Testimony of VAHHS on S.245 February 12, 2016

Senate Committee on Health and Welfare

Jill Mazza Olson, MPA

Vice President of Policy and Legislative Affairs, Vermont Association of Hospitals and Health Systems

Why do physicians become employed by hospitals (or FQHCs)?

- In Vermont, it's most often about preserving access to services.
- 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.
- 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.
- Many younger physicians prefer employment to independent practice.
- Mousetrap Pediatrics example.

What is Provider Based Billing aka “facility fees”

- Hospitals bill **inpatient** professional (e.g. physician) services separately from hospital services like pharmacy, lab, nursing care, room and meals, physical therapy.
- The hospital services are the “facility fees.”
- MEDICARE, under rules for “provider-based billing,” has allowed hospitals to bill professional services separately from facility services in the **outpatient** setting too, including the **physician office practice**.
- Outpatient services run the gamut – from office visits to surgery.

What is Provider Based Billing aka “facility fees”

- In the independent primary care 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) primary care 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 charge.

Clearing up some “Facility Fee” Myths and Misunderstandings

- The “facility fee” issue is a MEDICARE ONLY issue. Commercial payers DO NOT allow for provider based billing. Medicaid technically mirrors Medicare, but patients don’t have out-of-pocket obligations and total reimbursement is limited by the legislative appropriation.
- Under provider-based billing, the “facility” portion of the bill is paid on a Medicare fee schedule – it is not open-ended and hospitals do not set the amount.
- The physician fee schedule is LOWER under hospital provider-based billing than it is under the non-hospital physician fee schedule.

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 largely because the Medicare benefit design and how it assigns out-of-pocket costs on the facility portion of the bill.
- Why do hospitals use provider based billing? Because on balance it improves their Medicare reimbursement, and Medicare doesn't pay for the full cost of care.

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 like primary care offices.
- 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.

General Comments on S.245

- Many of the bill's provisions are already covered by current federal law or state regulation.
- Creating barriers to affiliation could hurt access.

Specific Comments on S.245

- Notice of Affiliation:
  - The GMCB already has a formal process in place for hospitals to notify them/submit financial data when they are planning to take on a new independent practice because of the potential impact on net revenue caps.
  - Larger acquisitions (hospital purchasing another hospital) would be reviewed under Vermont's CON law.
- Annual Reporting of Affiliation:
  - No strenuous objection if the definition of affiliation remains intact and it is limited to hospital and hospital system affiliations, as it is in the bill as introduced.
- Notice to Patients:
  - Medicare (the only payer where provider based billing is an issue) already requires an extensive notice.
  - As drafted, the notice provision cannot be implemented. Hospitals do not have the data necessary to predict the impact of the change on patients' future out-of-pocket costs. Doing so would require predicting future care needs and access to the fee schedules of all payers.
- Referrals to Affiliated Providers:
  - Burdensome compliance requirement on physicians.