July 01, 2016

Mr. Al Gobeille
Chair, Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

Via E-mail

RE: Vermont Act 54 of the 2015 Legislation Section, Sec. 23.

Dear Mr. Gobeille:

Enclosed for your review please find MVP's report on Vermont Act 54 of the 2015 Legislation Section, Sec. 23.

Sincerely,

Karla Austen
Chief Financial Officer & Executive Vice President, Network Management

Enclosure.

Copies:
Judy Henkin, General Counsel, GMCB
Jamie Fisher, Executive Assistant to the Chair
George Thomson, Vice President, MVP
Susan Gretkowski, Senior Strategist, MVP
Craig Jasenski, Director, MVP

An implementation plan for providing fair and equitable reimbursement amounts for professional services in Vermont.

MVP Healthcare

July 1, 2016

Introduction.

Per Vermont Act 54 of the 2015 Legislation Section, Sec. 23., the Green Mountain Care Board (GMCB) "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."

As a health insurer in Vermont with over 12,000 covered lives, MVP respectfully submits this implementation plan to GMCB to address our commitment to that Vermont statute.

It is important to note that the cost of healthcare has become an escalating cost burden on Vermonters, Vermont employers and the State of Vermont itself, a burden increasingly disproportional to the cost of living increases. MVP takes its fiduciary role very seriously to mitigate healthcare costs to its Vermont subscribers, their families and to the Vermont employer groups. Our implementation plan therefore complies with the statute's further provision that "each plan shall ensure that proposed changes to reimbursement create no increase in health insurance premiums or public funding of health care".

Section 1. Fair and equitable reimbursement amounts for professional services provided by academic medical center physicians.

MVP has been directly contracted with the single academic medical center, The University of Vermont Medical Center's (UVMC) and it's employed physicians, in Vermont for decades. MVP also has a number of other directly-contracted academic medical centers in markets across MVP's regional network, all of which also include their employed academic medical center physicians. These facilities all have complimentary hospital services and likewise serve as their region's tertiary care trauma centers and referral centers for highly-specialized hospital and physician services. MVP's informatics group has completed a detailed analysis of the physician payments rates on all those academic medical center practices.

In MVP's experience, academic medical centers and their academic medical groups serve as tertiary care trauma centers as well as referral centers for sicker populations with higher comorbidities that require higher intensity of services. This is especially true of the Medicaid populations but also applies to the Medicare and Commercial populations. In order to address the needs of these sicker patients and indeed to save their lives, the academic medical centers must therefore provide higher-acuity services through the use of more expensive, technologically-advanced equipment and employ highly specialized physicians and technical staff. Coupled with their medical school teaching obligations, academic medical centers and their academic medical groups are generally expected to have marginally higher costs of operations than other independent physician practices, leading to an appropriate reimbursement differential.

While MVP's contracted rates are proprietary and confidential, we were able to analyze and compare academic medical group physician rates on a comparative and level playing field across our whole network. For the purposes of this report, MVP Informatics department analyzed each academic medical group's commercial claims paid at a percentage of CMS' published Medicare physician fee schedule for their region (CMS' Regionally-Adjusted Medicare Fee Schedules). Contracting physicians based on a percentage of that region's CMS Medicare fee schedule is the most common form of fee-for-service physician reimbursement between physicians and health plans. On this fair and equitable comparative CMS Medicare fee schedule basis, MVP can state that the physicians at UVMC are reimbursed significantly above their Vermont CMS Regionally-Adjusted Medicare fee schedule as compared to all other contracted academic tertiary care medical groups across MVP's regional networks. MVP's findings are reflective of UVMC's own view of their overly high physician fees in as much as UVMC has already proposed to MVP a notable reduction in their own physician rates starting in 2017 and while directionally correct and favorable, it falls far short of "fair and equitable" reimbursement for academic medical center physicians based on the physician reimbursement data MVP has compiled from other regions.

In order to support and facilitate the intent of the statue, MVP's recommends two steps to achieve fair and equitable reimbursement over a two year period. First, MVP believes it is critically important to move UVMC on to a standard fee schedule that is based on Vermont's regionally-adjusted CMS Medicare fee schedule. CMS' Medicare fee schedules are nationally recognized as the gold standard of acceptable actuarially-determined reimbursement based on time-proven federal calculations. Second, that the UVMC physician fee schedule will also require corrective steps downward of twenty three percent (23%) in each of the next two years, beginning in calendar year 2017 and ending in calendar year 2018. With GMCB's approval and enforcement of these two steps, MVP's UVMC fee schedule will achieve fair and equitable levels within our network of contracted tertiary care trauma academic medical groups by the end of 2018. However, as the UVMC academic medical center practices are but part of the UVMC system, MVP recommends that GMCB guard against allowing UVMC to cost-

shift the physician reductions by adding back those revenues through corresponding increases to the hospital rates. It is important to note that UVMC's hospital rates already generated a significant, publically-reported, surplus in revenues to UVMC in 2015.

Furthermore, MVP would like to request the GMCB apply serious consideration to applying the fair and equitable intent of this statute to other hospital employed physicians, especially those in Rutland County employed by Rutland Regional Medical Center (RRMC). In Rutland County the higher physician rates demanded by RRMC for routine physician office services rendered by their employed physicians result in excess physician costs to Vermonters and Vermont employers in Rutland and its surrounding communities. Given that health plans must contract with that hospital and its employed physicians to meet Vermont's network adequacy standards, the physician rates in the Rutland community are significantly artificially inflated compared to the other independent physician rates throughout Vermont. MVP is therefore requesting GMCB's approval and enforcement to bring RRMC's employed physician rates onto MVP's Vermont CMS Medicare-based community physician fee schedule in order to achieve fair and equitable reimbursement with their Vermont physician peers.

Section 2. Fair and equitable reimbursement amounts for professional services provided by independent practice physicians.

In its 30+ year history, MVP has been directly contracting with over 25,000 physicians for Commercial, Medicare and New York Medicaid plans. The breadth of this multi-decade experience, combined with MVP's 21st century informatics and analytics capabilities, have contributed to MVP being able to complete a detailed analysis of current independent practice physicians (independent: not owned/employed by a hospital) and their Commercial reimbursement levels as a percentage of CMS Medicare across our many regions.

While MVP's contracted rates are proprietary and confidential, our analysis of Commercial fee schedule paid amounts, as a percentage of CMS' published Regionally-Adjusted Medicare physician fee schedules, has revealed that the independent physician fee schedules in Vermont are reimbursed above the regionally-adjusted Medicare fee schedules for our other independently contracted physicians across MVP's regional networks. Based on this analysis, MVP is certain that our existing Vermont reimbursement for professional services provided by independent practice physicians is fair and equitable.

Note: in addition to a fee-for-service, qualified primary care physicians receive an extra financial reimbursement incentive in the form of Patient-Centered Medical Home (PCMH) payments under the Vermont Blueprint for Health. While MVP did not apply for CPC+ in Vermont, as we believe our physician fee schedules to be higher than our competitors', and should CPC+ be approved with BC-VT and Medicaid, MVP is willing to transition from the Vermont Blue Print for Health to CPC+. BC-VT did apply for CPC+, but with the caveat that the existing Vermont Blueprint for Health be terminated.

Conclusion.

At the end of two years, the strategy presented herein, with the strong support of the GMCB, will produce a strategy that equalizes competitive reimbursement for professional services in Vermont. MVP also asserts that the true beneficiaries of this strategy, as envisioned by the intent of the statute, will be the Vermonters and Vermont businesses that actually pay for these healthcare services.

Additional Comments.

Vermont does not currently have a robust network of physician-owned, free-standing outpatient centers, which is unlike surrounding states. In MVP's other surrounding regions, experience has demonstrated that these physician-owned, free-standing outpatient centers provide: the same or higher-quality, more geographically accessible services, more highly-satisfied members and at significantly lower cost. For example, providers in many other states and regions are the owners and staff free-standing imaging centers, ambulatory surgical centers, lab draw stations, endoscopy and colonoscopy centers, sleep labs, urgent care centers and infusion centers, among other services. Available 21st century technology and its impact on the related cost-per-procedure have significantly driven down the cost of services provided while improving on the quality of those services. This is much like the technological advancement of the personal computer since the 1990s has commoditized the pricing of from thousands of dollars plummeting down to a few hundred dollars today (and even less for tablets). High-quality, nationally-certified and licensed centers are recognized and approved by CMS for their Medicare members as a well as by states for their Medicaid members. Commercial employer groups and their employees and families regularly rate their experiences at our contracted free-standing centers as more highly satisfied while simultaneously financially realizing an average savings of 50% compared to the exact same services provided at a hospital. MVP strongly encourages Vermont and the GMCB to seriously consider approving these highly competitive physician-owned free-standing centers so that Vermonters and Vermont employers can have additional choice and access points to healthcare services while alleviating the spiraling costs of insurance premiums and mitigating public funding of health care in Vermont.

Summary.

In closing, per Vermont Act 54 of the 2015 Legislation Section, Sec. 23, MVP is respectfully submitting this implementation plan to GCMB for the provision of fair and equitable reimbursement amounts for professional services in Vermont provided by academic medical centers and other independent professionals. Within that statute, upon approval of a plan pursuant to this section, MVP is asking GMCB to subsequently require the Vermont academic medical center to accept the reimbursements included in this plan, and RRMC as well, through their budget processes and other appropriate enforcement mechanisms available at its perusal.

Reference: Vermont Act 54 of the 2015 Legislation Section, Sec. 23.

PAYMENT REFORM AND DIFFERENTIAL PAYMENTS TO PROVIDERS

(a) In implementing an all-payer model and provider rate-setting, the Green Mountain Care Board shall consider:

(1) the benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service models;

(2) the impact of hospital acquisitions of independent physician practices on the health care system costs, including any disparities between reimbursements to hospital-owned practices and reimbursements to independent physician practices;

(3) the effects of differential reimbursement for professional services provided by health care providers employed by academic medical centers and by other health care providers and methods for reducing or eliminating such differences, as appropriate;

(4) the effects of differential reimbursement for different types of providers when providing the same services billed under the same codes; and

(5) the advantages and disadvantages of allowing health care providers to continue to set their own rates for customers without health insurance or other health care coverage.

(b) The 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.

(c) The Board shall include a description of its progress on the issues identified in this section in the annual report required by 18 V.S.A. § 9375(d).