Testimony of VAHHS on S.245
House Health Care

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What is Provider-Based Billing aka “facility fees”

- Hospitals bill inpatient and outpatient professional (e.g. physician) services separately from hospital services like pharmacy, lab, nursing care, room and meals, operating room time, physical therapy.
- The hospital services are the “facility fees.”
- Under MEDICARE’s rules for “provider-based billing,” hospitals bill professional services separately from facility services in the physician office practice setting.

What is Provider-Based Billing aka “facility fees”

- In the independent practice setting:
  - Physicians bill “evaluation and management codes” and procedure codes. The Medicare non-hospital physician fee schedule evaluation and management code payments are meant to account for (1) the visit (2) malpractice insurance and (3) office overhead.
- In the “provider-based” (hospital-owned) office:
  - As for hospital inpatient, there are separate bills for the physician and the facility.
  - Like non-hospital fee schedules, the physician component includes evaluation and management codes and procedure codes.
  - BUT: the fee schedule for the physician evaluation and management codes is lower than the non-hospital physician fee schedule - it only includes (1) the visit and (2) malpractice.
  - Office overhead is billed separately on a different form, as a facility fee, and is paid on a fee schedule set by Medicare (not the hospital).

What is the frustration about?

- The result of provider-based billing is that Medicare patients may pay more out-of-pocket for the same service if their independent physician becomes hospital-employed.
- That’s because of the Medicare fee schedule and the Medicare benefit design, i.e., how Medicare assigns out-of-pocket costs on the facility bill.

Changes are Coming

- On November 2, 2015 Congress enacted a big change to provider-based billing.
- Effective January 1, 2017, payments to an "off-campus department of a hospital" that was not billing as a hospital service prior to the date of enactment will be made under a non-hospital payment system.
- In other words – Medicare is eliminating provider based billing/facility fees for newly employed physician practices.
- Hospital are waiting for more guidance from CMS on this change.
- Medicare is also requiring more data on existing practices and we expect more changes are in store.

Commercial Payers

- Vermont's commercial payers do not use the provider-based billing methodology. Neither BCBVT nor MVP pay a separate facility fee for office overhead, whether the provider is hospital-employed or independent.
- Patients sometimes need a physician/office visit AND hospital services such as laboratory tests or imaging. Those patients will receive two bills – one for the office visit and one for the hospital services. That can happen whether the physician is employed by the hospital or independent.
- Some independent physicians may perform services beyond the clinical exam/office visit in the physician office setting, such as imaging or administering chemotherapy. For independent physicians those services are always billed on the physician form. Depending on the service, hospital-based practices may bill on the facility form.

Medicaid

- DVHA has been aligning it's reimbursement methodology with Medicare's methodology, including a move to provider-based billing for office visits.
- The move was intended to be budget-neutral to fit the appropriation – there would be two bills, but the total reimbursement would be the same.
- Provider-based billing has little impact on out-of-pocket costs for Vermonters insured by Medicaid because they have so little cost-sharing.

Why do hospitals (or FQHCs) Employ Physicians?

- To preserve access to physician services.
- In the absence of hospitals and FQHCs employing physicians over the last decade, the physician landscape in most communities would look very different.
- Hospitals are not immune to the negative impact of poor reimbursement – it's not unusual for hospitals to lose money on the practices they take on.
- Mousetrap Pediatrics example.
- For many private practice physicians the costs of doing business (electronic health records, malpractice insurance, compliance and billing requirements) combined with poor reimbursement rates has simply become too challenging.
- Many younger physicians prefer employment to independent practice.

Specific Comments on S.245

- Section 1: Notice of Affiliation to Patient
  - Suggest removing the phrase “during the previous three-year period”
- Section 2: Reporting to AGO
  - We believe the requirement is unnecessarily duplicative; no language suggestions
- Section 3: Medicaid Reimbursement
  - Medicaid making some relevant changes to payment methodology that may impact section