State of Vermont
Green Mountain Care Board
89 Main Street
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Report to the Legislature

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

In accordance with Act 143 of 2016, Section 4

Submitted to the
House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

Submitted by the
Green Mountain Care Board

February 1, 2017

Introduction and Statutory Charge

Act 143 of 2016 requires the Green Mountain Care Board 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." Act 143 (2016) § 4. No later than February 1, 2017, the Board must report its findings and recommendations, including the timeline and process for implementation of any of its recommendations. The core question presented to the Board is 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.

This report first provides background information on recent trends in market consolidation and the associated movement towards greater site neutrality in reimbursements by Medicare. It then describes billing practices in Vermont as they relate to physician practice transfers and acquisitions. Finally, it concludes with a recommendation for carriers to resubmit plans for fair and equitable payment that are consistent with the Medicare Payment Advisory Commission's (MedPAC) recommendations on site-neutral payments.

Summary of the Board's Key Findings and Recommendation

The Board's **key findings** are:

- Nationally, there has been a growing trend towards greater consolidation in the health care sector. Vermont's experience mimics national trends. In addition to recent affiliations among individual hospitals, twelve physician practices in Vermont have transitioned from independent to hospital-acquired within the past two years. Of the twelve, the majority are specialty practices; only three are primary care practices.

- Market consolidation can lead to greater efficiencies and more care integration, but also to higher prices through increased bargaining power and reimbursement policies that permit hospital-affiliated practices to charge higher fees for services than non-hospital practices. Provider-based billing allows hospitals and hospital-affiliated practices to charge a separate facility fee in addition to the fee for the physician's professional services; freestanding clinics and independently-owned physician offices cannot charge a facility fee.

- In response to trends in consolidation, shifts in care settings, and efforts to contain costs, Medicare has recently moved towards greater site neutrality in its fee schedule. Beginning January 1, 2017, newly acquired off-campus physician practices will no longer be eligible for reimbursement under Medicare's Outpatient Prospective Payment System (OPPS). Instead, these providers will be paid under the (typically lower) Physician Fee Schedule (PFS). As explained in this Report, the Medicare Payment Advisory Commission (MedPAC) has also recommended applying site-neutral payments for patient evaluation and management (E/M)

visits and an 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."

- As of July 1, 2016, the Department for Vermont Health Access (DVHA) no longer uses provider-based billing for E/M codes, regardless of site of service. Hospital-based physicians are reimbursed for E/M codes per the facility rate schedule, and non-hospital based physicians are reimbursed per the non-facility rate schedule.

- Currently, MVP and Blue Cross and Blue Shield of Vermont (BCBSVT) each use a unique billing methodology. Because the commercial payers separately negotiate payment amounts with individual providers, each payer has more than one fee schedule. Thus, the impact of practice transfers or acquisitions very much depends on the insurer, the service, the practice and the hospital.

- BCBSVT does not utilize provider-based billing. BCBSVT reimburses physician practices that become affiliated with an academic medical center (AMC) by the higher AMC fee schedule.[1] Physician practices that affiliate with a community hospital generally do not see a change in the BCBSVT fee schedule.

- MVP utilizes a "split-billing" or provider-based billing methodology; independent practices that become affiliated with either an AMC or a community hospital may see changes in reimbursements under MVP's payment methodology.

The Board **recommends** 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:

- 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 fee 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

[1] Although Central Vermont Medical Center (CVMC) is part of the UVM Health Network, practices affiliated with CVMC are not considered affiliated with an academic medical center for billing purposes.

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.

Background

Market consolidation

Over the past few decades, our national health care system has transformed from one characterized by a diverse network of largely independent hospitals, clinics and physician practices to a more highly concentrated system with one or more academic 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% 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).[2] Specifically, researchers find that "sixty percent of hospitals are now part of health systems, up 7 percentage points from a decade ago…[and] from 2004 to 2011, hospital ownership of physician practices increased from 24% of practices to 49%."[3] Vermont's experience in the past few years follows national trends; UVMMC, CVMC and soon Porter Medical Center will become an affiliated hospital system, and twelve physician practices have transitioned from independent to hospital-acquired practices in the past two years alone.

Multiple factors including reduced reimbursements, greater fixed costs, and a need for better access to capital have driven health system consolidation. Further, technological innovations and stronger incentives for care coordination generated by the Affordable Care Act have shifted care— and the revenues associated with that care—away from inpatient hospitals towards less intensive care settings. In this new paradigm, independent physicians are quickly becoming an artifact of the past as reimbursement pressures, growing risk and complexities of running a practice, and lifestyle preferences for consistent schedules and predictable salaries have led many

[2] D. Cutler and F. Morton, *Hospitals, Market Share and Consolidation*, JAMA. 2013;310(18):1964-1970.
[3] *Id*. at 1965-66.

providers to seek employment or affiliation with larger institutions. One national study reports that only 37% of providers claimed to be independent in 2013, down from 57% in 2000.[4]

Greater concentration in the health care sector has both pros and cons. On the one hand, consolidation can lead to greater integration of care, which in turn has potential to improve patient outcomes and lower costs. For example, a more integrated system may better ensure that patients are treated in the most appropriate, cost-effective setting and may generate quality improvements through higher volumes of specialized procedures and broader geographic coverage. Better communication between providers along the care continuum may reduce costly duplication of services and lead to more coordinated, holistic and consistent approaches to patient care, and greater economies of scale may be achieved by spreading fixed costs over more entities in the network. On the other hand, market concentration may stifle innovation and increase prices. Hospital systems facing little competition have less incentive to innovate and greater market power to negotiate contracts with health insurance companies. Also, some payers reimburse hospital-owned practices more than independent practices for the same service. To the extent that these services are not more costly to provide, this drives up system-wide health care expenditures and may create greater incentives for market consolidation.

Medicare's move to greater site neutrality

Recent trends in the marketplace have raised concerns about the shift in care from independent physician offices to hospital-affiliated practices. The concerns stem from Medicare's provider-based billing policy that reimburses more for services delivered in hospital outpatient departments (HOPDs) than in physician offices.[5] Medicare makes a single all-inclusive payment for professional services provided in physicians' offices through its Physician Fee Schedule (PFS). It reimburses both physician's professional fees and facilities fees for services provided in HOPD's through its PFS and its Outpatient Prospective Payment System (OPPS) fee schedules. The additional facility fees are designed to cover the higher overhead costs incurred by hospitals. There are questions, however, when and if these higher reimbursements may be justified.

Recent studies by the nonprofit RAND Corporation, MedPAC, the U.S. Government Accountability Office, and the Office of the Inspector General (OIG) at the Department of Health and Human Services, suggest that Medicare's provider-based billing policy, coupled with recent trends in consolidation, has increased costs to the system and to patients and recommend greater site neutrality in payment policy. In a report issued by the RAND Corporation and sponsored by the U.S. Department of Health and Human Services, researchers explained:

> Our findings confirm that payments tend to be higher for services provided in hospitals

[4] The Accenture Study is available at https://www.accenture.com/us-en/insight-clinical-care-independent-doctor-will-not-see-you-now.

[5] This does not include physician practices located on a hospital campus as defined by federal regulation, *see* 42 CFR § 413.54(a)(2), dedicated emergency departments or rural health clinics.

> than for those provided in physician offices . . . but they also indicate that payment differentials generally exceed cost differentials and vary by procedure. These payment differences are generally attributable to how the payment systems have evolved and do not reflect differences in patient characteristics or the nature of the procedure across settings.[6]

Similarly, in its June 2014 Report to Congress, MedPAC, a nonpartisan agency that provides the Congress with analysis and policy advice about the Medicare program, concluded that "if patient severity is similar and a service can be provided in a lower cost setting without a reduction in quality or safety, Medicare should pay a rate based on the cost of the more efficient setting." [7] The report reiterates an earlier recommendation to apply site-neutral payments to patient evaluation and management visits and adds an 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."[8]

In its December 2015 Report to Congressional Requesters, the U.S. Government Accountability Office explained that "[in] order to prevent the shift of services from lower paid settings to the higher paid HOPD setting from increasing costs for the Medicare program and beneficiaries, Congress should consider directing the Secretary of the Department of Health and Human Services (HHS) to equalize payment rates between settings for E/M office visits—and other services that the Secretary deems appropriate" [9] Additionally, in June 2016 the Office of the Inspector General issued a report affirming its continued support, consistent with MedPAC's recommendations, "to either eliminate the provider-based designation or equalize payment for the same physician services provided in different settings." [10]

There has been a significant change in federal law as a result of the continued interest in remedying disparities in provider reimbursement under Medicare rules. Pursuant to Section 603

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[6] The Rand report, "*Policy Options for Addressing Medicare Payment Differentials Across Ambulatory Settings*," is available at http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR979.pdf.

[7] 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.

[8] *Id.*

[9] U.S. Government Accountability Office, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform* (Dec. 2015), *available at* http://www.gao.gov/products/GAO-16-189.

[10] Department of Health and Human Services, Office of Inspector General, *CMS is Taking Steps to Improve Oversight of Provider-based Facilities, But Vulnerabilities Remain* (June 2016), *available at* https://oig.hhs.gov/oei/reports/oei-04-12-00380.pdf.

of the Bipartisan Budget Act of 2015,[11] beginning January 1, 2017, newly acquired off-campus physician practices will no longer be eligible for reimbursement under Medicare's Outpatient Prospective Payment System (OPPS). Instead, these providers will be paid under the (typically lower) Physician Fee Schedule (PFS).

Current billing practices in Vermont

Vermont has two insurers —Blue Cross Blue Shield of Vermont and MVP—offering coverage in the individual and small group market. This section describes how each insurer currently pays providers and what happens when a provider's office affiliates with a hospital.[12] For comparison purposes, this section also describes the billing practice of the Department of Vermont Health Access (DVHA) for services covered by Medicaid.

DVHA

As of July 1, 2016, DVHA no longer uses provider-based billing for E/M codes, regardless of site of service. Hospital-based physicians are reimbursed for E/M codes per the facility rate schedule, and non-hospital based physicians are reimbursed per the non-facility rate schedule.

Blue Cross and Blue Shield of Vermont (BCBSVT)

BCBSVT does not use provider-based billing. BCBSVT's fee schedules are inclusive so that services are billed at a single fee that includes the charges for professional services, malpractice insurance and all facility costs associated with the provider. BCBSVT does not allow billing for both a facility charge and professional services charge.

In practice, BCBSVT primarily uses two types of fee schedules: 1) a community fee schedule for independent physician practices and Vermont hospitals other than UVMMC, and 2) an academic medical center fee schedule for UVMMC and its affiliated practices.[13] In addition, the insurer has negotiated unique reimbursement arrangements with some of the physician practices separate and apart from the community fee schedule referenced above. Because most hospitals and physician practices use the same fee schedule, however, amounts reimbursed to practices acquired by community hospitals largely do not change as a result of the affiliation. In contrast, practices affiliated with an academic medical center are reimbursed consistent with the higher,

[11] The Bipartisan Budget Act of 2015, signed into law on November 2, 2015, establishes a site-neutral Medicare reimbursement policy for newly acquired hospital-owned physician practices. 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. *See* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-01-3.html.

[12] Our understanding of the insurers' reimbursement practices is based on discussions between Board staff and Susan Gretkowski at MVP, and Kelly Lange at BCBSVT, and on materials provided by the carriers. Note that some materials are confidential and are therefore not directly referenced in this report.

[13] Dartmouth Hitchcock Medical Center, located in New Hampshire, negotiates an academic medical center fee schedule separate and apart from the one negotiated by UVMMC.

academic medical center fee schedule. As a result, physician practices that become affiliated with an academic medical center would see an increase in the amount of reimbursed fees, and patients subject to coinsurance would face higher out of pocket costs associated with the higher fees.

MVP
MVP does not use the term "provider-based billing" but its methodology appears to be consistent with how the term is defined elsewhere and appears to align with Medicare methodology. For certain services, hospitals and their affiliated physician practices use "split-billing," which like provider-based billing, splits the charge into two separate components: 1) a professional component (provider services), and 2) a technical component (facility/equipment). Billing in this manner is also commonly referred to as "clinic billing," because once a physician practice is acquired, the hospital considers it a clinic of the hospital. Split-billing is only used when hospital services, like diagnostic labs or x-ray, are delivered as part of the visit. When only professional services are provided, such as an office visit that does not include lab work or x-rays, the professional services are billed as a single claim.

Physician practices that are not affiliated with a hospital generally bill services to MVP on a single claim form and are reimbursed by a "global," or all-inclusive (covering professional services, malpractice insurance, and overhead) payment. The practices do not "split bill" for diagnostics that are provided in the office.

MVP primarily uses three types of fee schedules: 1) fee schedules negotiated separately with hospitals and hospital-owned practices, 2) fee schedules negotiated with larger independent physician practices, and 3) a base community fee schedule. The fee schedules vary among providers based on the result of their negotiations with MVP, and the resulting fees are based on a negotiated percentage above what would be paid by Medicare. Because of these variations, MVP has multiple fee schedules in Vermont.

Physician Acquisitions
The Green Mountain Care Board has been tracking physician office affiliations with hospitals through its hospital budget process since 2015[14]. For the two-year period from January 1, 2015 through December 31, 2016, twelve offices have affiliated with hospitals, with one additional affiliation that will not be publicly announced until terms of the transfer are completed.

[14] For fiscal year (FY) 2016, the Board adopted a written policy regarding physician transfers and acquisitions. The policy, intended to assist the Board in its review and understanding of individual hospital budgets and on system-wide health care costs, was recently updated for FY 2017. It is available on the Board's website at http://gmcboard.vermont.gov/sites/gmcb/files/files/hospital-budget/GMCB%20Hosp%20Bud%20Submission%20Rptng%20Req%20FY17%20with%20Phys%20Policy%201_1_17_WEB.pdf.

The following table illustrates the affiliations since January 2015:

Table 1. Physician Practice Transfers Completed from January 1, 2015 to December 31, 2016

Hospital	Type of Practice	Effective Date of Transfer
CVMC	Orthopedics	4/1/16
CVMC	Primary Care	3/9/15
CVMC	Wound Care	1/12/15
Gifford MC	Radiology	4/1/15
North Country Hospital	Pediatrics	4/1/15
Northwestern MC	Pediatrics	1/1/16
RRMC	Urology	1/1/15
RRMC	Orthopedics	10/1/15
RRMC	Neurology	11/1/15
Southwestern MC	Urology	10/1/16
Southwestern MC	Gastroenterology	10/1/16
UVMMC	Orthopedics	4/1/16

During the two-year period, nine specialty practices and three primary care practices, including two pediatric practices, became affiliated with hospitals. In addition, only one of the practices became affiliated with an academic medical center, as opposed to eleven that affiliated with community hospitals.[15]

Because only one of the practices listed above became affiliated with an academic medical center (UVMMC), it is the only instance where there would be a change in the fee schedule for patients with BCBSVT health plans. As discussed above, BCBSVT's fee schedule for academic medical centers provides for higher reimbursement than does its community fee schedule. The remaining eleven practices would continue to be reimbursed under BCBSVT's community fee schedule, as had been used prior to their affiliation with a hospital.

For patients covered by an MVP health plan, the information provided by the carrier indicates that the newly-acquired practices would begin "split billing" for certain services. Because MVP

[15] It is important to note that while CVMC is affiliated with UVMMC, it is paid by BCBSVT on the community fee schedule.

separately negotiates fee schedules with independent practices and with each hospital, however, it is unclear to the Board whether any given practice will increase its overall charges as a result of a new affiliation.

Discussion and Recommendation

What are the potential impacts on patients?
The number and variations of insurance plan designs— there are 18 plan designs[16] in the individual and small group market, and many more in the large group market — make it difficult to fully and accurately quantify the impacts on patients from changes in fee schedules. Further limiting our analysis is the unavailability of plan designs used by employers who are self-insured. Because of these limitations, we have chosen two silver plans for illustrative purposes, one with copayments and one with co-insurance.[17]

The plan with the highest enrollment in the individual market is the BCBSVT Standard Silver Plan. This plan has a $2,150 deductible that does not apply to certain services that include office visits, preventive care, urgent care, and ambulance services. These services are instead subject to a $25 copayment for primary care providers, and a $65 copayment for specialists. When a physician practice affiliates with a hospital and the affiliation results in a new fee schedule (as described above), the copayment for these services would not vary as long as the total fee is more than the copayment. For example, a patient seeing a specialist for an office visit that costs $100 prior to the affiliation and $200 after the affiliation, pays $65 for the visit in either instance.[18]

The co-insurance plan with the highest enrollment is the BCBSVT Silver Consumer Directed Health Plan. This plan has a $1,550 deductible which is waived for preventive services. A specialist office visit in this plan is subject to the deductible, so in the same example as above (where an affiliation results in a new fee schedule), the patient would see an increase in out-of-pocket cost for the office visit both before and after meeting his or her deductible. If the patient had not yet met the deductible, he or she would pay $200 after affiliation; before the affiliation, the same office visit would have cost $100. Once the deductible is met, a patient with a 25% co-insurance payment would pay $25 for the office visit (25% of $100) prior to the affiliation, and $50 (25% of $200) after the affiliation.

Also, it is important to note that when transfers and acquisitions increase provider reimbursement rates, health insurance premiums are likely to increase to reflect these added costs.

[16] Of the 18 plan designs, two are catastrophic plans only available to those under 30 in the individual market.
[17] This analysis is descriptive in nature and is not a comprehensive analysis of impacts on individuals, which will vary greatly depending on individual use of health care services and specific plan designs.
[18] The amounts used in this example are illustrative only, and are not based on any actual fee schedule.

Should a physician practice that become affiliated with a hospital be able to charge higher fees for the same services?

Payment variation driven by type of ownership rather than underlying resource cost has potential to drive up health care costs without improving health outcomes. It is important to note that the rationale for having an academic medical center fee schedule is that an academic medical center requires a premium to provide Level 1 Trauma emergency care, uncompensated/charity care, special high-acuity services, medical education and research, and standby capacity. That being said, if the same service can be safely provided in different care settings at the same cost, payments should be equalized across sites. Through extensive study over a number of years, MedPAC has recommended several instances where site neutral payments would be prudent, thereby providing clear parameters and useful benchmarks for the State to follow. With that in mind, the GMCB makes the following recommendation.

Recommendation

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:

- 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.