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

I. Introduction

The 2015 Vermont Legislature passed **Act No. 54. An act relating to health care** requiring defined health insurers to submit a plan pertaining to the reimbursement for professional services.

> **Sec. 23. PAYMENT REFORM AND DIFFERENTIAL PAYMENTS TO PROVIDERS.**
> (b) The [Green Mountain Care] Board shall require any health insurer, as defined in 18 V.S.A. § 9402, with more than 5,000 covered lives for major medical insurance to develop and submit to the Board, on or before July 1, 2016, an implementation plan for providing fair and equitable reimbursement amounts for professional services provided by academic medical centers and other professionals. Each plan shall ensure that proposed changes to reimbursement create no increase in health insurance premiums or public funding of health care. The Board may direct a health insurer to submit modifications to its plan and shall approve, modify, or reject the plan. Upon approval of a plan pursuant to this section the Board shall require any Vermont academic medical center to accept the reimbursements included in the plan, through the hospital budget process and other appropriate enforcement mechanisms.

Blue Cross Blue Shield of Vermont (BCBSVT) submitted its plan in accordance with Act No. 54. Summarily, in its plan BCBSVT proposed a phased-in transition of an Academic Professional Fee Schedule allowing for a cost differential between the Academic Schedule and the BCBSVT Community fee schedule similar to Medicaid and Medicare reimbursement policies.

The Green Mountain Care Board (GMCB) reviewed BCBSVT's plan in accordance with Act No. 54 and **Section 4 of Act No. 143 (2016)**, which requires the GMCB to "consider the advisability and feasibility of expanding to commercial health insurers the prohibition on any increased reimbursement rates or provider-based billing for health care providers newly transferred to or acquired by a hospital." On

February 1, 2017, the GMCB reported to the Legislature its findings and recommendations to the Vermont Legislature framing the core question presented before it as: "whether a physician practice that becomes affiliated with a hospital should be able to change its fee schedule based on the new affiliation, resulting in higher fees for the same services." GMCB Report, *The Advisability and Feasibility of Expanding to Commercial Health Insurers the Prohibition on Any Increased Reimbursement Rates or Provider-Based Billing for Health Care Providers Newly Transferred to or Acquired by a Hospital*, February 1, 2017, page 1.

The February 1, 2017 GMCB Report recommended the following:

> In order to ensure fair and equitable payments that reflect underlying costs, the Board has requested that the carriers resubmit the plans required under Section 23 of Act 54 (2015) no later than March 15, 2017. The Board asks that the carriers revise their plans consistent with the following phased-in approach:
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> - For newly acquired physician practices, insurers should align their fee schedules to reflect current MedPAC recommendations on site-neutral payments. More specifically, a practice that becomes affiliated with a hospital should not increase or change its fees schedule for those services included in the E/M codes and 66 site-neutral ambulatory payment classifications (APCs) identified by MedPAC in its March 2014 report. Technical fees or facility fees should not be applied to these services.
> - For physician practices currently affiliated with a hospital, the carriers should outline their plans to align fee schedules, consistent with the MedPAC recommendations, as soon as is practicable.
> - The carriers should include in their plans the proposed effective date of each of the two reimbursement practices listed above, as well as an analysis of their impacts, if any, on 2018 health insurance plan designs, 2018 health insurance rates, and implementation of the All-Payer Accountable Care Organization (ACO) Model.
> - The Board will review the revised implementation plans and begin a public process to develop guidelines and criteria to be used to foster equity in payment practices.
> - As part of its evaluation of its regulatory processes to align with implementation of the All-Payer ACO Model Agreement, the Board will explore additional longer term recommendations for measuring and aligning payments across providers and care settings.

Id., page 12.

In accordance with the GMCB's February 1, 2017 request, BCBSVT submits the following evaluation of implementation of MedPAC[1] recommendations as cited in the GMCB findings, impact analysis on 2018 rate filings, impact analysis of the All Payer Model, proposed implementation plan for 2018 newly acquired practices, and proposed continued evaluation of treatment of grandfathered practices.

II. Analysis of GMCB request for BCBSVT to follow MedPAC recommendations

[1] Medicare Payment Advisory Commission (MedPAC), 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.

MedPAC's 2014 report recommended Medicare apply site-neutral payments to patient evaluation and management visits along with additional 66 ambulatory services that "do not require emergency standby capacity, do not have extra costs associated with higher patient complexity in the hospital, and do not need the additional overhead associated with services that must be provided in a hospital setting."[2] This recommendation addressed Medicare's reimbursement policies that permitted "provider-based billing" for a provider practice acquired by a facility. Following acquisition, a practice, subject to exceptions, could receive a facility fee under the Medicare Outpatient Prospective Payment System (OPPS) in addition to their Medicare Physician Fee Schedule (PFS).[3] This treated off-campus professional practices the same as those located within the campus of a facility.

Medicare began a phased-in approach to implementation of MedPAC's recommendation. As of January 1, 2017, Medicare no longer permitted facilities to bill the facility portion of professional services for off-site practices, subject to exceptions, acquired after November 2, 2015.[4] Medicare defines off-site practices as those that are more than 250 yards from the main facility campus[5], with exception for certain facilities.[6] For services rendered at these practices, Medicare will continue to pay for professional services in the same manner they were prior to acquisition by a facility. Medicare has yet to propose a timeline for removing facility fees received by off-site practices acquired by a facility prior to November 2, 2015.

The GMCB identified BCBSVT already has a policy disallowing provider-based billing. Additionally, for professional services provided at a facility, BCBSVT does not pay a professional component and a facility fee. In this manner, BCBSVT's reimbursement policies already comply with the recommendations of MedPAC. While BCBSVT does not reimburse facilities a separate facility fee for professional services when a practice is acquired by an academic medical center there is increased reimbursement for professional services based on the contract negotiated with that facility. This does conflict with the underlying premise of the MedPAC report recommending site-neutral reimbursement for off-campus provider practices. It is within this context BCBSVT has evaluated the GMCB's request to consider implementing MedPAC's regulations.

BCBSVT's evaluation determined the implementation of a site-neutral reimbursement policy for practices acquired by a facility after October 1, 2017, can be done with moderate administration modifications to BCBSVT processes. There will be billing modifications required by the facilities.

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[2] *Id.*

[3] *Id.*

[4] Section 603 of The Bipartisan Budget Act of 2015, signed into law on November 2, 2015; The Centers for Medicare & Medicaid (CMS) has since issued a rule, published in the federal register and made available for comment, for implementing Section 603. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital, 81 Fed. Reg. 79562, 79712 (Nov. 14, 2016) (amending 42 C.F.R. Parts 414, 416, 419, 482, 486, 488 and 495)

[5] 42 C.F.R. § 413.65(a)(2).

[6] 42 C.F.R. § 419.48(b)

BCBSVT will work with facilities to create a process that limits the administrative burden to all parties. BCBSVT will create payment policies reflecting the impacted process changes along with a definition of "newly acquired practice".

As seen with Medicare's phased-in approach, making changes to reimbursement for professional services currently billed by a facility for offsite practices creates additional complexities including: identification of such practices, administrative burden of implementing billing changes, financial impact, and ensuring changes do not negatively impact rate payers. This evaluation requires more than a month and therefore BCBSVT requires more time to determine the path to transition practices acquired prior to October 2017, specifically by academic medical centers regulated by the GMCB, to the BCBSVT Community Fee Schedule. In addition to these considerations, BCBSVT will be evaluating the impact of new payment models and whether such negate the need to address the practices acquired prior to October 1, 2017.

III. Implementation for Newly Acquired Practices & Grandfathered Practices

The purpose of the BCBSVT plan submitted July 2016, in accordance with Act 54 of 2015, was to achieve fair and equitable reimbursements for professional services while ensuring no resulting premium increases to rate payers. This revised implementation plan is submitted with the same core objective. In compliance with the GMCB's February request, BCBSVT proposes the following:

1. Practices Newly Affiliated with hospitals (facilities), including academic medical centers regulated by the GMCB, on or after October 1, 2017, shall be reimbursed subject to contractual reimbursement terms for the acquired practices in effect prior to acquisition by a facility subject to the following exceptions:

    a. If the facility is participating in a value-based contract with BCBSVT, reimbursement terms may be modified in accordance with the terms of the value-based contract agreed upon by the facility and BCBSVT; or,
    b. If the practice, prior to being Newly Affiliated with the facility, received enhanced reimbursement from BCBSVT (for a pay-for-performance pilot or other similar program), the practice will be reimbursed in accordance with the BCSBVT Community Fee Schedule if the reasons justifying enhanced reimbursement do not continue following acquisition by the hospital.

1(b). For practices subject to this provision, the term "Newly Affiliated" shall be defined as an individual provider or group of providers that prior to 10/1/17 contracted and billed BCBSVT under a Tax Identification Number (TIN) that is distinct from a facility TIN, and subsequent to 10/1/17 bills, contracts and enrolls with BCBSVT under a facility TIN.

1(c). BCBSVT may implement a payment policy establishing specific enrollment, notification, billing and other requirements associated with this provision.

2. BCBSVT will continue to evaluate the potential to transition practices Currently Affiliated with facilities to the BCBSVT Community Fee Schedule addressing the following:
    a. Defining Currently Affiliated;

b. Financial impact, if any, of transition from current hospital reimbursement to BCBSVT community fee schedule;
c. Impact of All Payer Model or other value-based reimbursement arrangements; and
d. Administrative burden of any proposal.

3. The GMCB will ensure compliance of facilities with this plan through the hospital budget approval process and other appropriate enforcement mechanisms;

4. The Green Mountain Care Board will evaluate any impact on the cost shift from government to commercial payers resulting from changes in policies pertaining to provider based billing; and

5. The Green Mountain Care Board, in its evaluation of excess revenues experienced by academic medical centers, will determine if the facility shall use excess revenues to decrease BCBSVT contracted reimbursement amounts for professional services by BCBSVT thereby allowing such funds to be used to increase rates in BCBSVT's Community Fee Schedule

IV. Cost Shift Considerations

Consistent with the language of Act 54, the plan proposed by BCBSVT ensures premiums are not increased as a result of this proposal. The first phase (#1) leads to little concern of premium impact as noted in Section V below. The future plan related to Currently Affiliated practices does have the potential to impact premiums if hospitals are able to cost shift any reduction in reimbursement in professional services to inpatient and outpatient services.

BCBSVT outlined the impact of moving hospital revenue from professional services to inpatient and outpatient services in its July 2016 report. As part of the evaluation of Currently Affiliated practices there is the potential that a facility, particularly an academic medical center, would receive reduced revenue if practices are moved to BCBSVT's Community Fee schedule. If the hospital proposes increasing commercial inpatient and outpatient rates to compensate for lost professional revenue, this will likely result in higher premiums to commercial rate payers. BCBSVT will establish a policy preventing such cost shift yet will look to the GMCB to enforce should a hospital object. Finally, the GMCB should consider any excess revenue experienced by a facility as an offset to any resulting reduction in professional revenue that may result from future BCBSVT policies pursuant to the GMCB's Act 143 request.

V. Impact on 2018 Qualified Health Plan Filings

As set forth in Section III of this report, BCBSVT proposes a phased-in approach to addressing reimbursement to practices acquired by facilities. The first phase of this proposal, with an effective date of October 1, 2017, does not *per se* impact BCBSVT's 2018 rate development.

BCBSVT develops its rates using historical claims data, which for 2018 would include the experience of facilities and independent practices during calendar year 2016. In compliance with this plan, any practice newly acquired/affiliated with a facility after October 1, 2017, would remain under the same

reimbursement terms as were captured in the rate development claims experience. With the reimbursement remaining as it is modeled and expected, there would be no impact to the QHP rate development.

The second phase of this plan, the transition of Currently Affiliated practices, has yet to be fully developed or assigned an effective date. Therefore, there is also no impact on 2018 QHP rate development. As BCBSVT develops its implementation plan and payment policies for Currently Affiliated practices, it will do so in a manner ensuring members do not pay higher premiums as a result of its plan, consistent with the language in Act 54. BCBSVT will look to the GMCB to ensure compliance by facilities so that there is no increase in rates as a result of BCBSVT's policies resulting from the Act 54 and Act 143 implementation plan.

VI. Impact of ACO Model

BCBSVT will assess impact to the transition of Currently Affiliated practices and a potential ACO model. Under the current model, providers and facilities continue to submit claims and receive reimbursement from BCBSVT. The ACO performance on a total cost of care target is determined in a retrospective settlement. Therefore, operationally under such model there is little impact to the ACO.

In the future, if ACO reimbursement includes differential, capitation or other new reimbursement mechanisms to providers or facilities, such would likely need to operate as potential exceptions from the BCBSVT affiliated practices policies.

VII. Summary

BCBSVT's current policies support the premise of "site-neutral" reimbursement for professional services. With the exception of reimbursement for professional services rendered at academic medical centers and in limited value-based contract circumstances, BCBSVT reimburses professional services using a statewide fee schedule. The proposal in Section III above will allow for expansion of BCBSVT's site-neutral reimbursement in instances when practices are acquired by academic medical centers subject to the GMCB's oversight.

BCBSVT's phased-in approach addresses newly acquired practices but due to complexities discussed herein reimbursement changes for practices acquired prior to October 1, 2017 requires detailed evaluation.

The plan proposed by BCBSVT requires the GMCB to approve all of the plan not simply portions of it. The phased-in approach with enforcement by the GMCB ensures proper evaluation of operations, administration and cost shift implications. Finally, the proposed model may require modification as BCBSVT considers new payment models. BCBSVT will continue to work with the GMCB and stakeholders providing updates regarding future modifications.