and **level** of their income.

- The top three most commonly cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement. The same top three threats apply to employed clinicians.[14]

Despite frustrations, the majority of clinicians, whatever their employment setting, are generally optimistic about their current employment and anticipate continuing to practice as they are today.

It is worth noting that *certainty of income,* rather than the *level of income,* is the more likely driver of hospital-based employment choices. National data from the 2017 Medscape Physician Compensation Report shows independent physicians tend to make higher salaries than employed physicians.[15] The salary gap is larger for specialists ($81k) than for primary care providers ($9k). The Board was unable to obtain comparative Vermont data on employed vs. independent physician salaries. All fourteen Vermont hospitals, the Brattleboro Retreat and Dartmouth Hitchcock Medical Center complied with the Board's request for their IRS Form 990, which includes some physician salary information. For comparative purposes, the Board requested salary information for independent physicians through HealthFirst, Vermont's independent practice association, which declined the request. However, we have no reason to believe that the national findings, summarized in the figure below, are not generalizable to Vermont.



Key Point #3: Fee-for-service rate differentials exist between hospital-based practices and independent settings for professional services. In Vermont, the greatest differential is between the academic medical center and other providers.

[14] The fourth most commonly cited threat for independent clinicians was commercial reimbursement and for employed clinicians was Electronic Health Records.
[15] The Medscape Report is available at http://www.medscape.com/slideshow/compensation-2017-overview-6008547.

Several researchers have attempted to quantify the impact of growing consolidation on prices in the healthcare sector. For example, one study showed that metropolitan areas with greater vertical integration experienced faster growth in prices and spending for outpatient services, and little impact on inpatient prices and spending.[16] Another study finds that hospital acquisition of physician practices is associated with an overall increase in physician prices of 14 percent, and an increase in primary care spending of about 5 percent[17].

In Vermont, the data suggests that the largest differential exists between the academic medical center and other physicians.[18] An analysis done by Onpoint Health Data using Vermont's All-Payer Claims Database serves to quantify this differential for primary care practices. Table 2 provides information about the primary care charges and total care costs incurred by patients attributed to the Vermont Blueprint for Health practices in various practice settings for commercial payers only.[19]

Table 2. Average allowed amount, utilization and allowed per-member-per-month (PMPM) for commercial payers

COMMERICAL payers	Blueprint practices	Avg. allowed amount	Services per patient	Allowed PMPM
FQHC/RHC	41	$95.66	2.06	$17.60
Academic Medical Center	10	$167.58	1.86	$27.32
Independent	47	$99.72	2.41	$21.29
Community Hospital	34	$103.31	2.09	$19.12

For commercial payers, the data suggests that the $168 "Average Allowed Amount"[20] for a primary care service at the academic medical center is significantly more than the amount for the same service at community hospitals ($103), independent practices ($100), and FQHCs/RHCs ($96). It is important to note, however, that the academic medical center provides fewer services per patient than the other providers, narrowing the differential on a PMPM basis.

For combined public and private payers (commercial, Medicare, and Medicaid) the differential is less pronounced. FQHCs/RHCs receive enhanced payments for providing care and wrap-around services to

[16] Neprash *et al*., *Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices*, JAMA Intern Med. (Dec. 2015).
[17] Capps *et al.*, *The effect of hospital acquisitions of physician practices on prices and spending* (Jan. 2017), *accessed at* http://economics.mit.edu/files/12747.
[18] Vermont Agency of Administration, *Report on Payment Variation in Physician Practices* (Nov. 26, 2014), *available at:* http://legislature.vermont.gov/assets/Legislative-Reports/303323.pdf; *see also MVP Implementation Plan for Fair and Equitable Reimbursement* (July 1, 2016) and *BCBSVT Implementation Plan for Fair and Equitable Reimbursement*, (July 1, 2016). Both reports are available at: http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports.
[19] Onpoint data table is provided in Attachment C.
[20] The average allowed amount is the maximum amount a plan will pay for a covered health care service, i.e., the negotiated rate.

underserved populations, resulting in higher allowed reimbursements. As shown in Table 3 below, when combined payer mix is taken into account, the PMPM payments for independent practices and FQHC/RHCs are only slightly different, while community hospitals receive the lowest PMPM.

Table 3. Average allowed amount and PMPM for COMBINED (public/private) payers

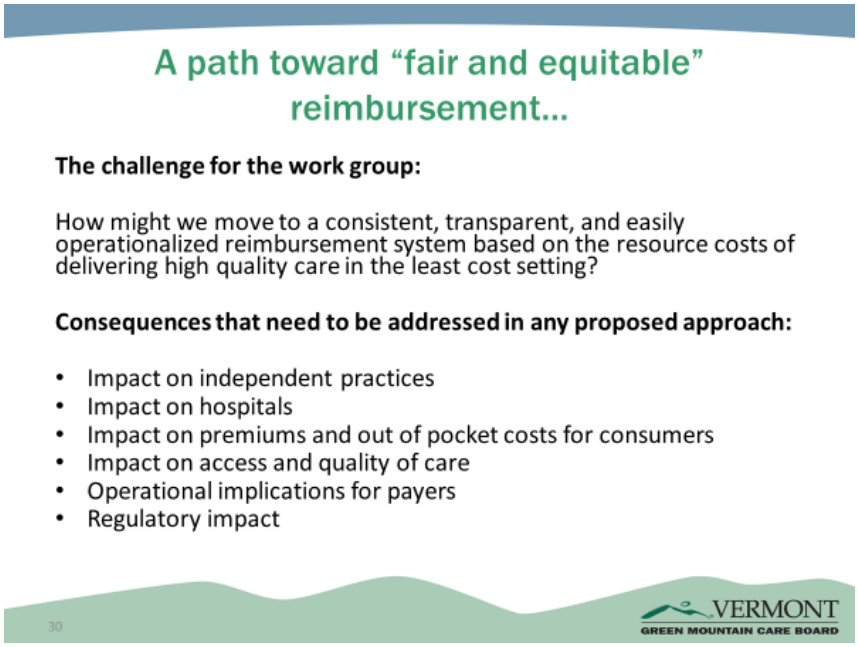
COMBINED (public/private)	Blueprint practices	Avg. allowed amount	Allowed PMPM
FQHC/RHC	41	$120.39	$24.51
Academic Medical Center	10	$112.51	$26.27
Independent	47	$91.57	$23.79
Community Hospital	34	$80.34	$19.41

A significant caveat is that this analysis is done for Blueprint primary care practices only, and for a defined set of codes. Different patterns may emerge for specialty practices and services.

It is also worth noting that both carriers' July 2016 implementation reports recommend closing the reimbursement differential between the academic medical center and other practices. Specifically, BCBSVT's proposal includes reducing academic medical center professional fees for E/M codes (i.e. office visits), would take into account graduate medical education payments and disproportionate share hospital payments, and would be accomplished over the course of three years. Importantly, BCBSVT expects that there would be a commensurate increase in negotiated reimbursements for inpatient services, and cautions that the reimbursement changes could impact consumer insurance premiums. MVP reported that it reimburses UVMMC at a higher rate than other tertiary care providers in its network, and independent providers at a higher rate than other independently contracted physicians in its network. MVP recommends an across-the-board downward adjustment to the academic medical center fee schedule over two years, with no upward adjustment in independent rates.

Key Point #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.

This point was the focus of the provider reimbursement workgroup convened in the spring and summer of 2017. The workgroup provided a venue for discussion among stakeholders and enabled the Board to collect input on options for addressing fee-for-service price differentials. The Board presented the following challenge to the workgroup:



Although the workgroup did not come to consensus on either the definition of fair and equitable reimbursement or how to achieve greater equity, the discussions were lively, informative and thought-provoking. One theme emerged: there are complexities and unintended consequences associated with changing one aspect of a very complex fee-for-service reimbursement system. The system is built like a "house of cards" and removal of one card, without a deep understanding of the implications, can have significant financial and operational consequences.

Many, but not all, of the stakeholders agreed that value-based payment reform can address reimbursement differentials based on practice setting and/or ownership type. The Vermont All-Payer Accountable Care Organization Model deemphasizes fee-for-service reimbursement, and moves the system toward capitated and global payments tied to quality. Accountable Care Organizations participating in the model can choose to receive All Inclusive Population Based Payments (AIPBP) instead of fee-for-service reimbursement. The AIPBP is based on the historical health care expenditures of attributed Vermonters, and will be provided to the ACO for distribution among participating providers. This pre-paid model creates an opportunity for an ACO to reward participating providers for high quality, high value care and to invest more in those services that keep patients healthy as opposed to those that have the most favorable reimbursement. In its 2018 budget submission, OneCare Vermont allocated dollars for a comprehensive payment reform pilot program, for independent primary care providers, that includes $1.8 million in supplemental investment to develop a multi-payer, blended capitation model for primary care services.

Additionally, on September 1, 2017, UVMMC advised the Board that ACO investments

> are effectively being redirected from participating hospitals to primary care and other community providers. Looking at primary care practices alone, OneCare Vermont has estimated that UVM Medical Center will be funding about $2.5 million of those payments in 2018. If you look at

> payments flowing to both primary care and continuum-of-care providers, UVM Medical Center's share rises to $3.2 million.[21]

The Board has been charged by the Legislature to oversee successful implementation of the All-Payer ACO Model Agreement between the state and the federal government.[22] The Agreement requires the majority of Vermont residents to be attributed to a value-based payment model, rather than traditional fee-for-service, by the end of 2022. Additionally, the Legislature charged the Board with continuing to monitor the effects of reimbursing providers differently when providing the same service, and reducing or eliminating the differential as appropriate through all-payer model implementation.[23] With the last charge in mind, the following section outlines Board Actions.

Board Actions to Achieve Site Neutral, Fair Reimbursement for Medical Services

Successful implementation of the All-Payer ACO Model Agreement is the Board's payment reform priority. If implemented and regulated properly, it can help address pay parity concerns. To address legislative concerns over fee-for-service price differentials in the immediate short term, the Board has exercised its regulatory authority to reduce payment differentials and move closer to "fair and equitable reimbursement" for providers.

Hospital budget review. At its publicly-held board meeting on September 14, 2017, the Board voted unanimously to approve UVMMC's fiscal year 2018 (FY18) budget with a condition that it reduce payment differentials for a set of well-established site-neutral services, consistent with the Board's prior recommendations concerning payment differentials. The condition directs UVMMC to reallocate an $11.3 million proposed reduction in professional fees to E/M codes (both primary and specialty care), and to implement the reallocation in a manner that does not result in any increase in rate beyond the 0.72 percent approved by the Board or net patient revenue growth above 3.39 percent. The Board instructed the hospital that implementation of the reduction cannot negatively impact its participation in the ACO.[24]

Specifically, the Board included in its order:

> The Hospital is directed to apply the entire $11.3M reduction in professional fees to E&M codes (99201-99499) in the FY18 budget to address provider reimbursement differentials. The reduction should not negatively impact the Hospital's ACO participation or target.[25]

The Board included within its findings the hospital's calculation of the impact of reallocating a reduction in provider fees to enumerated E/M codes, stating that "the Hospital has estimated the gap in reimbursement levels is reduced to approximately 10%."[26] In a letter to the Board, BCBSVT confirmed that the differential will be reduced by approximately 34 percent for these specific codes, and that by

---

[21] *See* Letter to Kevin Mullin, Chair, from Todd Keating, Chief Financial Officer, University of Vermont Health Network (Sept. 1, 2017), available at: http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports. See Attachment D.
[22] Act 113 (2016), Sec. 2.
[23] Act 54 (2015), Sec 23.
[24] Due to the complexity of adjusting fee-for-service rates, and taking into consideration input from stakeholders, the Board focused its actions on E/M codes only. *See* f.n. 5.
[25] Fiscal Year 2018 UVMMC Hospital Budget Order (Sept. 28, 2017), ¶ C, *available at* http://gmcboard.vermont.gov/content/fy18-individual-hospital-budget-information.
[26] *Id*. at ¶ 14. The remaining differential is approximate and does not account for the provider tax (independent practices do not pay the tax) or differences in payer mix between providers.

aligning reimbursement rates between providers, consumers will experience lower out-of-pocket costs for E/M services at UVMMC, and "will no longer be surprised by dramatically different reimbursement for the same fundamental healthcare practices."[27]

Although the Board ordered that UVMMC direct its proposed rate reductions to specific E/M codes, the Board has declined to recommend a commensurate increase in rates to independent providers. The assertion that inadequate commercial reimbursement rates for Vermont's independent physicians is the primary driver of their financial struggles or key reason they seek hospital-based employment has not been verified by data, cannot be gleaned from information provided by the carriers, and is contrary to the results of our clinician survey. Moreover, given that the Board does not regulate independent practice budgets and has no access to their financial information or data, the Board declines to recommend that their reimbursements be increased. Rather, any difference in reimbursements among providers that does not reflect increased services or a heightened level of care should be addressed by the site-neutral policy promoted by the Board, and implemented through our regulatory authority, as discussed in this memorandum.

Rate review. In addition to adjusting UVMMC's budget, the Board ordered a substantial reduction in the insurers' medical trends in the 2018 Vermont Health Connect (VHC) Qualified Health Plan rate filings. These reductions were intended, among other things, to encourage the insurers to negotiate rates with providers in a way that promotes reimbursement parity between academic medical centers, community hospitals, and independent providers for site-neutral services. The Board's decision regarding 2018 BCBSVT's VHC filing states: "[W]e reasonably expect that insurers will vigorously negotiate rates with the hospitals, including those that are outside our borders, in a way that promotes parity in reimbursements between academic medical centers, community hospitals and independent providers. Provider reimbursements should reflect actual costs of care rather than site of service." The 2018 MVP rate decision included substantially similar language.[28]

Increased Transparency. The Board remains committed to the premise that the public should have access to important information regarding health care costs and pricing. The Board recently requested and received tax information from each of the fourteen Vermont hospitals, the Brattleboro Retreat and Dartmouth Hitchcock Medical Center and published on its website the names and salaries of the hospitals' highest earners, including physicians.[29] For comparative and contextual purposes, the Board requested similar salary information from independent physicians through HealthFirst. HealthFirst declined the request.

Conclusion

As described in this report, the Board took substantial action to achieve site-neutral, fair reimbursements for medical services. The Board ordered that UVMMC, Vermont's academic medical center, reallocate $11.3 million in rate reductions to address the differential, cutting fees for E/M services and reducing out-of-pocket costs for consumers. The Board formed a workgroup of stakeholders to focus on the issue of pay parity, and generate possible solutions that could be implemented. The Board conducted a survey and

[27] *See* Letter to Kevin Mullin from Sara Teachout, Director, Government, Public and Media Relations, BCBSVT (Sept. 28, 2017), *available at* http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports, and included with this report as Attachment E.

[28] The 2018 VHC rate decisions are available on the Board's rate review website at http://ratereview.vermont.gov/.

[29] Based on information taken from each of the fourteen Vermont hospital's (regulated by the Board) 2016 Schedule H, Form 990s, the Board compiled and posted a list of hospital salaries exceeding $400k. *See* http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/Hospital%20Salary%20Info.pdf.

garnered useful information from a significant segment of providers in independent practices. Although the Board continues to focus on the transition from a fee-for-service reimbursement model to population-based payments, the Board's recent orders and recommendations, including those relating to transparency, will narrow the gap between providers, and move the State closer to a site-neutral reimbursement structure.

This memorandum satisfies the charge put forth by the legislature in Act 85 of 2017.

Attachments

A. Clinician Landscape Study Report
B. Payment Differential and Provider Reimbursement Reports: Update and Discussion
C. Onpoint Health Data Blueprint primary care analysis data table
D. Letter to Kevin Mullin from Sara Teachout, Director, Government, Public and Media Relations, BCBSVT (Sept. 28, 2017)
E. Letter to Kevin Mullin, Chair, from Todd Keating, Chief Financial Officer, University of Vermont Health Network (Sept. 1, 2017)

VERMONT

Vermont Clinician Landscape Study Report

October 1, 2017

Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

802-828-2177

http://gmcboard.vermont.gov/

Table of Contents

Executive Summary 3

Methodology 5

Demographics 6

Survey Findings 7

- **Independently Practicing Clinicians** 7
- **Clinicians Employed by an Academic Medical Center, Community Hospital, Federally Qualified Health Center, or Rural Health Center** 9
- **Professional Morale** 11

Focus Group Findings 12

Appendix: Clinician Landscape Survey Tool 15

Executive Summary

The Green Mountain Care Board administered an anonymous survey of active clinicians and conducted focus groups of active physicians in order to better understand the medical care climate in Vermont. Specifically, we were interested in learning what clinicians find most rewarding, the stressors they face in their practices, the factors that drive their employment choices, and their outlook on the profession in Vermont. After reviewing over 400 survey respondents, we identified the following key takeaways:

- Independently practicing clinicians cite strong patient relationships, the opportunity to run their own practice as well as flexibility and choice over work schedules as the factors most satisfying about their work.

- Independent clinicians are most frustrated by billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice and accessing costly technology.

- Employed clinicians are most satisfied about not having to run their own business, not being responsible for high practice costs, the opportunities to work with colleagues, and the certainty of their income in an employed setting.

- Like independent clinicians, employed clinicians find administrative burdens frustrating. They also identify the limited control they have over practice management, lack of control over their work schedule, and level of their income as frustrations.

- The top three most commonly cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement. The same top three threats apply to employed clinicians.[1]

- Despite frustrations, the majority of clinicians, whether practicing independently or employed through a hospital, academic medical center, Federally Qualified Health Center (FQHC) or health clinic, are generally optimistic about their current employment and anticipate continuing to practice as they are today.

In focus group sessions, participating clinicians discussed these findings in more detail. Specifically, three focus groups were held in Middlebury, Montpelier and Burlington to learn more about the factors related to employment choice, how healthcare and payment reform efforts impact clinical practices, perceptions about the future of healthcare in Vermont, and what Vermont's health policy makers need to know about the conditions in the healthcare marketplace. After the three focus groups, it became evident that

[1] The fourth most commonly cited threat for independent clinicians was commercial reimbursement and for employed clinicians was Electronic Health Records.

the issues facing clinicians in Vermont are varied and speak to the complexity of the healthcare landscape. There is not a single story of the "clinician experience" but a few key takeaways emerged:

- Independent physicians who have been practicing for many years expressed concern about the negative impact of regulatory and compliance burdens, federal and state payment reform efforts, and increasing administrative demands on their ability to remain independent and provide timely patient care.

- Clinicians who switched from independent to employed status overwhelmingly identify the increasing costs of running independent practices (e.g. malpractice insurance, electronic health record systems, and increasing administrative workforce demands) as a primary driver of their decision to leave private practice.

- Clinicians who have been employed by a hospital system or health clinic during their entire career suggested that practice start-up costs, student debt burdens, and lack of business acumen served as barriers to seeking self-employment as a physician.

Methodology

Between August 10, 2017 and August 22, 2017, the Green Mountain Care Board fielded an electronic survey of Vermont clinicians via SurveyMonkey. We requested distribution of the survey link through the following membership organizations:

- Vermont Medical Society
- Bi-State Primary Care
- Vermont HealthFirst

In addition, we asked the CEOs of Vermont's fourteen hospital systems to send the survey link to their network clinicians. From a total of 445 initiated surveys, we used 404 completed surveys in the analysis. Although we estimate that this survey yielded responses from approximately 20 percent of practicing clinicians in Vermont, the findings discussed in this report are derived from a convenience sample and can only be considered the opinions of the survey respondents. They may not represent the entire population of practicing clinicians in Vermont, estimated to be around 2,000.[2] The complete survey tool is included for reference in the Appendix.

The last question on the survey asked respondents if they would be willing to participate in a focus group session organized by the Green Mountain Care Board. Contacting those who responded yes, four focus group sessions were planned, and three were ultimately conducted. The first focus group was convened in the Middlebury area in August 2017. The second and third focus groups were held in Montpelier and Burlington respectively, during September 2017. A fourth focus group was planned for the Rutland area, but low participation forced us to cancel the session. The survey results did not yield sufficient numbers of willing participants in the regions of southern Vermont to enable us to plan a southern Vermont focus group session. Participants in the focus groups included independent clinicians, clinicians employed by an academic medical center or its networks, and clinicians employed by FQHCs or other small rural clinics. Focus groups lasted approximately 75 minutes and followed a consistent agenda with several probing questions used to launch participant discussion about their experiences as independent or employed practitioners, how their practices have changed over the years, the impact of healthcare reform initiatives on their practices, and thoughts about the future of healthcare in Vermont. It is important to note the possibility that those clinicians most frustrated and negatively impacted by recent trends in healthcare were more likely to have volunteered to participate in the focus groups, so the summary findings presented in this report may be suggestive of this selection bias.

[2] Vermont Department of Health, *2014 Physician Survey Statistical Report* (February 2016); Kaiser Family Foundation, *Total Professionally Active Physicians; State Health Facts* (April 2017).

Demographics

Surveys were completed by clinicians in every Hospital Service Area (HSA) in Vermont, although the concentration of respondents varies widely from 46 percent in the Burlington HSA to one percent in the Springfield HSA (see Table 1). Survey respondents were split between male and female (41 percent female, 57 percent male) with two percent of respondents preferring not to disclose their gender. The greatest percentage of respondents were in the 46-65 age range (25 percent in the 46-55 range, and 32 percent in the 56-65 range). Of the completed 404 surveys, 90 clinicians (22 percent) reported practicing independently, and 314 clinicians (77 percent) are employed by an academic medical center, community hospital, Federally Qualified Health Center (FQHC), or rural health center.

Table 1: Distribution of clinician respondents by Hospital Service Area

Hospital Service Area	Number of Responses	Percent
Barre	60	15%
Bennington	23	6%
Brattleboro	13	3%
Burlington	181	45%
Middlebury	7	2%
Morrisville	27	7%
Newport	4	1%
Randolph	3	1%
Rutland	15	4%
Springfield	5	1%
St Albans	29	7%
St Johnsbury	31	8%
White River Junction	6	1%

The medical specialties of respondents vary widely: 31 percent reported working in family medicine, general internal medicine, or other adult primary care, 9 percent reported working in pediatrics, with the remainder in other non-primary care specialties including anesthesiology, cardiology, dermatology, emergency medicine, gastroenterology, general surgery, hematology, infectious disease, neonatal medicine, nephrology, neurology, obstetrics and gynecology, orthopaedics, oncology, palliative medicine, psychiatry, radiology, rheumatology, urology. The majority of respondents (60 percent) work in small clinic settings of two to ten clinicians (see Table 2).

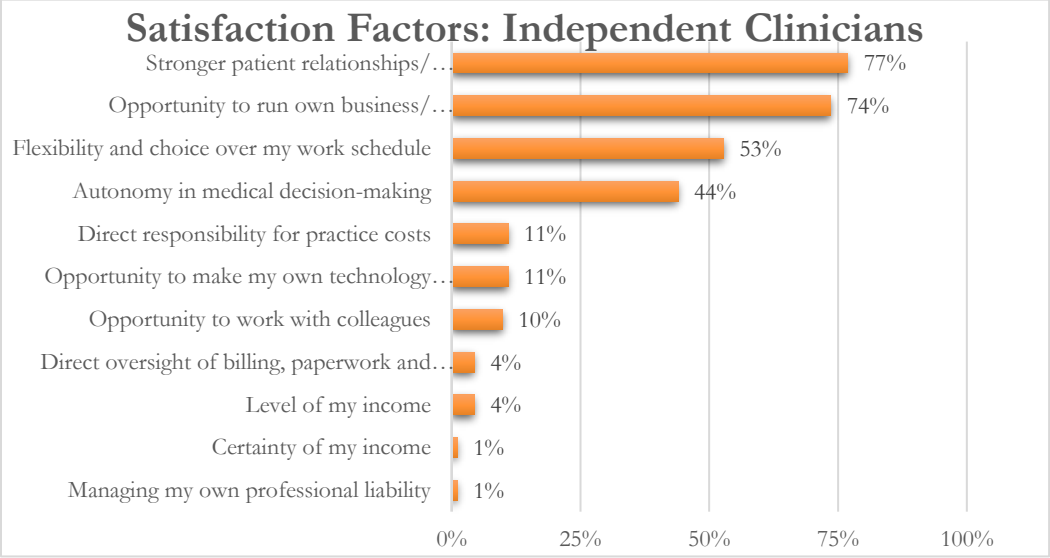
Table 2: Practice Size

Practice Size	Number of Responses	Percent
Solo	39	10%
2 – 5 Clinicians	129	32%
6 – 10 Clinicians	111	28%
11 – 30 Clinicians	61	15%
31 – 100 Clinicians	23	6%
More than 100 Clinicians	38	9%
Total Responses	**401 (99%)**	

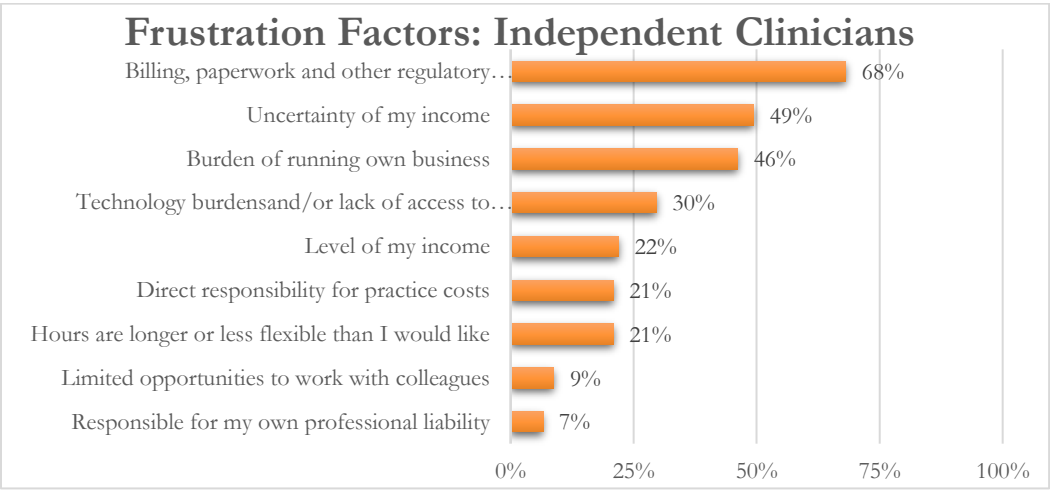
Survey Findings

Independently Practicing Clinicians

We asked clinicians to select the top three factors that are most satisfying as well as most frustrating about their practice. For clinicians practicing independently, the top three satisfiers are patient relationships and time with patients, the opportunity to run their own business, flexibility and choice over their work schedule, and autonomy in medical decision-making. The top factor – strong patient relationships – aligns with national findings from the Physician's Foundation 2016 Survey of America's Physicians.[3]

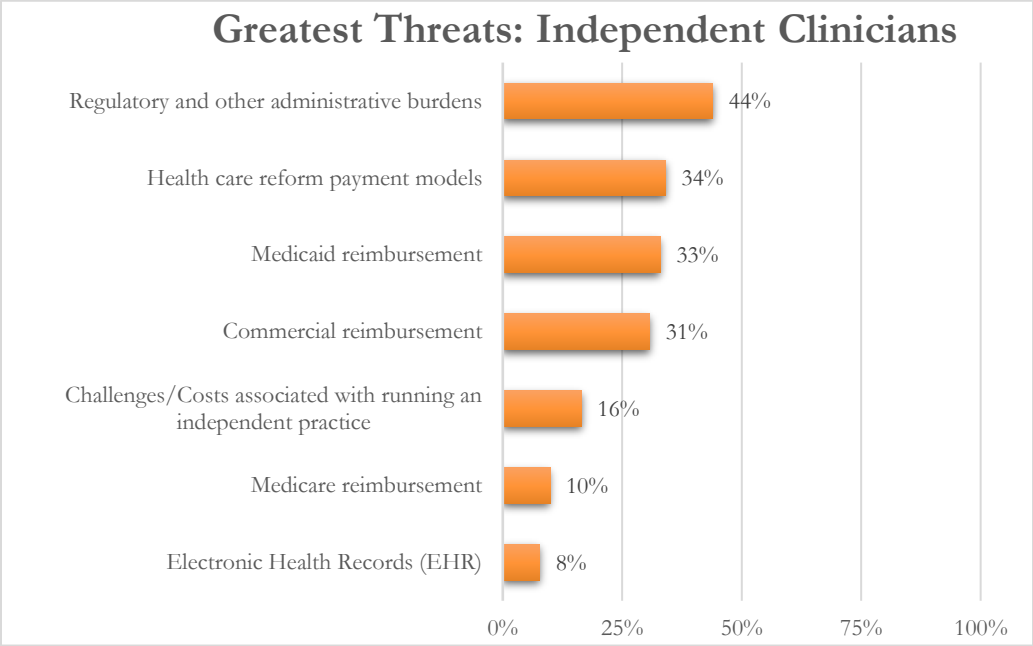


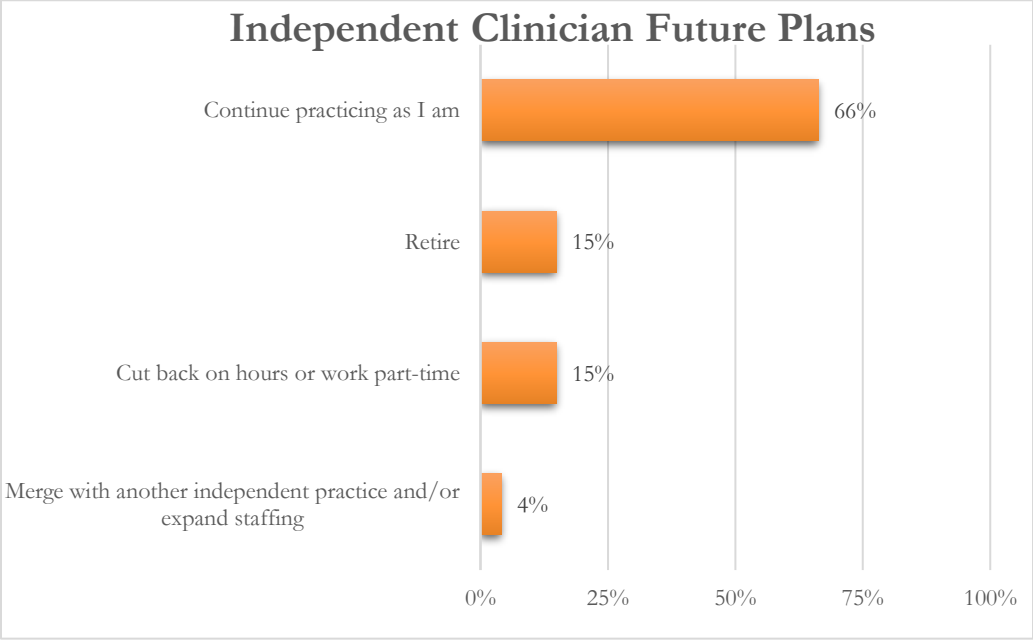
Most frustrating to independent clinicians are the billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice (including technology). Again, we find that frustrations around regulatory and paperwork burdens align with the findings nationally.



[3] The Physicians Foundation, *2016 Survey of America's Physicians Practice Patterns & Perspectives: An Examination of the Professional Morale, Practice Patterns, Career Plans, and Perspectives of Today's Physicians, Aggregated by Age, Gender, Primary Care/Specialists, and Practice Owners/Employees* (September 2016).

Independently practicing clinicians say that the greatest threats to their practices are regulatory and administrative burdens, healthcare reform payment models and Medicaid reimbursement. Commercial reimbursement is also cited as a threat, though below the top three. We included healthcare reform payment models as a choice when asking about threats, but we did not specify particular payment models, nor did we differentiate between state or federal reform initiatives, so perceived threats around payment reform models will need further investigation to better understand these results.

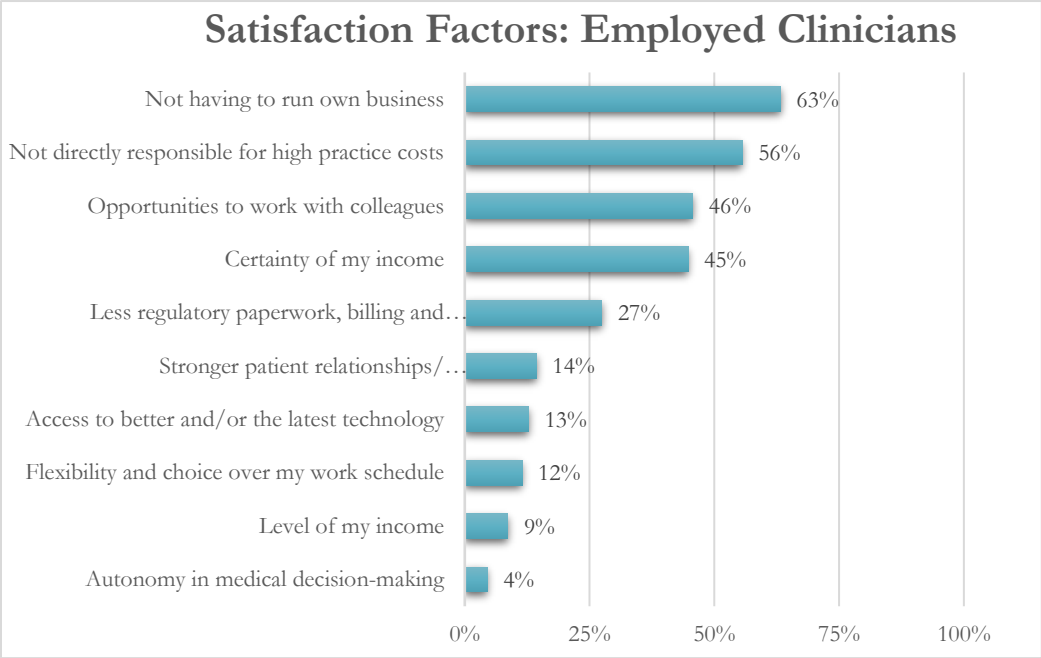




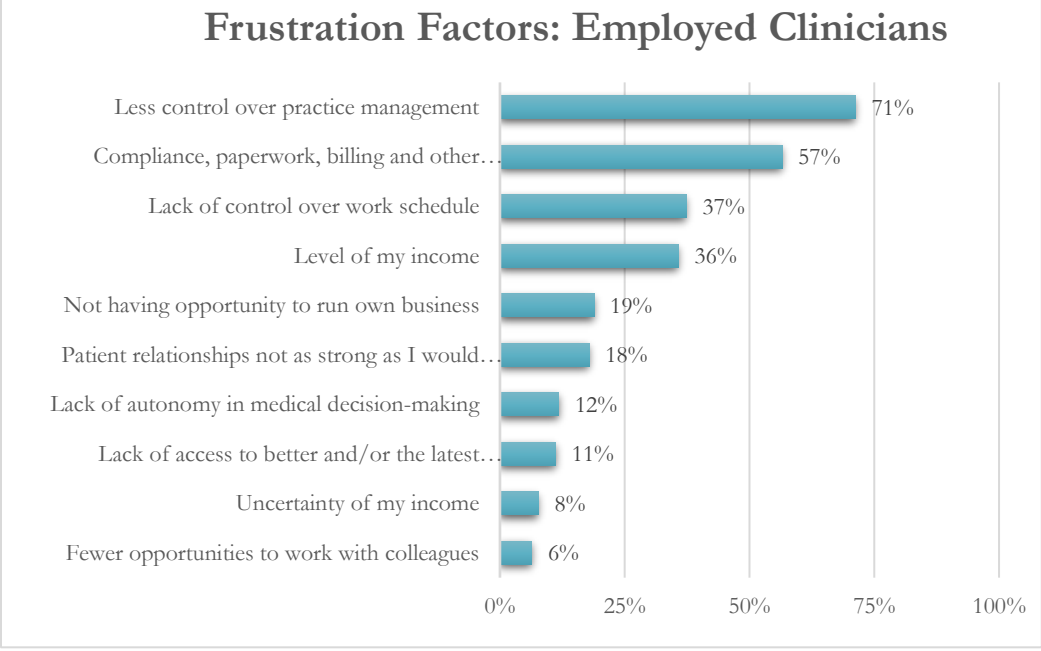
Despite the frustrations, two-thirds of independent providers plan to continue practicing as they are over the next three years, with 15 percent planning to retire and another 15 percent planning to reduce their hours.

Clinicians Employed by an Academic Medical Center, Community Hospital, Federally Qualified Health Center, or Rural Health Center

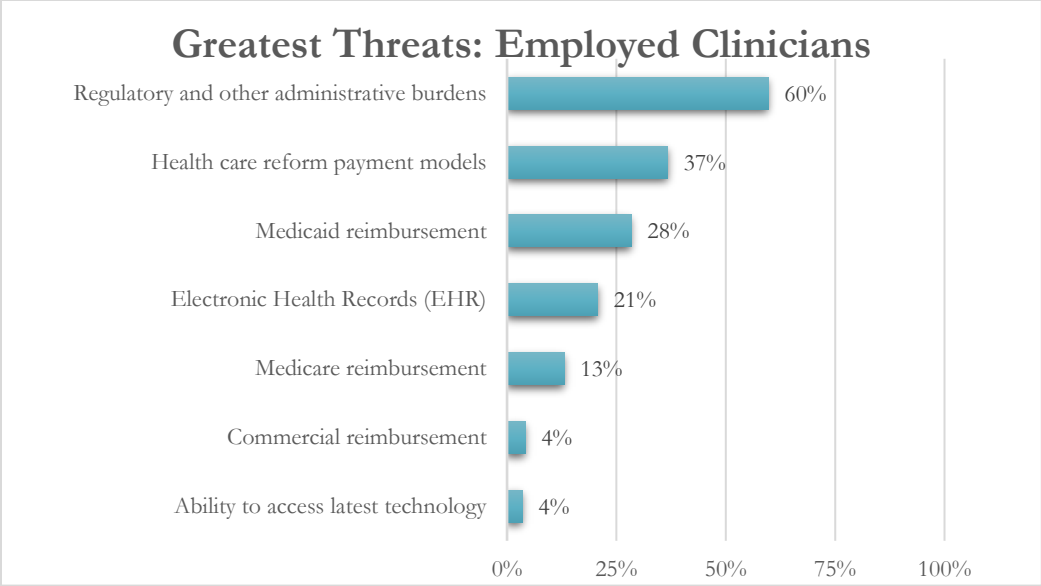
Employed clinicians are most satisfied by not having to run their own business, not being directly responsible for high practice costs, enjoying the opportunity to work with colleagues, and benefitting from the certainty of income in an employed setting.

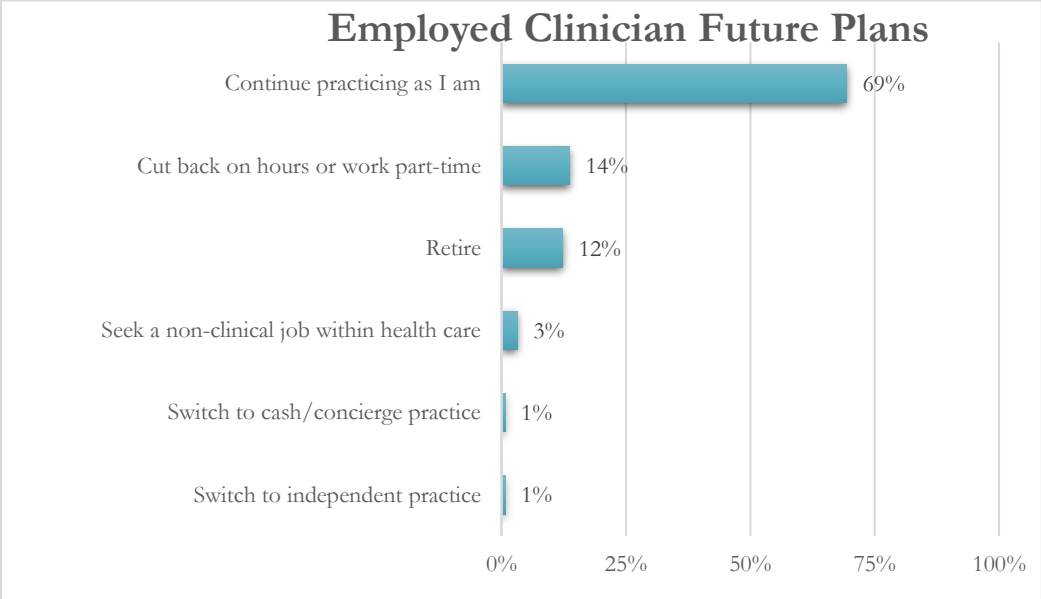


Most frustrating to employed clinicians is their limited control over practice management, billing and other administrative burdens, lack of control over work schedules, and the level of their income.



For clinicians who are employed, the top three greatest threats to the success of their practices are the same as those identified by independent clinicians: regulatory/administrative burden, federal and/or state healthcare reform payment models, and Medicaid reimbursement. Somewhat lower than the top three threats for employed clinicians is the use of electronic health records. Here again, we included healthcare reform payment models as a choice when asking about threats to employed clinicians, but we did not specify particular payment models, nor did we differentiate between state or federal reform initiatives, so perceived threats around payment reform models will need further investigation to better understand these results.

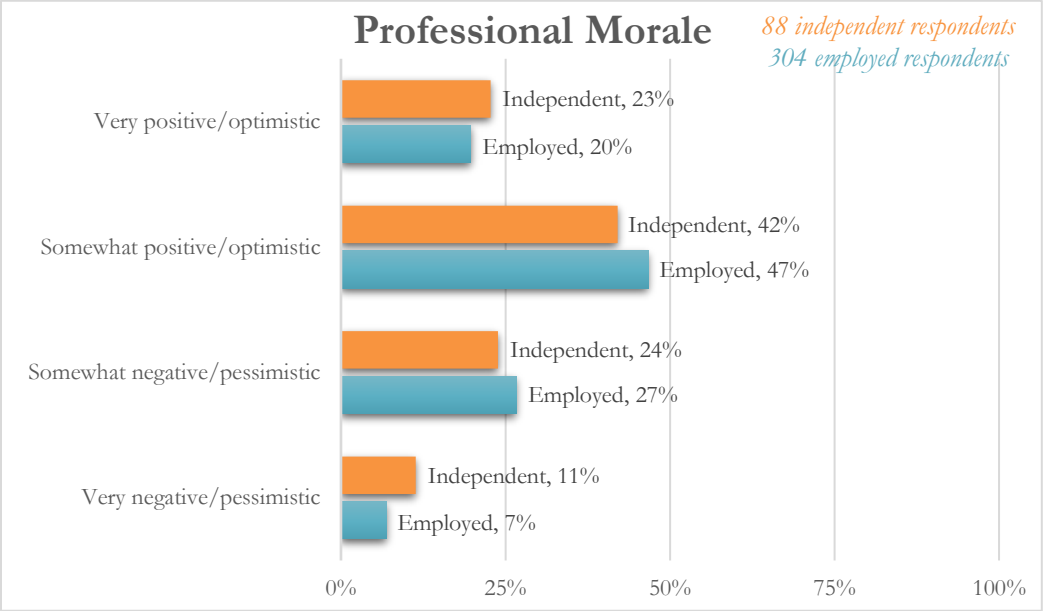




Again, despite the frustrations, almost 70 percent of employed providers plan to continue practicing as they are over the next three years, with 14 percent planning to reduce their hours and 12 percent planning to retire.

Professional Morale

Clinicians—whether practicing independently or employed through a hospital, academic medical center, FQHC or health clinic—are generally positive and optimistic about their current employment situation, and it doesn't vary much by employment status. Notably, Vermont providers appear to be more optimistic than their national counterparts; according to the Physician's Foundation 2016 Survey of America's Physicians, only 47 percent were optimistic about their employment status and the profession,[4] compared to two-thirds of Vermont clinicians.



[4] The Physicians Foundation, *2016 Survey of America's Physicians Practice Patterns & Perspectives: An Examination of the Professional Morale, Practice Patterns, Career Plans, and Perspectives of Today's Physicians, Aggregated by Age, Gender, Primary Care/Specialists, and Practice Owners/Employees* (September 2016).

Focus Group Findings

Vermont clinicians discussed several rewarding aspects of practicing medicine in Vermont including direct patient care, the small-town approach to practicing medicine, and the overall collegiality found in Vermont. Interestingly, some clinicians shared that the rural nature of the state precludes opportunities to work with and learn from other colleagues; for some, there may be only one specialist serving a large geographic area and such isolation and patient responsibility can take its toll. Clinicians also spoke about care coordination and the inception of Community Health Teams (CHT) as a very positive aspect of the changing landscape of healthcare in Vermont. One clinician commented: "Community Health Teams have changed the quality of patients' lives more than anything I could have done in 25 years [of practice]. Our social worker has helped patients find jobs, helped them get resources, helped them fill out forms." Another clinician echoed that sentiment: "CHT is one of the best things that has happened over the past few years, and it has helped our patients in ways that we couldn't."

In focus groups clinicians echoed the following themes:

- *Administrative requirements are increasingly burdensome. Data collection requirements continue to increase; clinicians are spending more time on collecting data and less time on direct patient care.*
- *Data systems are increasing in volume but still not well-coordinated and this is a growing problem in terms of direct patient care, and particularly challenging for care coordination.*
- *Payment reform and practice transformation models are viewed with cautious optimism, but questions remain around the value of quality measures, and whether quality payment structures will result in improved outcomes as intended.*
- *Physicians in small independent practices are disproportionately burdened by the costs associated with administrative, data, and payment reform requirements.*

Overall, four consistent themes emerged from the focus groups in Middlebury, Montpelier, and Burlington:

1. administrative burden;
2. challenges with data systems;
3. complexities associated with payment reform and practice transformation models, and
4. declining independent practice in Vermont.

Administrative Burden

For those practicing independently, the ability to care for patients "the way we want to" is seen as a major reason to stay in independent practice, despite the growing administrative, cost and practice management burdens associated with independent practice. These clinicians expressed challenges with what they see as an enormous growth in administrative burden. Many noted that independent practices cannot afford to hire the staff needed to remain in compliance with new payment models, care coordination, and state and federal mandates. Independent clinicians also expressed frustration with ever-increasing costs to own and run their practices coupled with stagnant reimbursement rates. Whether employed or independent, clinicians expressed that

administrative requirements are increasingly burdensome. Data collection requirements continue to grow and clinicians report spending so much time on collecting data that they have less and less time to engage in direct patient care. Some clinicians who switched from independent to employed shared that little changed in terms of administrative burden, operations, and/or flow of clinical staff. As one clinician put it: "[E]veryone's so busy and needing to fill spaces so it's not surprising that help isn't shared more widely." However, there is hope for better support for groups that join networks, and optimism that current coordination challenges and administrative burdens facing practices will improve over time in network settings.

Data System Challenges

According to the clinicians interviewed, broad-sweeping efforts to move toward more comprehensive electronic medical records have led to less patient interaction and more electronic interfaces, not better coordination or better outcomes. Some expressed the challenges of coordinating care with highest-need patients, for whom records are kept in different uncoordinated systems. As one focus group respondent stated: "[I]f the patient is in the office and you could access all information immediately, that's going to help with care." Clinicians talked about frustration with Electronic Health Record (EHR) requirements that burden them as front-line care providers ("we're staring at screens"), coupled with what they perceive to be an enormous amount of financial investment over many years—both at the state and local system levels—stressing that the investment should be making their jobs easier and improving care but it only continues to complicate their ability to provide care. Some clinicians expressed a desire to see one statewide EHR that allows for more seamless integration between providers, with the caveat that it must be a system "everyone" can agree to live with, use, and support.

Payment Reform and Practice Transformation Models

Independent clinicians are wary of the risks associated with payment reform models, leading to increased anxiety about the sustainability of their private practices. Echoed throughout the focus groups is the need for stability in independent practices. More generally, both independent and employed focus group respondents expressed doubt about what they termed "pay for value, pay for quality, pay for outcomes," asking for evidence to show that these changes lead to improved patient outcomes overall. Independent clinicians expressed that a shift toward pay-for-performance payment models is "insulting to us" because they already provide high quality and low-cost care. They also discussed the new Medicare MACRA/MIPS[5] requirements as onerous and burdensome, and expressed a desire to slow down payment reform until practice transformation efforts have more time to take hold.

Many clinicians appreciated the move toward population health, but found the concept still challenging as they contemplate how to shift their practices to achieve population health goals. Clinicians expressed frustration with accountability for population health goals while still operating in a fee-for-service

[5] MACRA is the Medicare Access and CHIP Reauthorization Act, signed into law in 2015; MIPS is the Merit-based Incentive Payment System. More information can be found about these programs on the Centers for Medicare & Medicaid Services' (CMS) website: https://qpp.cms.gov/.

system. As one clinician stated: "There's nothing in place to support population health because the whole system is set up for fee-for-service."

Declining Independent Practice in Vermont

Independent clinicians shared common frustrations in the burdens they face. As one clinician put it, "There's no future for private practice in Vermont if we keep going the way were going. There's so much added expense now and administrative burden that requires additional staff to fulfill." Another physician said: "If you put private practice at risk with these payment reform efforts, practices are going to close. Burden is so hard and we will lose primary care. Stability is key."

The independent clinicians explained that they make their independent practices survive by keeping longer hours, seeing more patients, and being readily available to patients over evenings and weekends. However, they also expressed worry that this trajectory is not sustainable. They talked about their deep concern over the ability to recruit new physicians to their practices, in part because they cannot offer competitive compensation and that they feel they are in a perpetual cycle of cutting costs wherever and whenever possible. One physician expressed his concerns for the future: "It is frustrating feeling like you are an endangered species, and you are going to be prehistoric pretty soon." Overwhelmingly, the clinicians spoke to their desire to see private practices survive because it's a good thing for Vermont, the independent practice model is good for the community, and independent clinicians provide an alternative to the larger hospital-based system. The clinicians expressed pride in their ability to keep patient wait times to a minimum relative to what they observe in larger systems, and see this is a function of their independence. They universally acknowledge that academic medical centers and hospital systems are necessary, but, that so too are smaller, independent practices.

Considerations for the Future

When asked what Vermont's health policy makers could consider to address the frustrations associated with the changing landscape of healthcare in Vermont, focus group respondents offered the following thoughts:

- Make wait times for appointments with physicians the primary "vital sign of the health of the medical system."
- Practicing in Vermont should be as minimally onerous as possible. New requirements at the federal level affect all states, but Vermont could improve workforce marketability by easing and simplifying healthcare administrative requirements.
- Break down the barriers of referrals.
- Be careful about cutting costs and increase services at the same time.
- Slow down payment reform until practice transformation efforts have time to take hold.
- Streamline electronic health record systems.
- Change needs to be collaborative.
- More uniformity among payers would go a long way toward reducing the expense and hassle of reforms and improve small practice sustainability.

Appendix: Clinician Landscape Survey Tool

The Green Mountain Care Board is conducting a brief on-line survey of Vermont providers to better understand the medical care climate in Vermont. We fully recognize that you are approached in numerous ways to provide data and information; we do not mean to burden you with this request or cause time away from direct care and service, BUT WE NEED YOUR HELP.

Please respond to this survey by Friday August 18, 2017.

Click here to access the survey.

The survey should take less than 10 minutes to complete. Responses are anonymous. The survey does not require you to identify yourself. If you have any questions about the survey, please contact Kathryn O'Neill, Payment Reform Program Evaluator at the Green Mountain Care Board, at (802)-272-8602, or kathryn.oneill@vermont.gov. We very much hope that you will participate in this important effort.

Tell us about yourself and your practice

1. What is your age?

- ☐ 35 or younger
- ☐ 36-45
- ☐ 46 – 55
- ☐ 56-65
- ☐ 66 or older

2. What is your Gender?

- ☐ Female
- ☐ Male
- ☐ Prefer not to say

3. What is your medical specialty?

- ☐ Family Medicine, General Internal Medicine, Other Adult Primary Care
- ☐ Pediatrics
- ☐ Other

4. What is the size of the practice where you spend the majority of your time? (if you are part of a network, do not include the entire network in your response.)

- ☐ Solo
- ☐ 2-5 clinicians
- ☐ 6-10 clinicians
- ☐ 11-30 clinicians
- ☐ 31-100 clinicians
- ☐ More than 100 clinicians

5. In which Hospital Service Area (HSA) do you spend the majority of your time serving patients? (check one that best applies)

- ☐ Barre
- ☐ Burlington
- ☐ Newport
- ☐ St Albans
- ☐ Bennington
- ☐ Middlebury
- ☐ Randolph
- ☐ St Johnsbury
- ☐ Brattleboro
- ☐ Morrisville
- ☐ Rutland
- ☐ White River Junction
- ☐ Springfield

6. What is your current professional status?

- ☐ Owner, partner, or associate in an independent private practice
- ☐ Employed by a community hospital
- ☐ Employed by an academic medical center
- ☐ Employed by a Federally Qualified Health Center (FQHC), rural health clinic, or other small health system

Independent Clinicians

NOTE: Only respondents who selected *Owner, partner, or associate in an independent private practice* to the above question #6 received the following questions in this section.

7. About how many years have you been an independent clinician?

- ☐ Scale Range from 0-50

8. Select the top three (3) factors that are the most satisfying to you about your decision to be an independent clinician.

- ☐ Opportunity to run own business/Autonomy over how practice is managed (hiring decision, location choice, etc.)
- ☐ Flexibility and choice over my work schedule
- ☐ Direct responsibility for practice costs (malpractice insurance, electronic health record (EHR) purchase, etc.)
- ☐ Managing my own professional liability
- ☐ Certainty of my income
- ☐ Level of my income
- ☐ Autonomy in medical decision-making
- ☐ Stronger patient relationships/ability to spend time with patients
- ☐ Direct oversight of billing, paperwork and other administrative responsibilities
- ☐ Opportunity to make my own technology decisions (electronic health records, technology adoption, etc.)
- ☐ Opportunity to work with colleagues (intellectual stimulation)
- ☐ Other (please specify)

9. Select the top three (3) factors that are the most frustrating to you about your decision to be an independent clinician.

- ☐ Burden of running own business (hiring decisions, compliance, practice management, etc.)
- ☐ Hours are longer or less flexible than I would like
- ☐ Autonomy in medical decision-making
- ☐ Responsible for my own professional liability
- ☐ Uncertainty of my income
- ☐ Level of my income

- ☐ Direct responsibility for practice costs (malpractice insurance, electronic health record (EHR) purchase, etc.)
- ☐ Billing, paperwork and other regulatory and administrative burden
- ☐ Patient relationships not as strong as I would like/lack of time with patients
- ☐ Technology burdens (purchasing, managing, maintaining technological advances) and/or lack of access to the latest technology
- ☐ Limited opportunities to work with colleagues (lack of intellectual stimulation)
- ☐ Other (please specify)

10. In your opinion, what are the top two (2) greatest threats to the success of your independent practice?

- ☐ Medicaid reimbursement
- ☐ Medicare reimbursement
- ☐ Commercial reimbursement
- ☐ Electronic Health Records (EHR)
- ☐ Challenges/Costs associated with running an independent practice (malpractice insurance, hiring/retention of staff)
- ☐ Health care reform payment models
- ☐ Regulatory and other administrative burdens
- ☐ Ability to access latest technology
- ☐ N/A
- ☐ Other (please specify)

11. In the next three years do you plan to:

- ☐ Continue practicing as I am
- ☐ Cut back on hours or work part-time
- ☐ Other (please specify)
- ☐ Retire
- ☐ Seek a non-clinical job within health care
- ☐ Seek employment with a hospital or FQHC
- ☐ Merge with another independent practice and/or expand staffing

In the past, have you been employed by a hospital or other health system?

- ☐ No
- ☐ yes (if yes, why did you switch to being an independent clinician?)

Employed Clinicians

NOTE: Respondents who selected one of the three *Employed* choices to the above question #6 received the following questions in this section.

7. About how many years have you been an employed clinician?

- ☐ Scale Range from 0-50

8. Select the top three (3) factors that are the most satisfying to you about your decision to be an independent clinician.

- ☐ Not having to run own business (staffing, compliance, etc.)
- ☐ Flexibility and choice over my work schedule
- ☐ Not directly responsible for high practice costs (malpractice insurance, electronic health record (EHR) purchase, etc.)
- ☐ Certainty of my income
- ☐ Level of my income
- ☐ Autonomy in medical decision-making
- ☐ Stronger patient relationships/ability to spend time with patients
- ☐ Less regulatory paperwork, billing and other administrative burden
- ☐ Access to better and/or the latest technology
- ☐ Opportunities to work with colleagues (intellectual stimulation)
- ☐ Other (please specify)

9. Select the top three (3) factors that are the most frustrating to you about your decision to be an employed clinician.

- ☐ Not having opportunity to run own business (hiring decisions, practice management, etc.)
- ☐ Lack of control over work schedule
- ☐ Less control over practice management (hiring decisions, technology adoption, etc.)
- ☐ Uncertainty of my income
- ☐ Level of my income
- ☐ Lack of autonomy in medical decision-making
- ☐ Patient relationships not as strong as I would like/Lack of time with patients
- ☐ Compliance, paperwork, billing and other administrative burden
- ☐ Lack of access to better and/or the latest technology
- ☐ Fewer opportunities to work with colleagues (intellectual stimulation)
- ☐ Other (please specify)

10. In your opinion, what are the top two (2) greatest threats to the success of your practice?

- ☐ Medicaid reimbursement
- ☐ Medicare reimbursement
- ☐ Commercial reimbursement
- ☐ Electronic Health Records (EHR)
- ☐ Health care reform payment models
- ☐ Regulatory and other administrative burdens
- ☐ Ability to access latest technology
- ☐ N/A
- ☐ Other (please specify)

11. In the next three years do you plan to:

- ☐ Continue practicing as I am
- ☐ Retire
- ☐ Switch to independent practice
- ☐ Switch to cash/concierge practice
- ☐ Cut back on hours or work part-time
- ☐ Seek a non-clinical job within health care
- ☐ Other (please specify)

In the past, have you been an independent clinician (not employed by a hospital or other health system)?

- ☐ No
- ☐ yes (if yes, why did you switch to being employed?)

Satisfaction with current practice situation

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

- ☐ very positive/optimistic
- ☐ somewhat positive/optimistic
- ☐ somewhat negative/pessimistic
- ☐ very negative/pessimistic

Please Explain

To what extent do you agree with the following statement? Hospital employment of physicians is a positive trend likely to enhance quality of care and decrease costs.

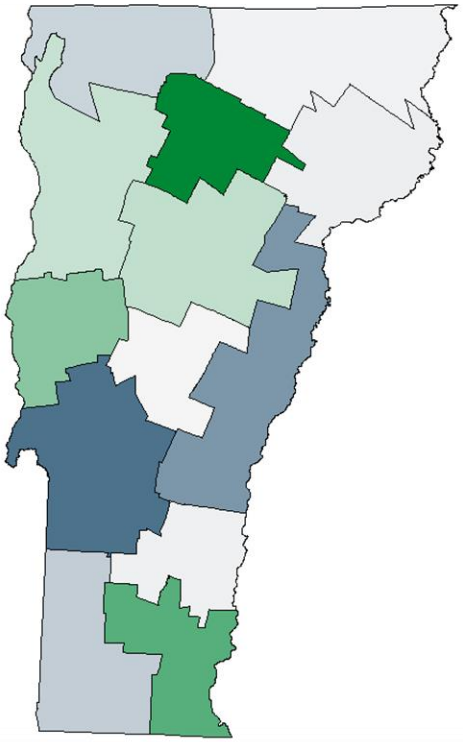
- ☐ Mostly agree
- ☐ Somewhat agree
- ☐ Somewhat disagree
- ☐ Mostly disagree

13. What else would you like to share?

14. Are you interested in participating focus group of Vermont clinicians organized by the Green Mountain Care Board?

- ☐ No
- ☐ Yes, I will send you my contact information separately via email to GMCB.Board@vermont.gov
- ☐ Yes, here is my contact information.
(If you click this option, your response to this survey will not be anonymous.)

Thank you!



Payment Differential and Provider Reimbursement Reports:
Update and Discussion

Marisa Melamed, Health Policy Advisor
Kate O'Neill, Payment Reform Evaluator

August 28, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

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 *Stakeholder process*	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 *Stakeholder process*	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 *Stakeholder process*	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, UVMMC, 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:
  - UVMMC 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.

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.

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.

Key Point #2

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

- Overall market concentration in U.S. hospital sector has increased 40% since mid-1980s, both vertical and horizontal consolidation (Cutler and Morton, 2013)

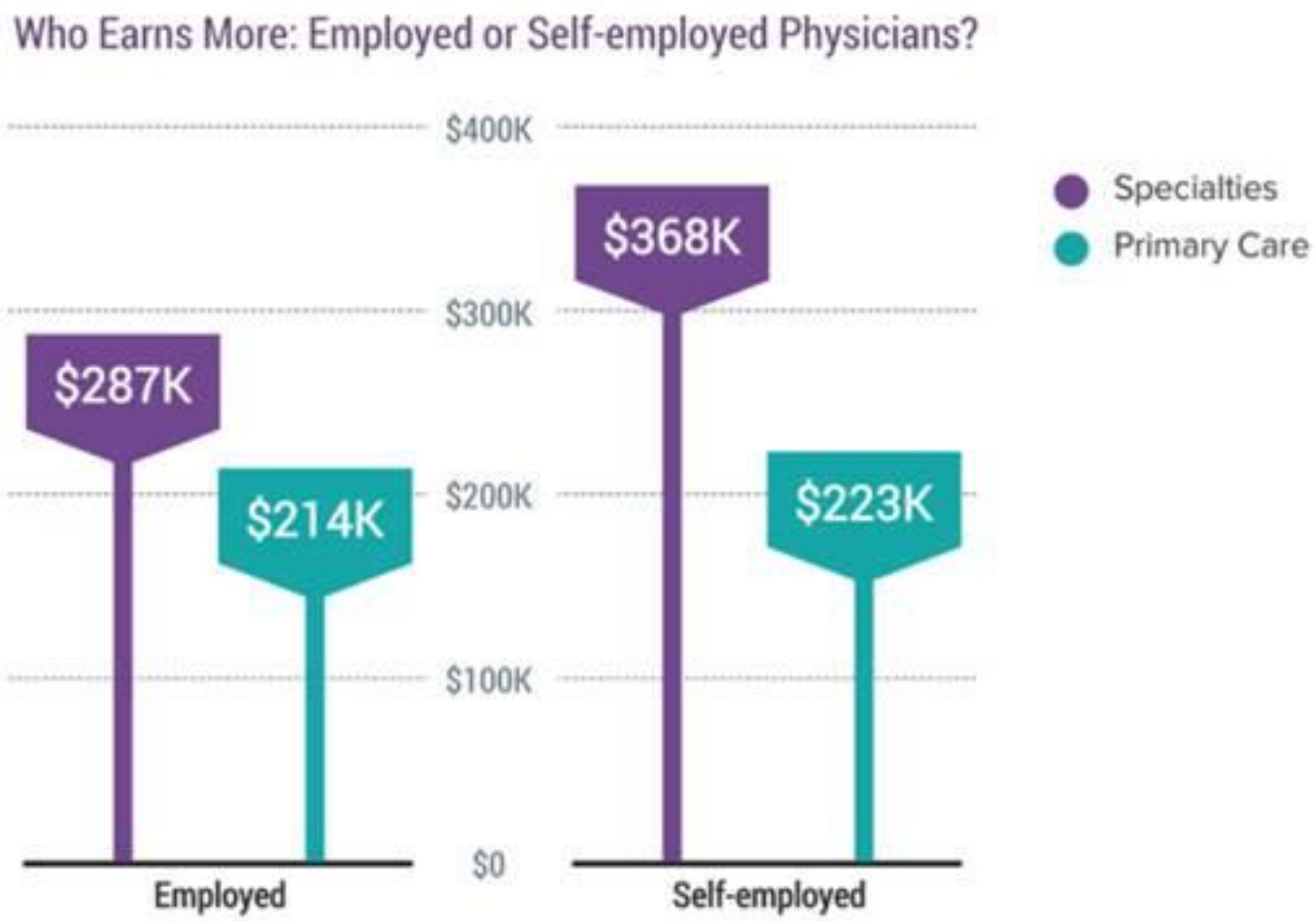
- Hospital ownership of physician practices increased from 24% of practices to 49% from 2004-2011 (Cutler and Morton, 2013)

- 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



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 Health*First*

Completed Responses:

404 clinicians

91 clinicians (23%) practicing independently

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

Demographics:

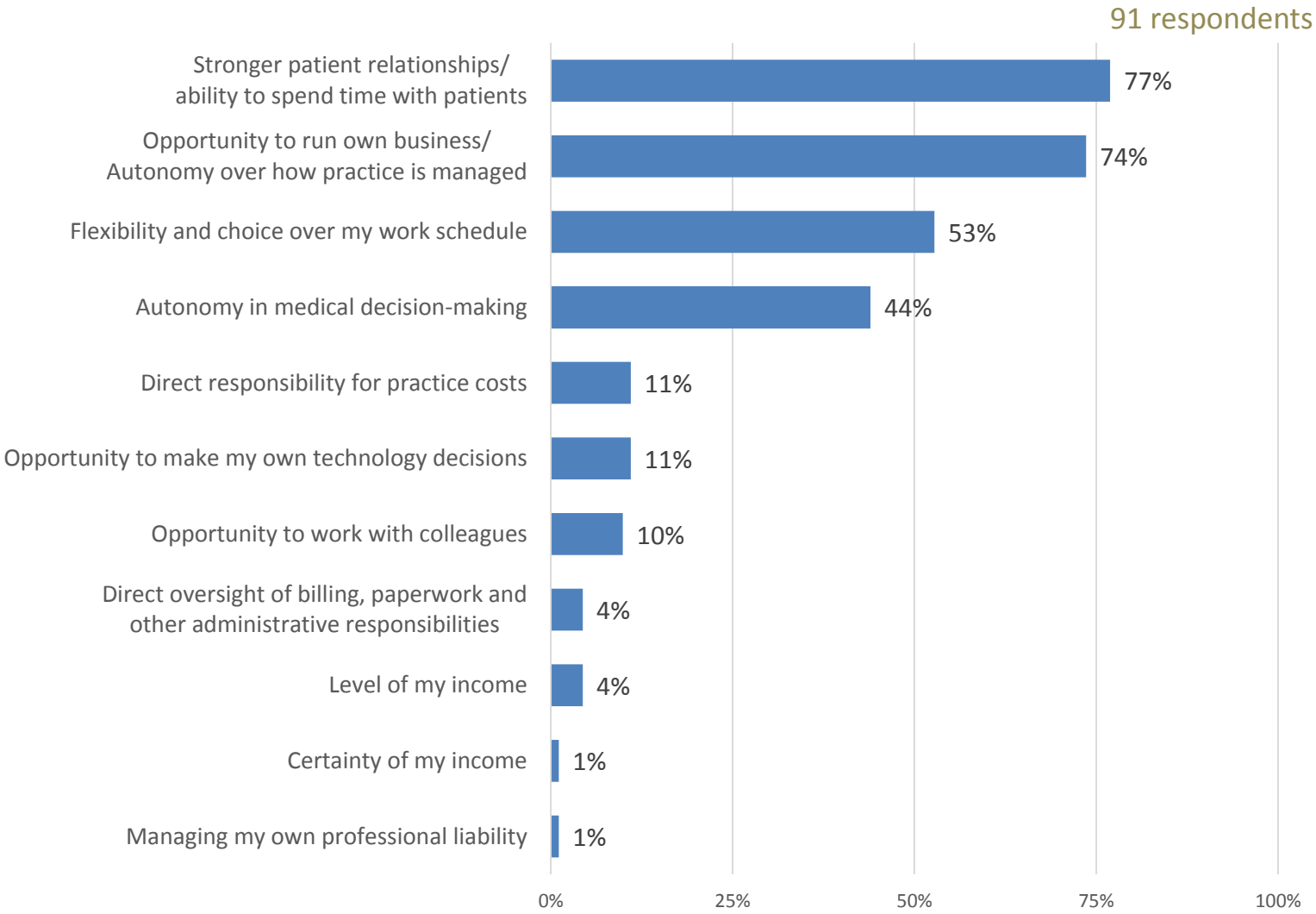
Primary care (30%)

Pediatrics (9%)

Specialty (61%)

HSA: all represented

Satisfying Factors: Independent Clinicians

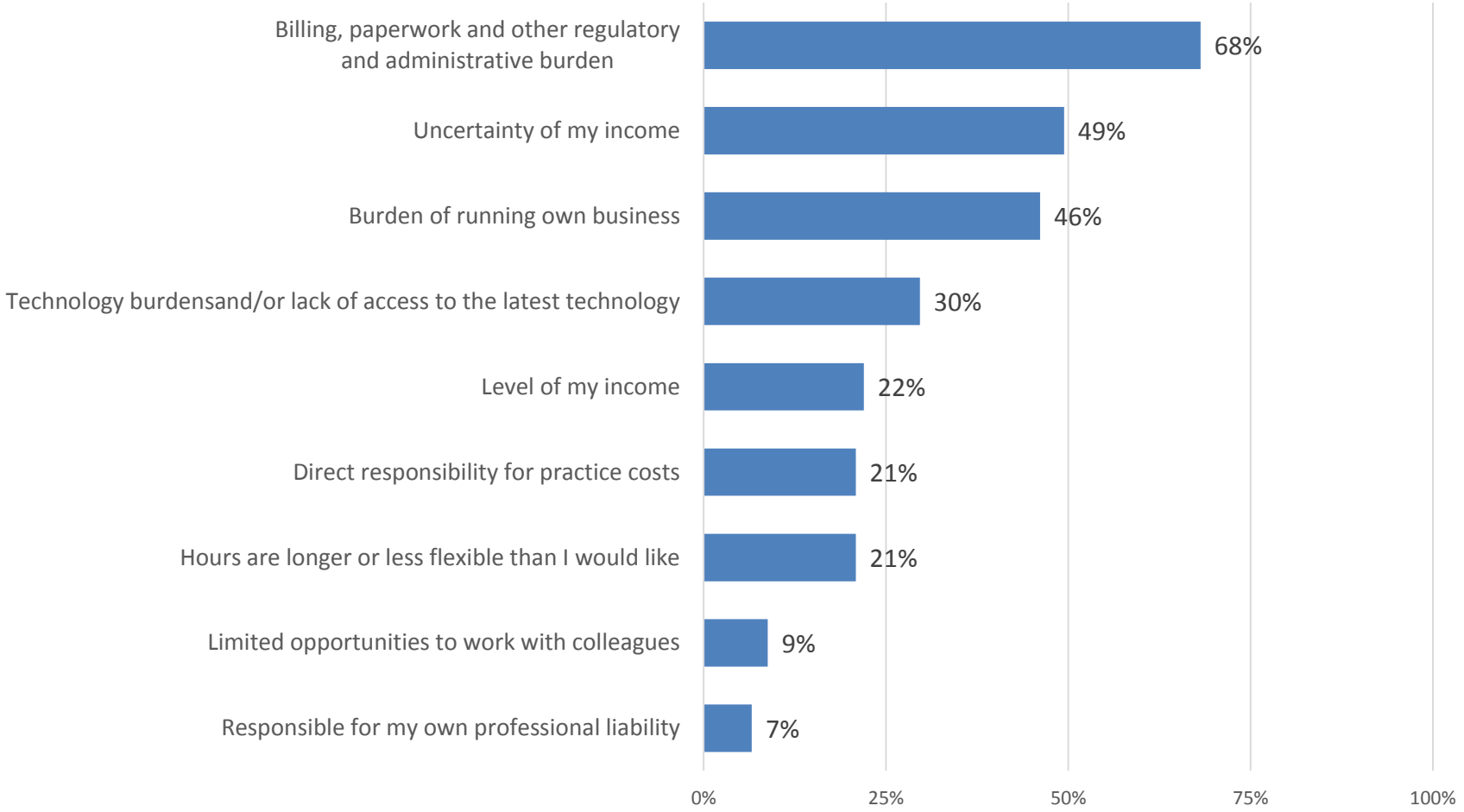


Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Frustrating Factors: Independent Clinicians

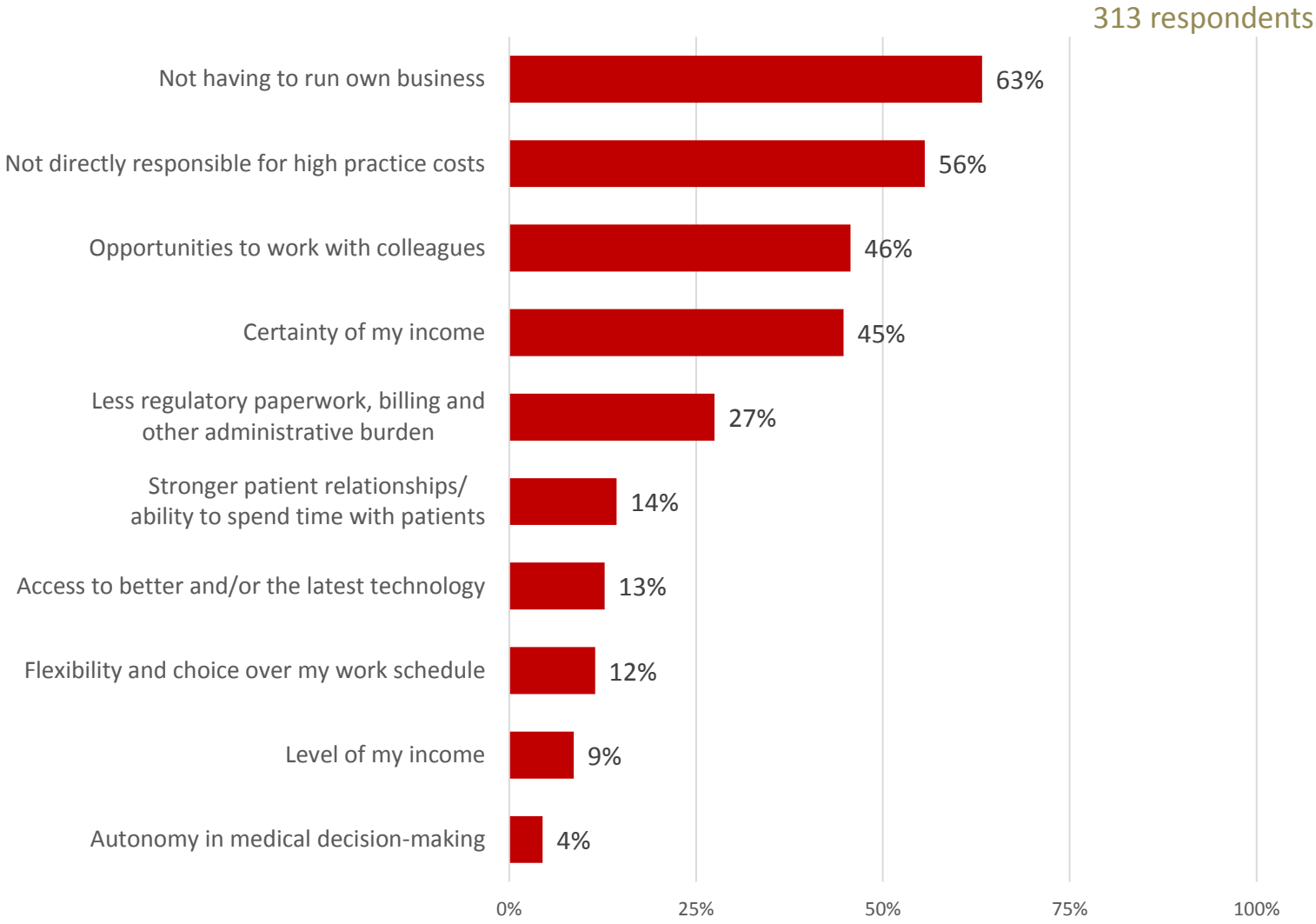
91 respondents



Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Satisfying Factors: Employed Clinicians



Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

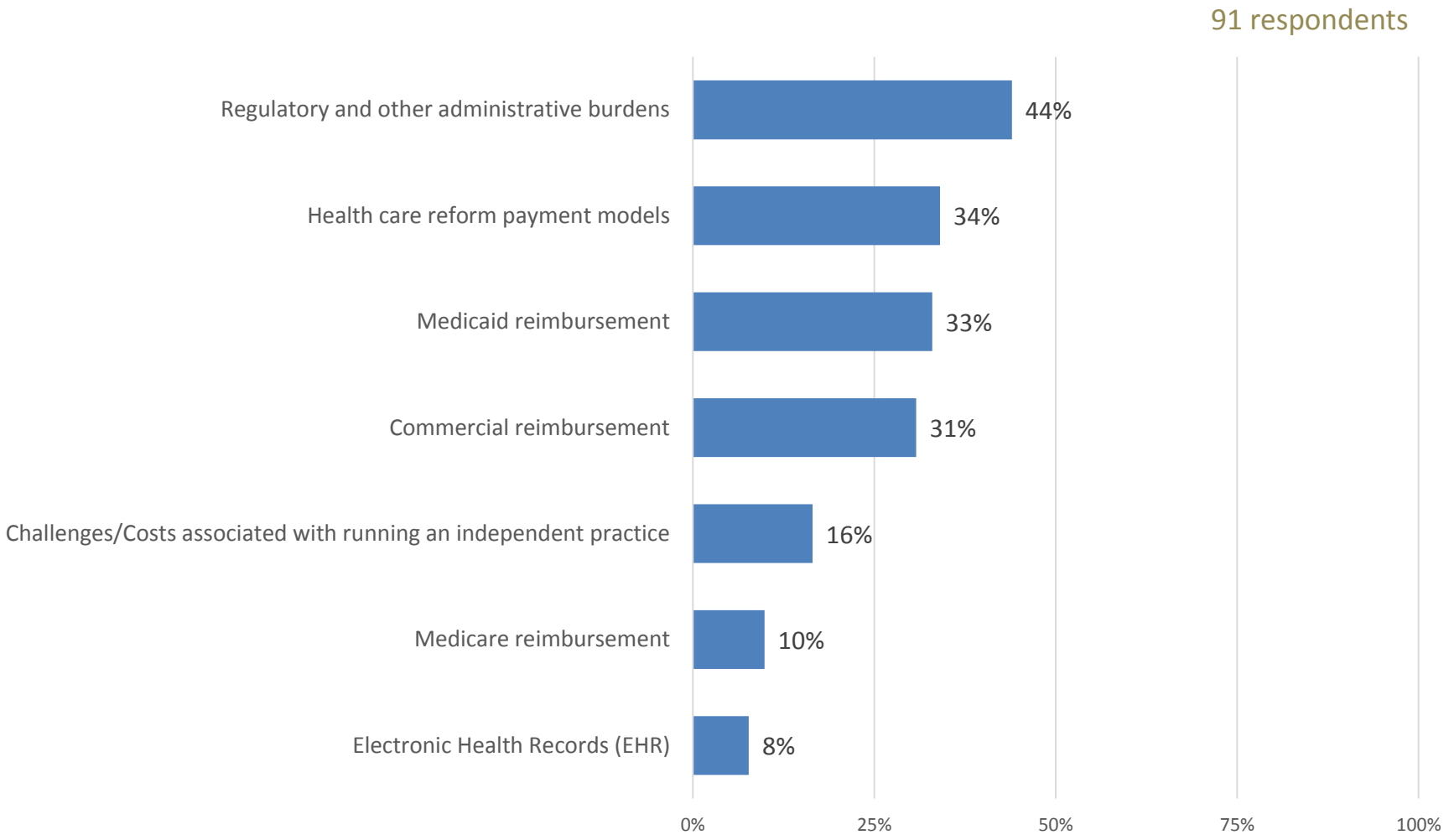
Frustrating Factors: Employed Clinicians

313 respondents

Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

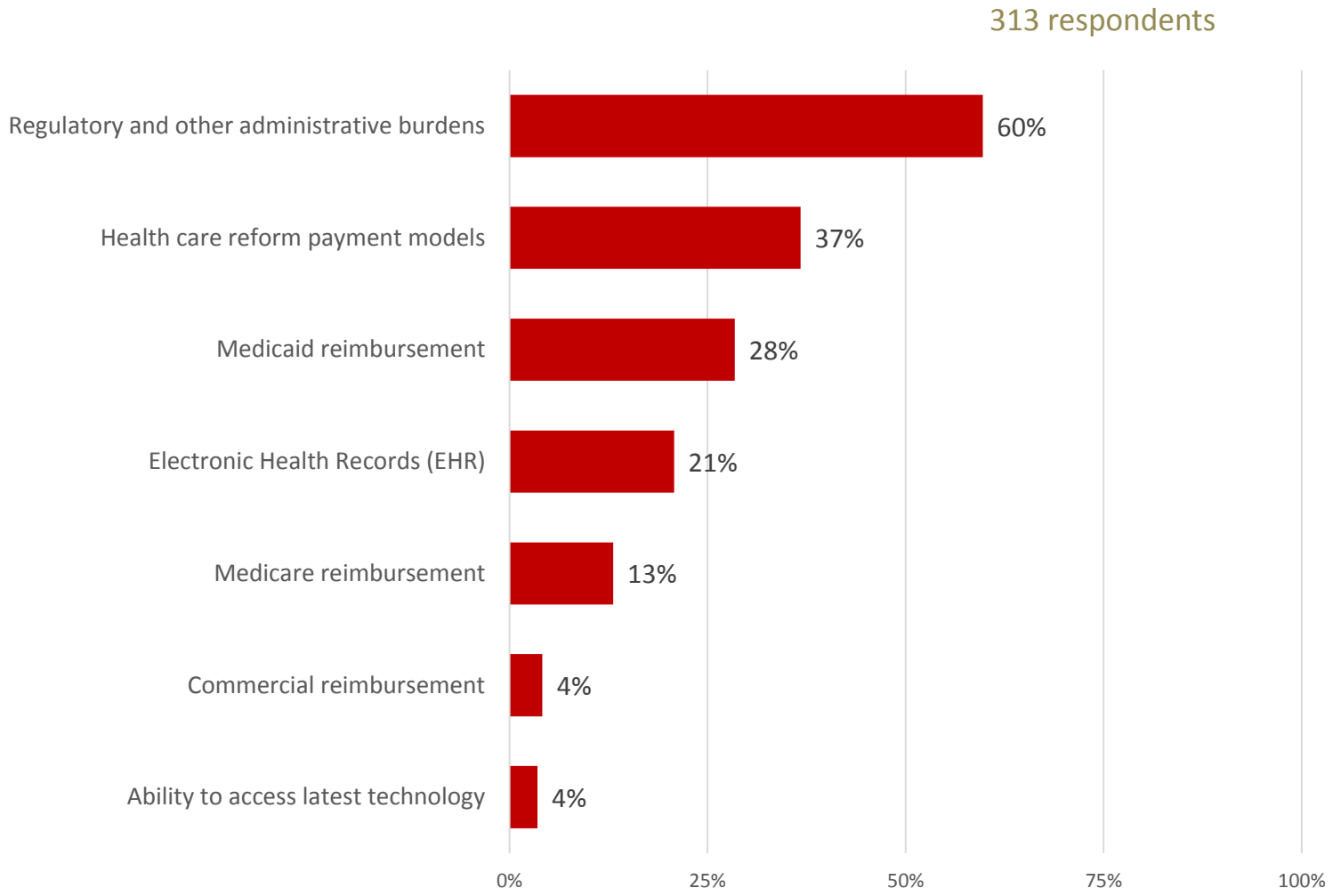
Greatest Threats: Independent Clinicians



Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

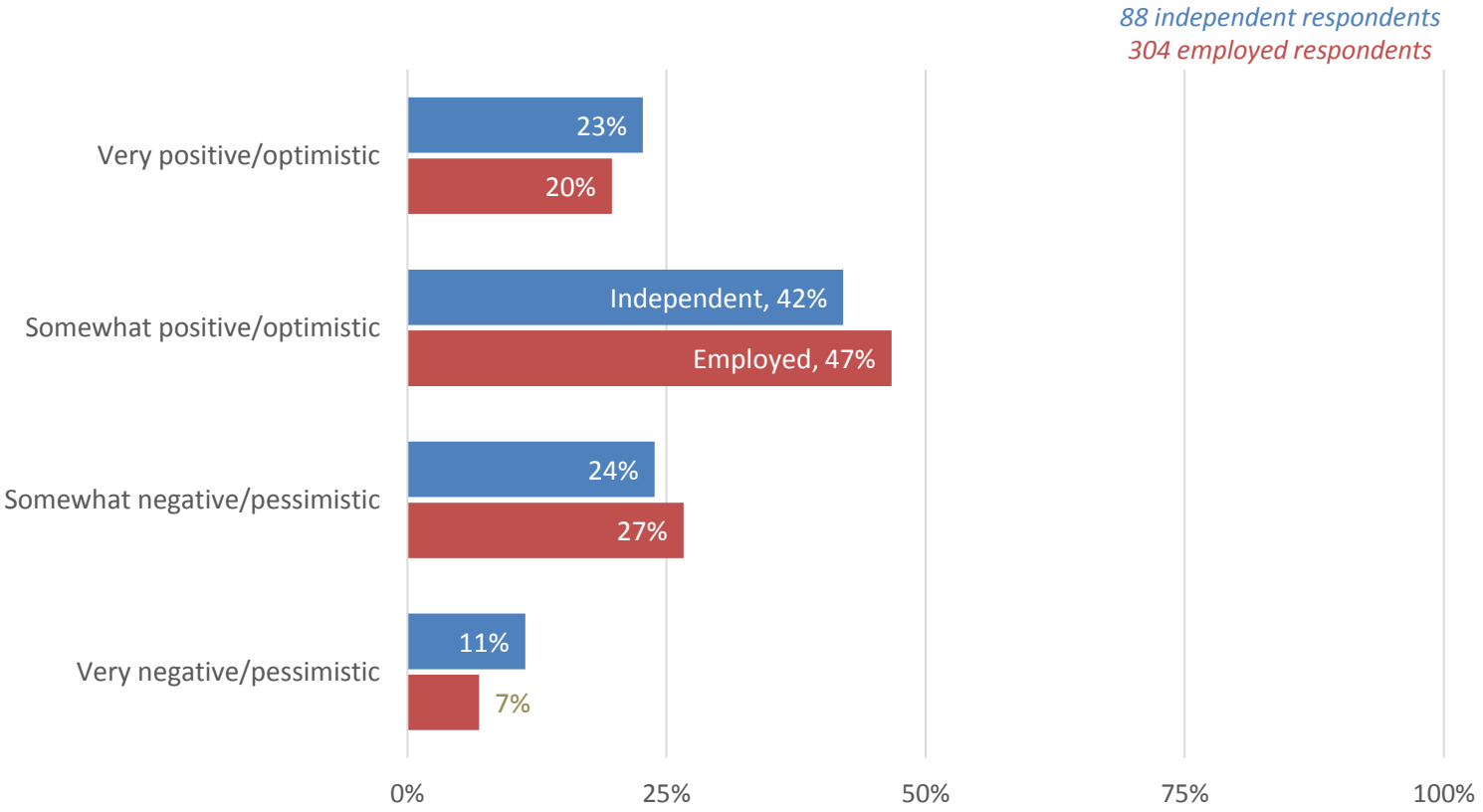
Greatest Threats: Employed Clinicians



Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

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

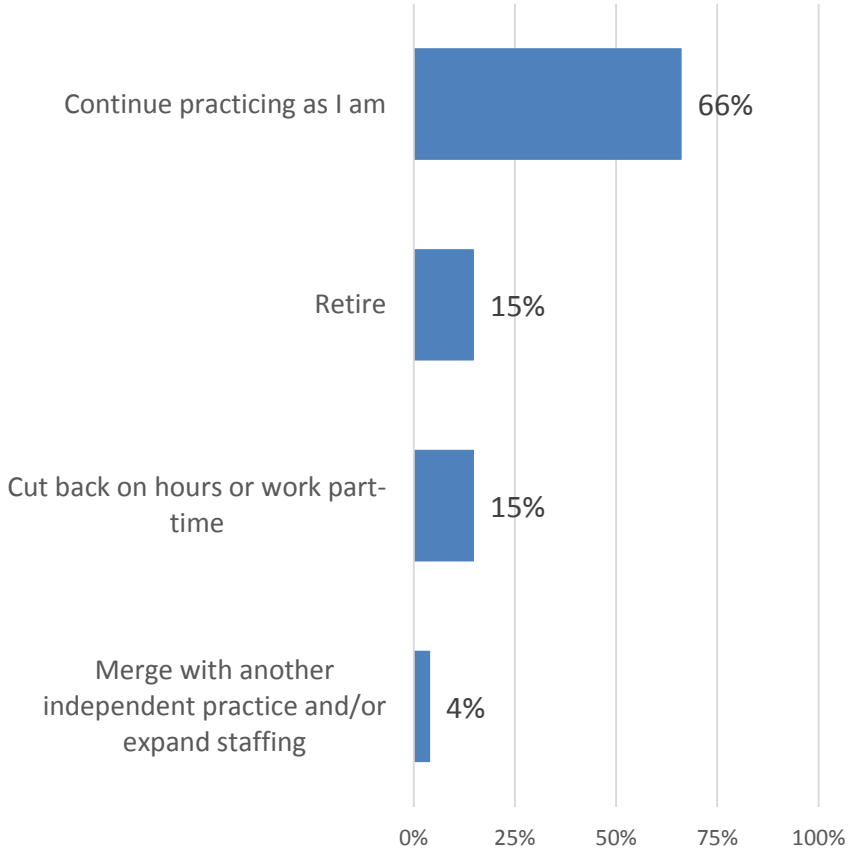


Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

Next Three Years

Independent Clinicians



74 respondents

Employed Clinicians

284 respondents

Source: GMCB Provider Landscape Survey, 2017

VERMONT
GREEN MOUNTAIN CARE BOARD

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

- UVMMC has proposed a 10% reduction for professional service fees in its FY2018 budget

A path toward "fair and equitable" reimbursement…

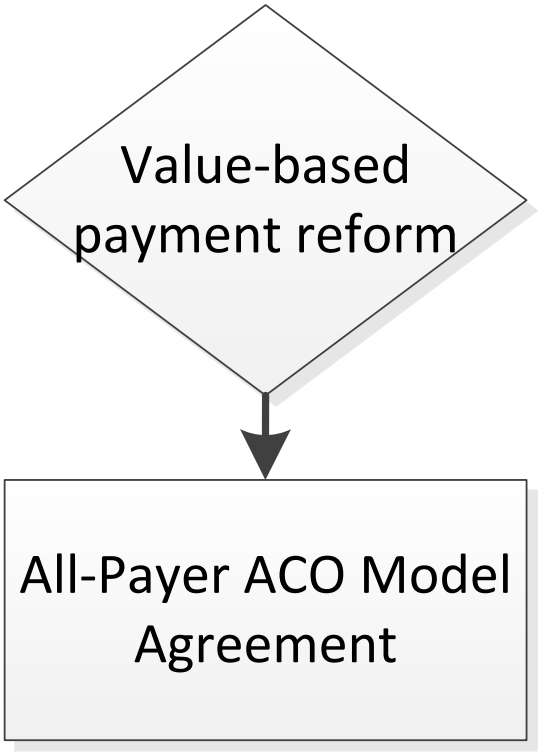
- Vermont is moving away from fee-for-service payments toward system-wide value-based payment reform
- The incentives of value-based payments are designed to address reimbursement differentials for providers participating in the model
- A short term fix to fee-for-service price differentials could have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

Vermont All-Payer Accountable Care Organization (ACO) Model

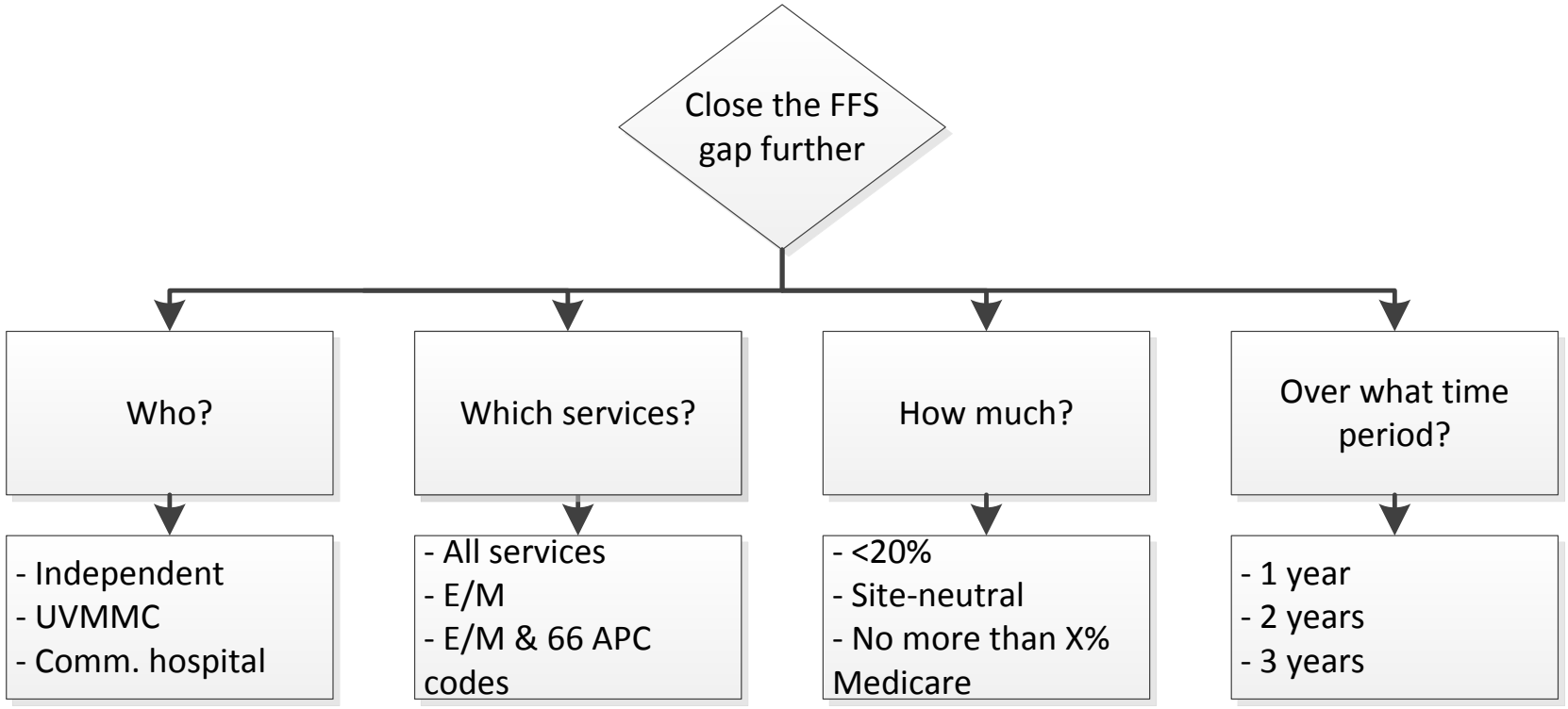
- Moves from fee-for-service reimbursement to a value-based payment model.

- 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

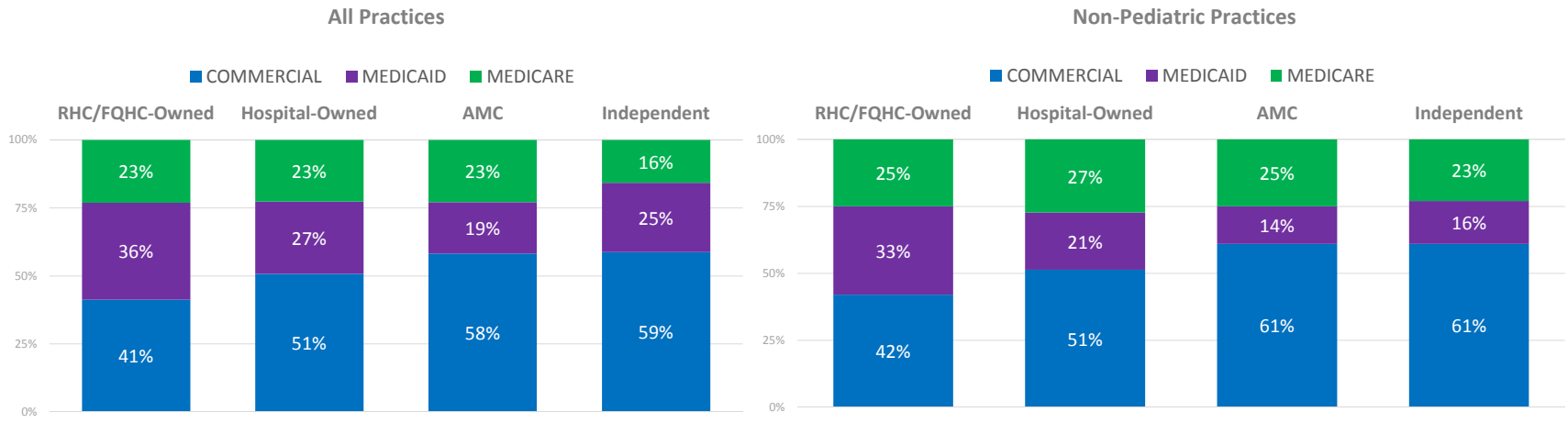
- April 27, 2017 Board meeting materials:
    - UVMHN Presentation - Act 54 and Act 143: "Fair and Equitable Payments" and Site Neutrality
    - GMCB Presentation - Act 54 (2015) and Act 143 (2016) Payment Differential and Provider Reimbursement Reports: Overview of GMCB Process and Progress Update
    - GMCB Act 143 Update

The table summarizes an analysis conducted by Onpoint Health Data. It provides information about the primary care costs incurred by patients attributed to a Blueprint for Health practice. Primary care services included office visits, encounter payments, preventative visits, vaccine administration, and care management services incurred in calendar year 2015 (with 3 months of paid run-out). Primary care services include those billed to a facility when the attending provider was affiliated with the practice.

Practice Type	Total Number of Practices	Practices with Average Patient Age Under 20	Payer Type	Count of Total Attributed Members	Payer Mix	Average Age of Members	Count of Attributed Members with Primary Care Services	Count of Primary Care Services	Total Attributed Member Months	Primary Care Services per attributed member	Primary Care Services Paid Amounts	Paid Per Member Per Month (PMPM)	Primary Care Services Allowed* Amounts	Allowed* PMPM	Average Total Allowed per Primary Care Service
All Practices Combined	132	24	COMBINED	362,980		41	286,504	959,477	4,143,220		83,462,619	$20.14	$96,854,069	$23.38	$100.94
			COMMERCIAL	183,052	50%	37	145,687	393,771	2,066,676	2.15	32,776,147	$15.86	$42,577,300	$20.60	$108.13
			MEDICAID	104,209	29%	25	87,350	330,905	1,201,747	3.18	33,288,063	$27.70	$33,564,789	$27.93	$101.43
			MEDICARE	75,719	21%	71	53,467	234,801	874,797	3.10	17,398,409	$19.89	$20,711,980	$23.68	$88.21
AMC	10	1	COMBINED	47,032		46	39,515	125,922	539,223		$11,463,156	$21.26	$14,167,510	$26.27	$112.51
			COMMERCIAL	27,361	58%	43	21,992	50,953	312,575	1.86	$6,627,687	$21.20	$8,538,504	$27.32	$167.58
			MEDICAID	8,882	19%	27	7,539	25,345	101,536	2.85	$1,601,645	$15.77	$1,656,470	$16.31	$65.36
			MEDICARE	10,789	23%	72	9,984	49,624	125,112	4.60	$3,233,824	$25.85	$3,972,536	$31.75	$80.05
FQHC-Owned and RHC Combined	41	4	COMBINED	133,392		42	96,635	309,512	1,520,438		$34,512,880	$22.70	$37,261,303	$24.51	$120.39
			COMMERCIAL	55,140	41%	39	42,448	113,714	617,949	2.06	$8,235,941	$13.33	$10,878,251	$17.60	$95.66
			MEDICAID	47,991	36%	27	39,626	146,421	554,065	3.05	$20,637,563	$37.25	$20,697,405	$37.36	$141.36
			MEDICARE	30,261	23%	70	14,561	49,377	348,424	1.63	$5,639,376	$16.19	$5,685,648	$16.32	$115.15
FQHC-Owned	33	2	COMBINED	102,798		41	76,313	246,002	1,170,446		$27,792,706	$23.75	$29,986,236	$25.62	$121.89
			COMMERCIAL	43,180	42%	39	33,513	89,865	483,689	2.08	$6,581,656	$13.61	$8,693,598	$17.97	$96.74
			MEDICAID	37,258	36%	28	30,594	113,564	429,384	3.05	$16,307,494	$37.98	$16,354,095	$38.09	$144.01
			MEDICARE	22,360	22%	69	12,206	42,573	257,373	1.90	$4,903,556	$19.05	$4,938,544	$19.19	$116.00
RHC	8	2	COMBINED	30,594		42	20,322	63,510	349,992		$6,720,173	$19.20	$7,275,067	$20.79	$114.55
			COMMERCIAL	11,960	39%	39	8,935	23,849	134,260	1.99	$1,654,285	$12.32	$2,184,654	$16.27	$91.60
			MEDICAID	10,733	35%	24	9,032	32,857	124,681	3.06	$4,330,068	$34.73	$4,343,310	$34.84	$132.19
			MEDICARE	7,901	26%	71	2,355	6,804	91,051	0.86	$735,819	$8.08	$747,103	$8.21	$109.80
Hospital-Owned	34	6	COMBINED	82,705		42	66,162	228,071	944,195		$15,244,701	$16.15	$18,322,534	$19.41	$80.34
			COMMERCIAL	41,919	51%	37	33,384	87,509	472,879	2.09	$6,986,282	$14.77	$9,040,517	$19.12	$103.31
			MEDICAID	21,958	27%	25	18,305	72,127	253,140	3.28	$4,158,148	$16.43	$4,275,078	$16.89	$59.27
			MEDICARE	18,828	23%	71	14,473	68,435	218,176	3.63	$4,100,271	$18.79	$5,006,939	$22.95	$73.16
Independent Combined	47	13	COMBINED	99,851		36	84,192	295,972	1,139,364		$22,241,882	$19.52	$27,102,722	$23.79	$91.57
			COMMERCIAL	58,632	59%	33	47,863	141,595	663,273	2.41	$10,926,238	$16.47	$14,120,028	$21.29	$99.72
			MEDICAID	25,378	25%	19	21,880	87,012	293,006	3.43	$6,890,707	$23.52	$6,935,837	$23.67	$79.71
			MEDICARE	15,841	16%	72	14,449	67,365	183,085	4.25	$4,424,938	$24.17	$6,046,858	$33.03	$89.76
Independent Multi-Site	8	5	COMBINED	23,127		24	20,143	73,324	262,974		$6,142,479	$23.36	$7,068,797	$26.88	$96.40
			COMMERCIAL	12,027	52%	24	10,234	32,625	134,633	2.71	$2,963,299	$22.01	$3,679,486	$27.33	$112.78
			MEDICAID	9,196	40%	14	8,141	33,243	106,282	3.61	$2,676,819	$25.19	$2,689,867	$25.31	$80.92
			MEDICARE	1,904	8%	67	1,768	7,456	22,059	3.92	$502,362	$22.77	$699,444	$31.71	$93.81
Independent Single-Site	39	8	COMBINED	76,724		40	64,049	222,648	876,390		$16,099,403	$18.37	$20,033,925	$22.86	$89.98
			COMMERCIAL	46,605	61%	36	37,629	108,970	528,640	2.34	$7,962,938	$15.06	$10,440,541	$19.75	$95.81
			MEDICAID	16,182	21%	23	13,739	53,769	186,724	3.32	$4,213,888	$22.57	$4,245,970	$22.74	$78.97
			MEDICARE	13,937	18%	72	12,681	59,909	161,026	4.30	$3,922,576	$24.36	$5,347,414	$33.21	$89.26

* Allowed amount = Plan paid + copay + deductible + coinsurance.

Proportion of Attributed Members by Payer Type



BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

September 28, 2017

Via Email Only

Chairman Kevin Mullin
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620-3601

Subject: Response to Chairman Mullin 09/18/17 Letter re: Implementation of UVMMC E/M Fee Schedule Adjustment

Dear Chairman Mullin,

Initial analysis by Blue Cross and Blue Shield of Vermont (BCBSVT) of the Green Mountain Care Board's (GMCB) ordered reduction of the professional reimbursement for the University of Vermont Medical Center (UVMMC) shows that effective January 1, 2018, the differential between the academic medical center E/M code reimbursement and the BCBSVT Community PCP and Specialty Fee Schedule will be reduced by approximately 34%. Detailed analysis is included in Confidential Attachment A to this letter. Please note that because BCBSVT is not the only health plan impacted by the ordered reduction of $11.3 million to UVMMC's professional reimbursement, $8 million is included in BCBSVT's analysis, the remaining $3.3 million is associated with other payers.

We wish to reiterate BCBSVT's commitment to implementing the GMCB's ordered reduction through negotiation with UVMMC and have in fact already begun working with them to implement the reduced E/M reimbursement. BCBSVT and UVMMC have worked together successfully to lower E/M code reimbursement over the past three negotiation cycles, but the reduction to UVMMC's professional fees ordered by the GMCB will accomplish in one move what we thought might take years.

Aligning UVMMC and community provider E/M reimbursement, regardless of whose name is on the door, will significantly improve the experience of our members. As of January 1, 2018, our members will experience significantly lower out-of-pocket costs when they have E/M services at UVMMC. Similarly, as they move around in the healthcare system and receive care and later bills from new practitioners, they will no longer be surprised by dramatically different reimbursement for the same fundamental healthcare practices. These changes will make it easier for our members to get the care they need when and where they need it.

If you have any questions please feel free to contact me.

Sincerely,

Sara Teachout

Sara Teachout
Director, Government, Public and Media Relations

cc: Judy Henkin, Esq., General Counsel, GMCB
Don George, CEO, BCBSVT
Andrew Garland, Vice President, Client Relations and External Affairs, BCBSVT
Kelly Lange, Esq., Director of Health Care Reform, BCBSVT

THE University of Vermont HEALTH NETWORK

September 1, 2017

The Honorable Kevin Mullin
Chair
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Re: Act 85 – Fair Reimbursement Report

Dear Chair Mullin:

I am writing to follow up on the discussion the Green Mountain Care Board had at Monday's meeting on the subject of fair and equitable reimbursement for physician services.

First, I want to share that I completely agree with the Board's assessment of the All-Payer ACO Model (APM) program as the most appropriate tool for addressing the issue of payment differentials that exist in today's fee-for-service (FFS) payment system. While the focus right now has been on the higher fees negotiated by the state's academic medical centers for their physicians' services, it's important to remember that state and federal policymakers have for decades supported systems that pay different types of professionals and provider organizations differently. Those differential payments have historically been made to support services deemed to be particularly important to patients and the communities being served – for example, enhanced Medicaid payments for Federally-Qualified Health Centers (FQHCs), and enhanced Medicare payments to Critical Access Hospitals.

In UVM Medical Center's case, more than twenty years ago our predecessor organization decided to negotiate higher payments from commercial insurers for physician services, and commensurately lower payments for inpatient and outpatient services. That decision was not made in a vacuum. Placing a higher value on physician services over inpatient and outpatient services has helped to keep more care in the physician's office, rather than in more expensive care settings – something that a number of utilization reports over the past several years have reflected. And appropriately valuing physician services, as reflected in fair payments for those services, was seen as the right thing to do.

As we have shared with the Board as part of recent budget reviews, we are regularly reviewing our reimbursement rates for services across the organization against the marketplace and regional and national benchmarks. As part of that review, we have been reducing our professional fees over the past several years. The total amount of revenue to the UVM Medical Center has remained stable – which means we are able to support critical safety net programs like our NICU, Level 1 trauma center, and psychiatry – but we are more in line with those benchmarks. Since 2015, the UVM Medical Center has

reduced professional fees significantly: by -8.3% in FY 2015, another -8.1% in FY 2017, and an additional -11.1% in our proposed FY 2018 budget. All told, those fees have come down 27.5% in that time period.

But as the GMCB recognized during its discussion on Monday, continuing to focus on FFS prices and payments is like trying to keep one foot on the dock while the health care reform canoe is pulling away at an ever-increasing pace.

The survey results that were shared at the meeting were enlightening. Like Dr. Holmes, I was very surprised that "administrative burden" was at the top of the list of practice dissatisfiers for both independent *and* employed physicians, especially since physicians employed by the UVM Medical Center (at least) have deep organizational support for many of the things that would seem challenging in private practice – like billing, malpractice insurance, HR support and risk management. But as both Dr. Holmes and Robin Lunge pointed out, the opportunities for reducing those burdens under the APM are very real. The Medicaid NextGen ACO program, in which UVM Medical Center started participating as of January 1 this year, has eliminated things like prior authorization requirements, and the Medicare program that will start in 2018 will bring other administrative relief – like eliminating the need to hospitalize someone as an inpatient for three nights before they can go to a skilled nursing facility. That's exactly the kind of burden that drives physicians crazy.

Another aspect of the APM that we've brought up during the work group discussion on fair and equitable payments is the fact that OneCare Vermont, the statewide ACO for the APM, will begin addressing the payment differential for participating primary care providers starting in 2018. Its 2018 budget – presented to the GMCB on July 13 – includes:

- $3.3 million in direct investments to primary care providers to support Blueprint activities, team-based care coordination, and the services of lead coordinators for the neediest patients.
- $5.4 million in per-member per-month payments to primary care providers for all of their attributed lives.
- $3.9 million invested in a Value-Based Incentive Fund to support primary care providers' engagement in quality improvement activities.
- $1.8 million directed specifically at developing and piloting sustainable payment models for independent primary care practices, intended to lead to predictable and adequate financial resources for those practices.

Those funds are effectively being redirected from participating hospitals to primary care and other community providers. Looking at primary care practices alone, OneCare Vermont has estimated that UVM Medical Center will be funding about $2.5 million of those payments in 2018. If you look at payments flowing to both primary care and continuum-of-care providers, UVM Medical Center's share rises to $3.2 million.

As UVM Medical Center's representatives shared with Dr. Holmes earlier in this process, these are sizeable investments, ones that we are willing to make because they start to realign incentives away from high-intensity acute care to the primary care, and primary prevention, setting. Importantly, the financial investments, under the APM through OneCare Vermont, will provide parity to participating primary care providers who are willing to commit to payment reform, rather than perpetuating a broken FFS system.

During the work group process we proposed that as the Board considers what actions to take, you filter them through two overarching principles:

- The APM is the payment and delivery system reform initiative that the State and the GMCB have committed to. Any changes to how professional services are paid should actively complement the APM, not compete with it. Ideally, payment changes would incentivize providers to participate in the APM.
- This initiative should recognize and account for the very real financial commitment that UVM Medical Center, along with other participating hospitals, is making to independent providers under the APM.

As I said, I am very encouraged that the importance of the APM and its potential for more fairly paying physicians for their services has been embraced by the Board. As you consider any short-term steps to take, please reflect on those principles, as it would be counterproductive to undermine the success of the APM through unintended consequences.

Very truly yours,

Todd Keating
Chief Financial Officer