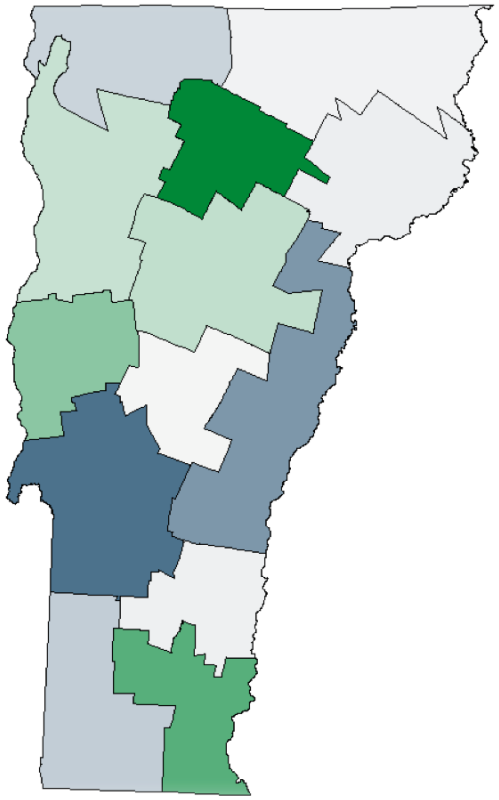

Payment Differential and Provider Reimbursement

Update and Discussion

Report to the Legislature

January 26, 2018

Jessica Holmes, PhD
Green Mountain Care Board

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Overview—what is the issue?

- **Difference in reimbursement rates between hospital-owned practices (most specifically, the Academic Medical Center) and independent practices for same medical services.**

- Legislature's concern:
  - Lower relative reimbursements for independents→ financial strain → loss of independent practices?
  - Increased consolidation and growth of hospital-owned practices→ greater out-of-pocket costs for consumers and greater health care costs for the state?

A Deeper Dive into the Reimbursement Differential, Health Care Consolidation and Clinician Landscape

- Literature review to understand national trends in provider consolidation
- Data analysis on reimbursement differential in Vermont
- Stakeholder work group meetings to address reimbursement differential
- VT Clinician landscape study (Survey and focus groups)
- Public Board Meetings

Key Points

1. **Both nationally and in Vermont, more providers are choosing employment in hospitals and health systems rather than practicing independently. This has led to greater consolidation in health care.**
2. Multiple factors explain the trend toward more hospital-based employment including growing costs and challenges of running a business, ACA incentives to integrate, and provider preferences for consistent schedules and salaries. Commercial reimbursement is not a primary reason for providers to choose employment in hospitals. Salaries are not likely to be higher in hospital-based settings
3. Fee-for-service rate differentials exist between hospital-based practices and independent settings for professional services. In Vermont, the largest differential exists between the academic medical center and other providers.
4. Adjusting fee-for-service rates through regulation is complex and will have impacts on consumer premiums and out-of-pocket costs, hospital budgets, as well as access and quality of care.

National Trends in Consolidation

The health care system nationally is transforming

FROM:	TO:
Diverse network of independent hospitals, clinics, physician practices	More concentrated system with one or more academic medical centers in full or partial control of surrounding community hospitals, physician practices and post-acute care facilities

Market concentration in U.S. has increased 40% since mid-1980s

- horizontal (hospitals buying hospitals)
- vertical (hospitals buying physician practices)

"Only 33% of physicians identify as independent practice owners or partners, down from 48.5% in 2012."

~ 2016 Survey of America's Physicians: Practice Patterns and Perspectives; Physicians Foundation

State Trends in Consolidation

VT's health care system is transforming as well

- According to market research firm SK&A, VT trends mimic national trends:
  - In 2011 **47%** of VT providers were **independent** while 53% were hospital-employed (recall, nationally, it was about 49% independent in 2012)
  - In 2017 **31%** of VT providers are **independent** while 69% are hospital-employed (recall, nationally it was about 33% independent in 2016)

- In VT, most of the transition occurred among specialists
  - Between 2011 and 2017, the proportion of **specialists** who practice independently fell from **44% to 23%**
  - Between 2011 and 2017, the proportion of **primary care providers** who practice independently fell from **54% to 46%**

Key Points

1. Both nationally and in Vermont, more providers are choosing employment in hospitals and health systems rather than practicing independently. This has led to greater consolidation in health care.
2. **Multiple factors explain the trend toward more hospital-based employment including growing costs and challenges of running a business, ACA incentives to integrate, and provider preferences for consistent schedules and salaries. *Commercial reimbursement is not a primary reason for providers to choose employment in hospitals. Salaries are not likely to be higher in hospital-based settings***
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Literature Review: Factors driving national consolidation

- Literature describes several main reasons physicians are seeking employment or affiliation with hospitals and health systems (note: commercial pay disparities is not one of them)
    - High costs associated with EMR implementation
    - Increasing measurement and reporting requirements
    - Challenges and risks of running a complex business
    - Income security
    - ACA and ACO incentives to integrate health care systems
    - Lifestyle preferences (e.g., consistent schedules, less call)

VT Clinician Landscape Survey

When:

Fielded an electronic survey (SurveyMonkey) between
8/10/2017 – 8/22/2017

How:

We requested distribution of survey link via:

Vermont Medical Society

Hospital Systems

Bi-State Primary Care

VT Health*First*

Completed Responses:

404 clinicians

91 clinicians (23%) practicing independently

313 clinicians (77%) are employed by AMC, community hospital, FQHC/rural health clinic

Demographics:

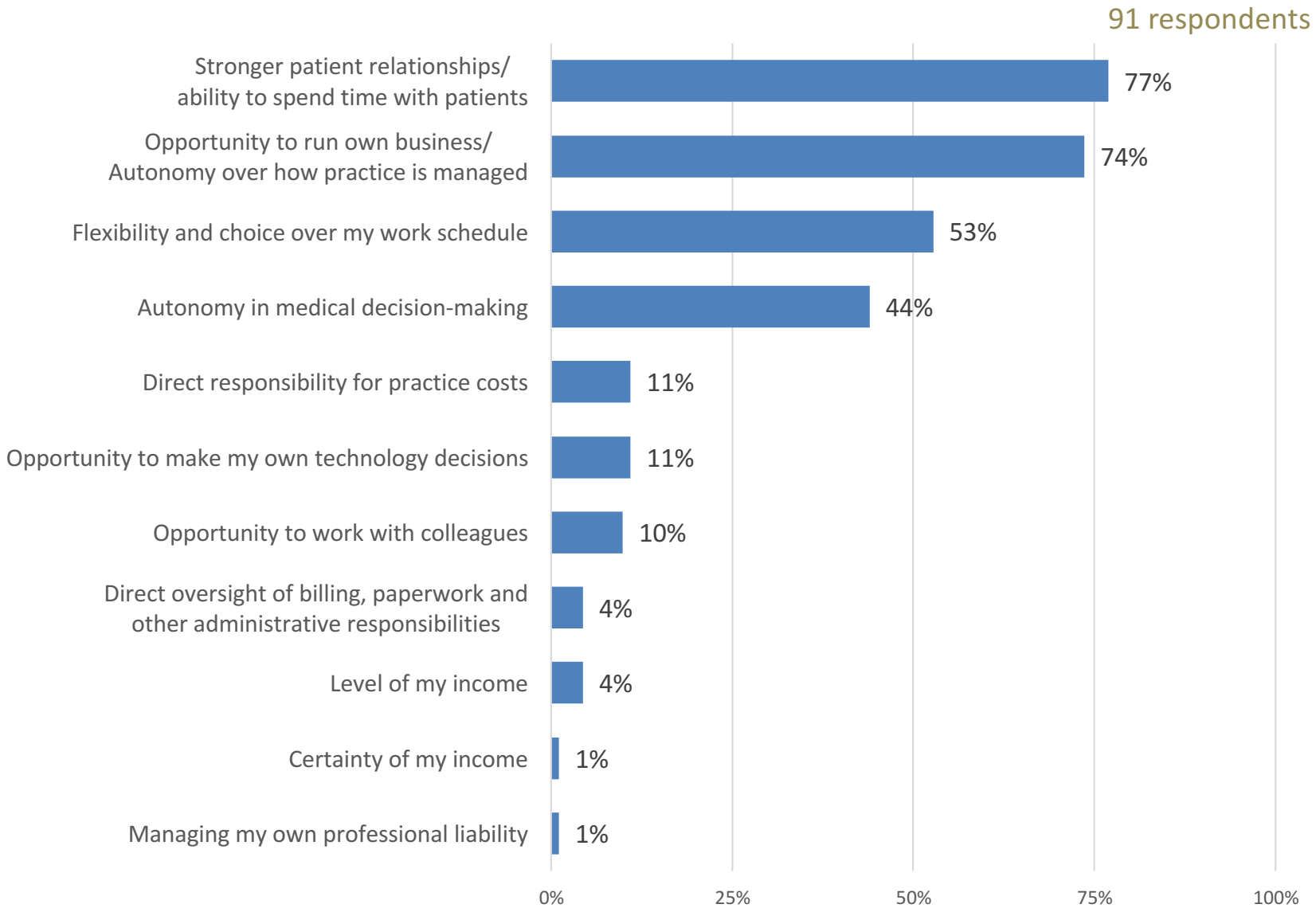
Primary care (30%)

Pediatrics (9%)

Specialty (61%)

HSA: all represented

Satisfying Factors: Independent Clinicians



Source: GMCB Provider Landscape Survey, 2017

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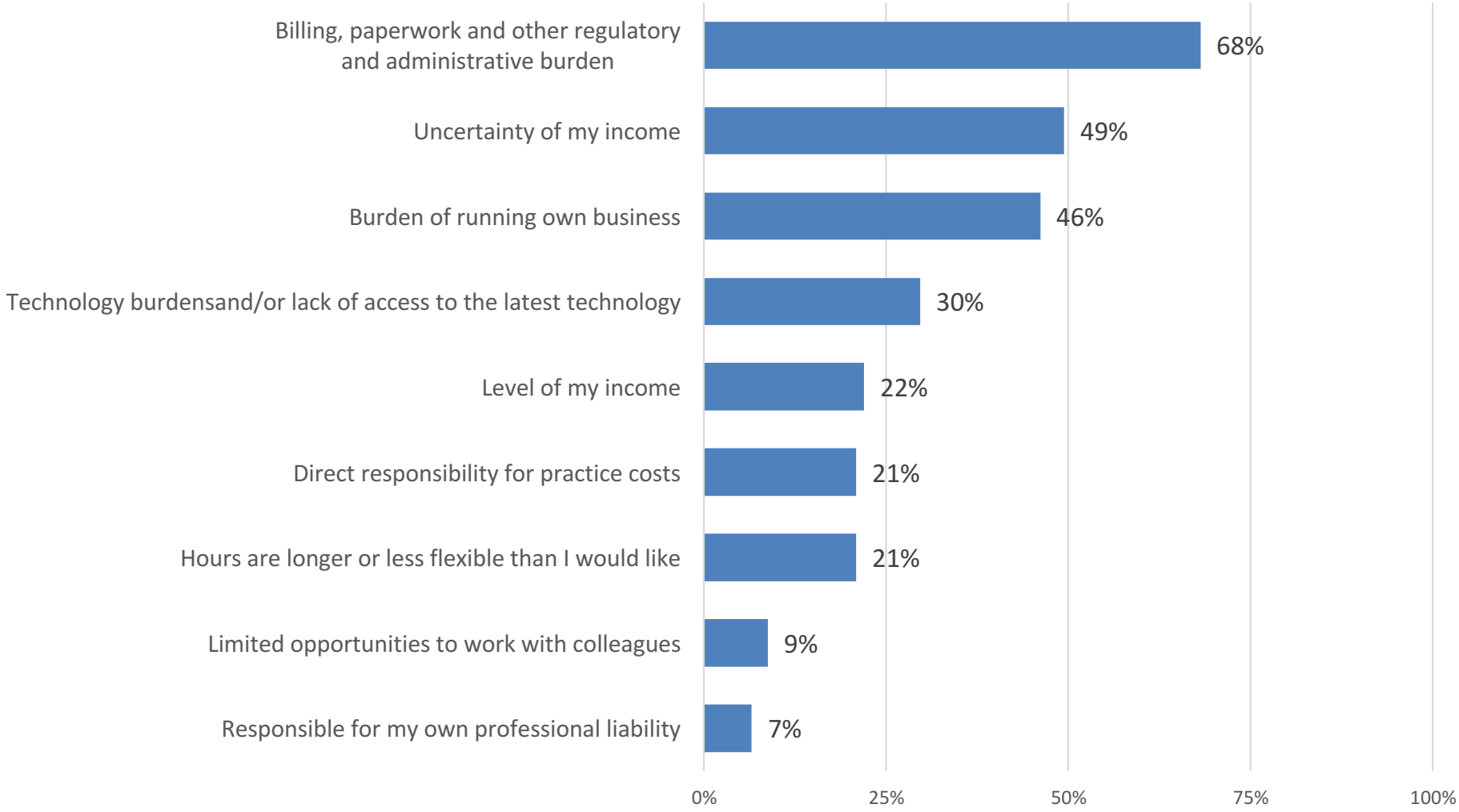
Frustrating Factors: Independent Clinicians

91 respondents



Source: GMCB Provider Landscape Survey, 2017

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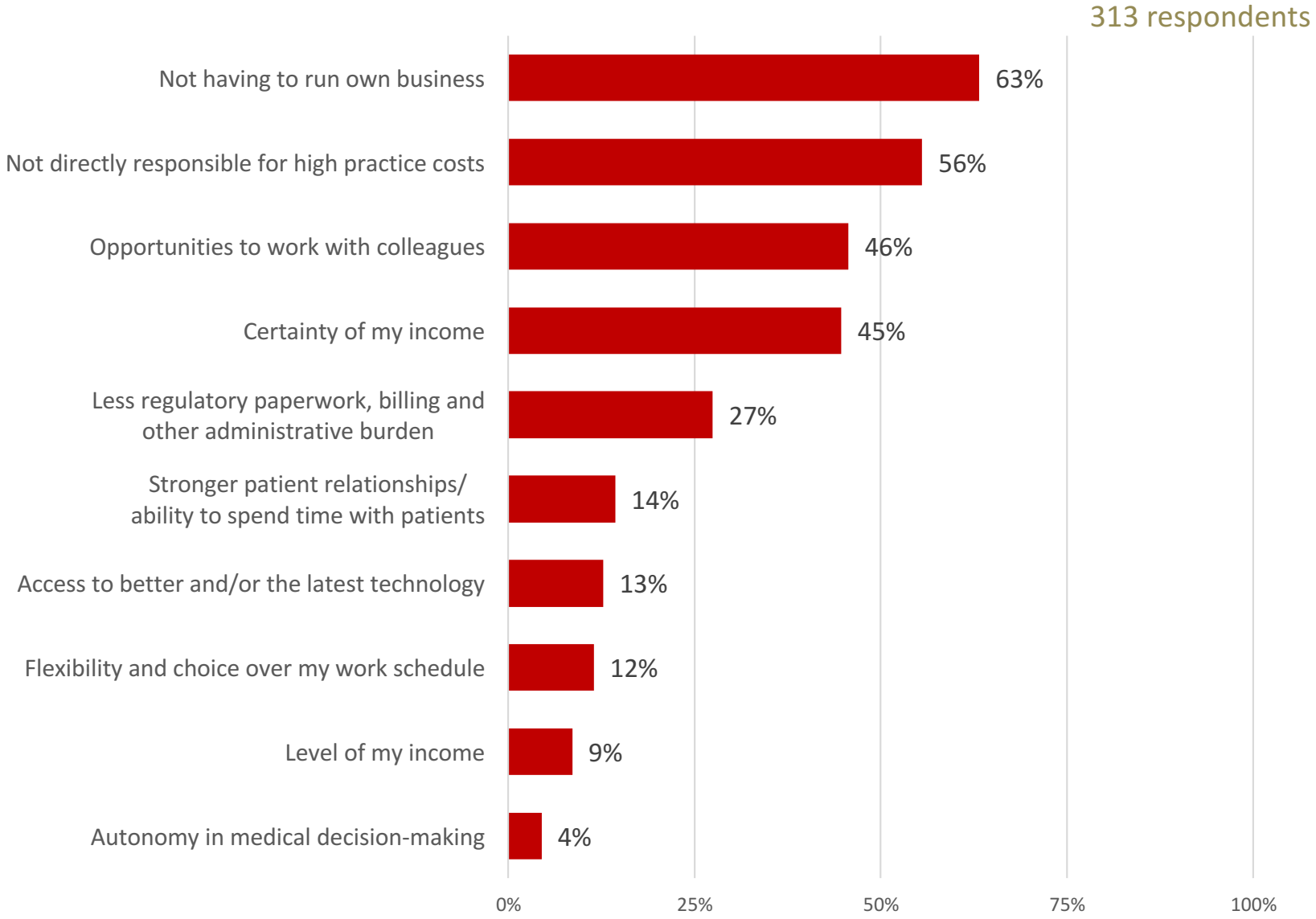
Satisfying Factors: Employed Clinicians



Source: GMCB Provider Landscape Survey, 2017

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Frustrating Factors: Employed Clinicians

313 respondents

Source: GMCB Provider Landscape Survey, 2017

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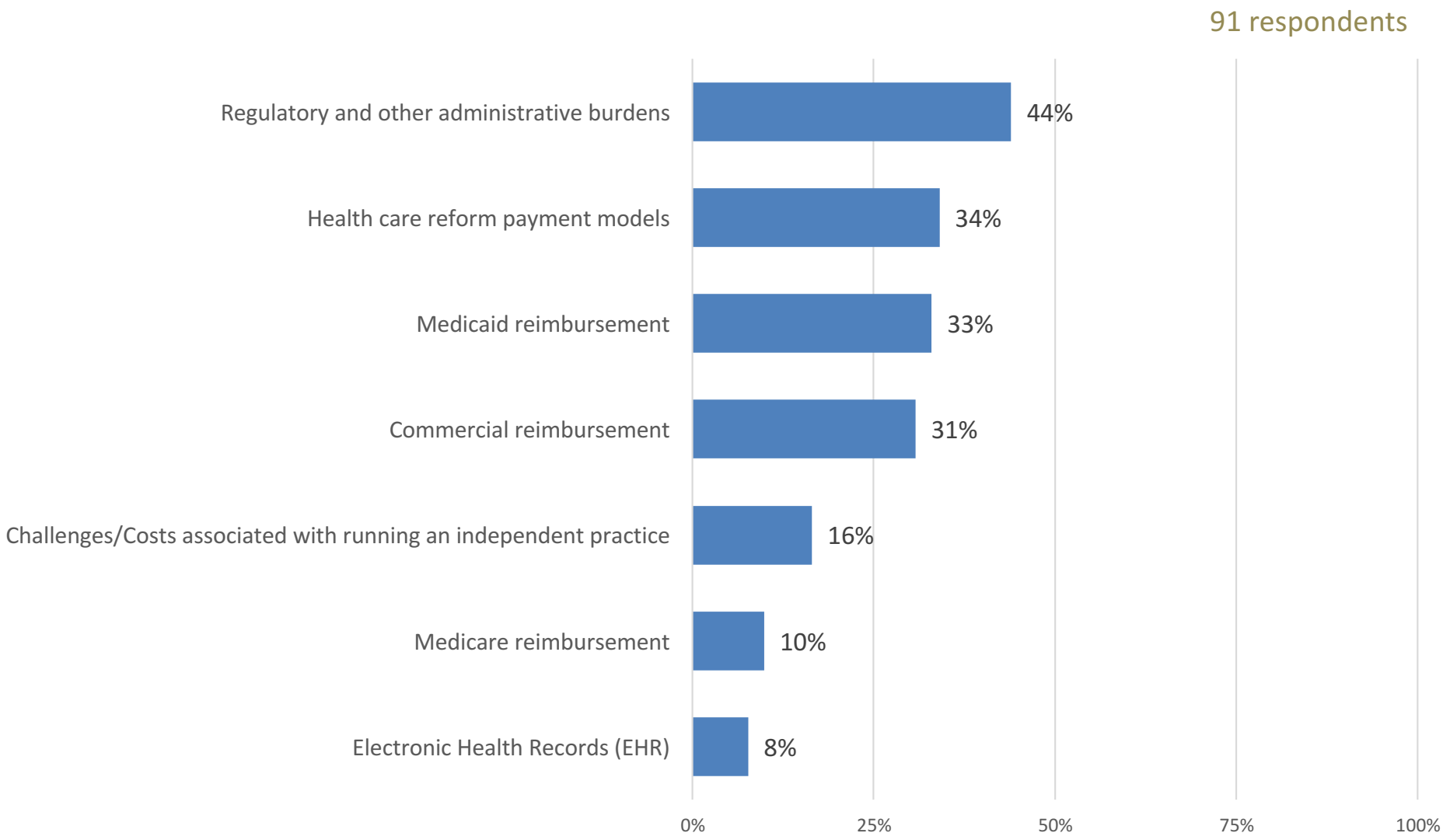
Greatest Threats: Independent Clinicians



Source: GMCB Provider Landscape Survey, 2017

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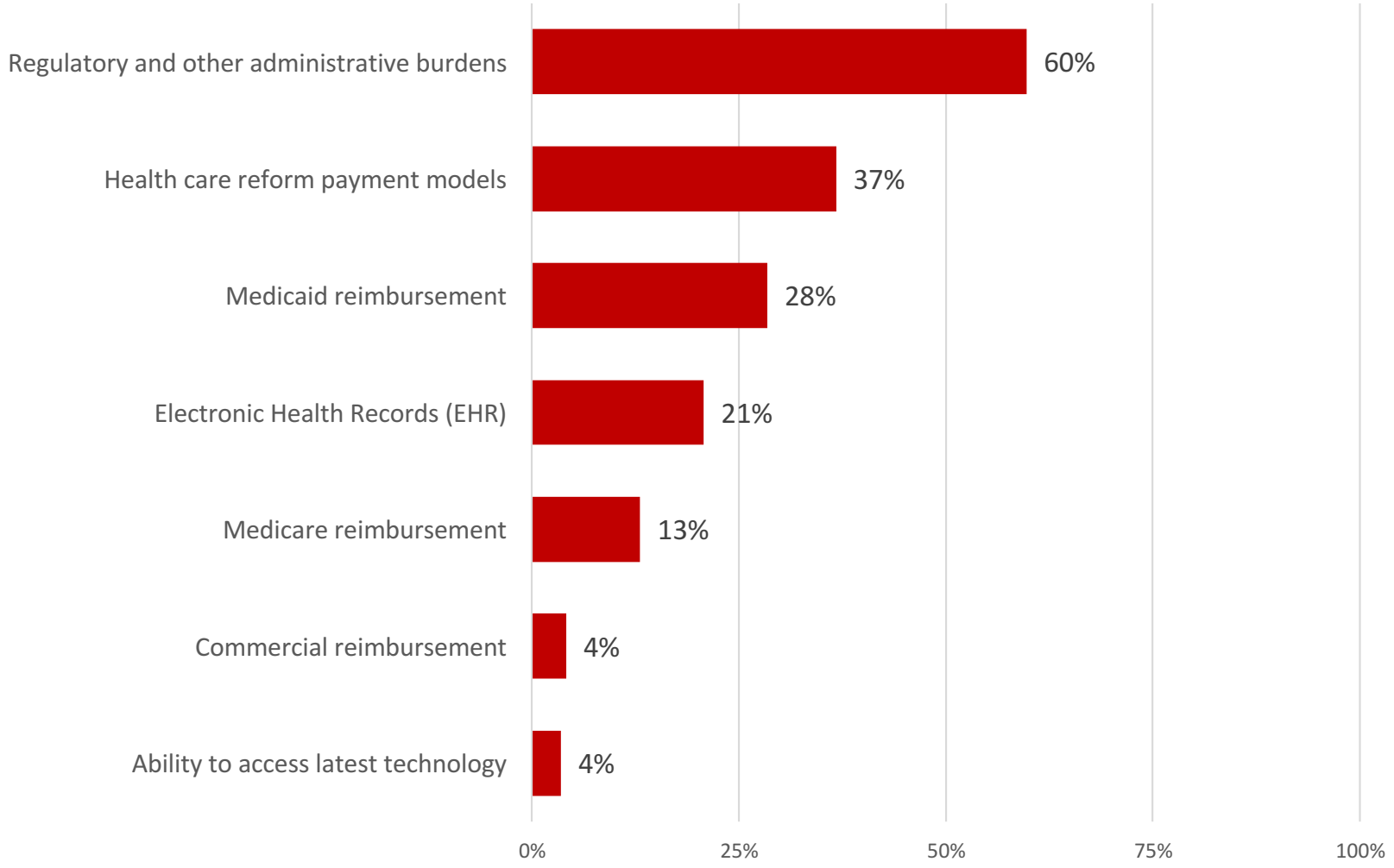
Greatest Threats: Employed Clinicians

313 respondents



Source: GMCB Provider Landscape Survey, 2017

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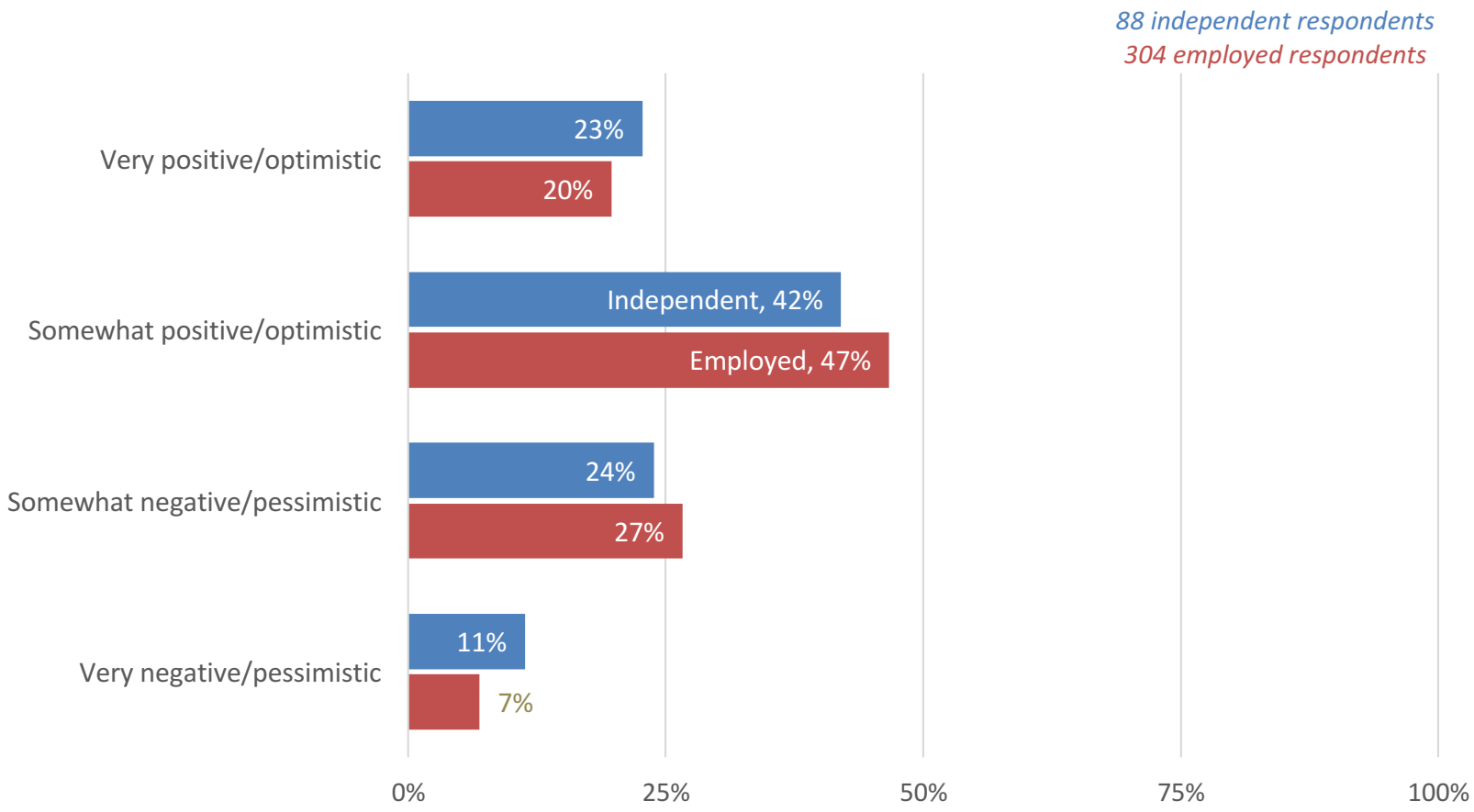
Which best describes your professional morale and your feelings about your current employment?



Source: GMCB Provider Landscape Survey, 2017

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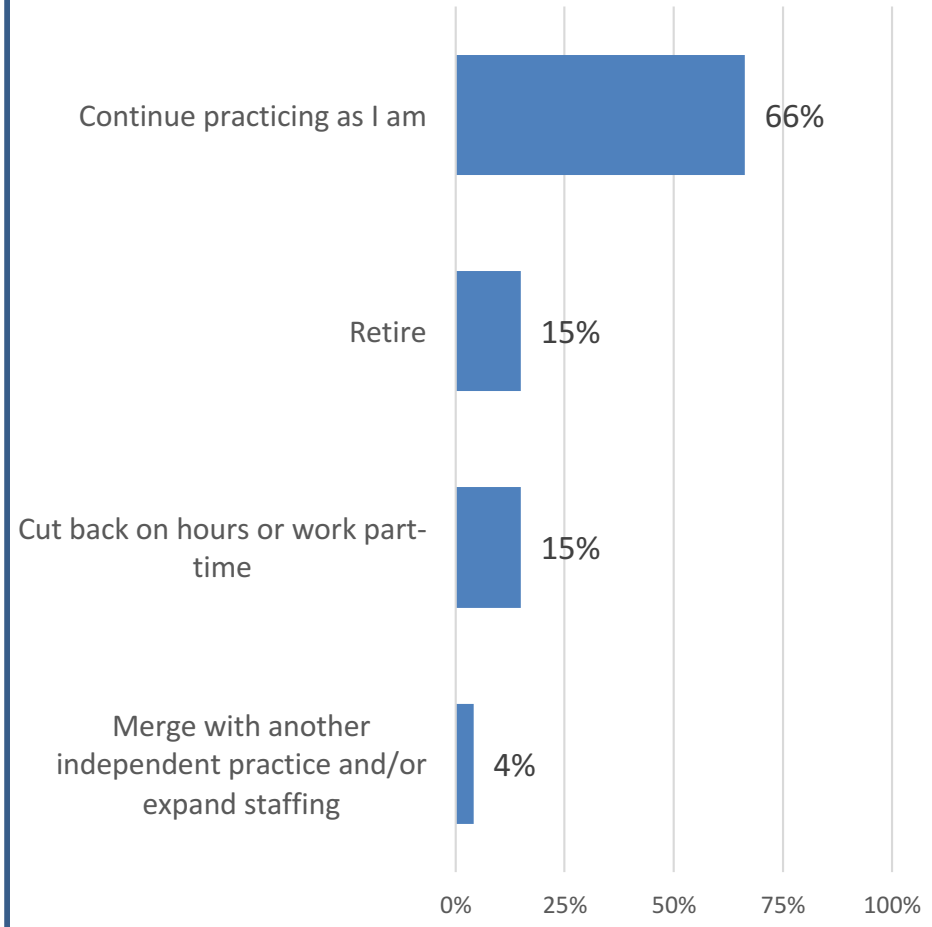
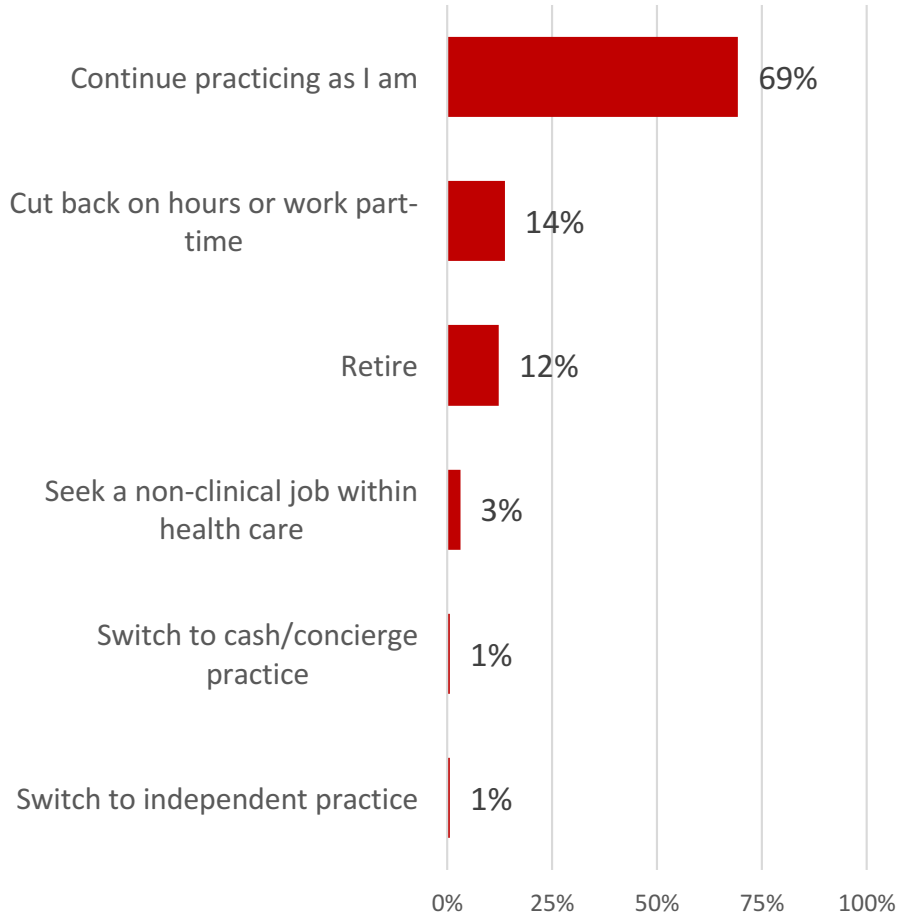
Next Three Years

Independent Clinicians



74 respondents

Employed Clinicians



284 respondents

Source: GMCB Provider Landscape Survey, 2017

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Takeaways from VT clinician survey

- Independent clinicians like the autonomy and flexibility that running their own practice provides while employed clinicians like not having to deal with the burdens and high costs of running their own practice.

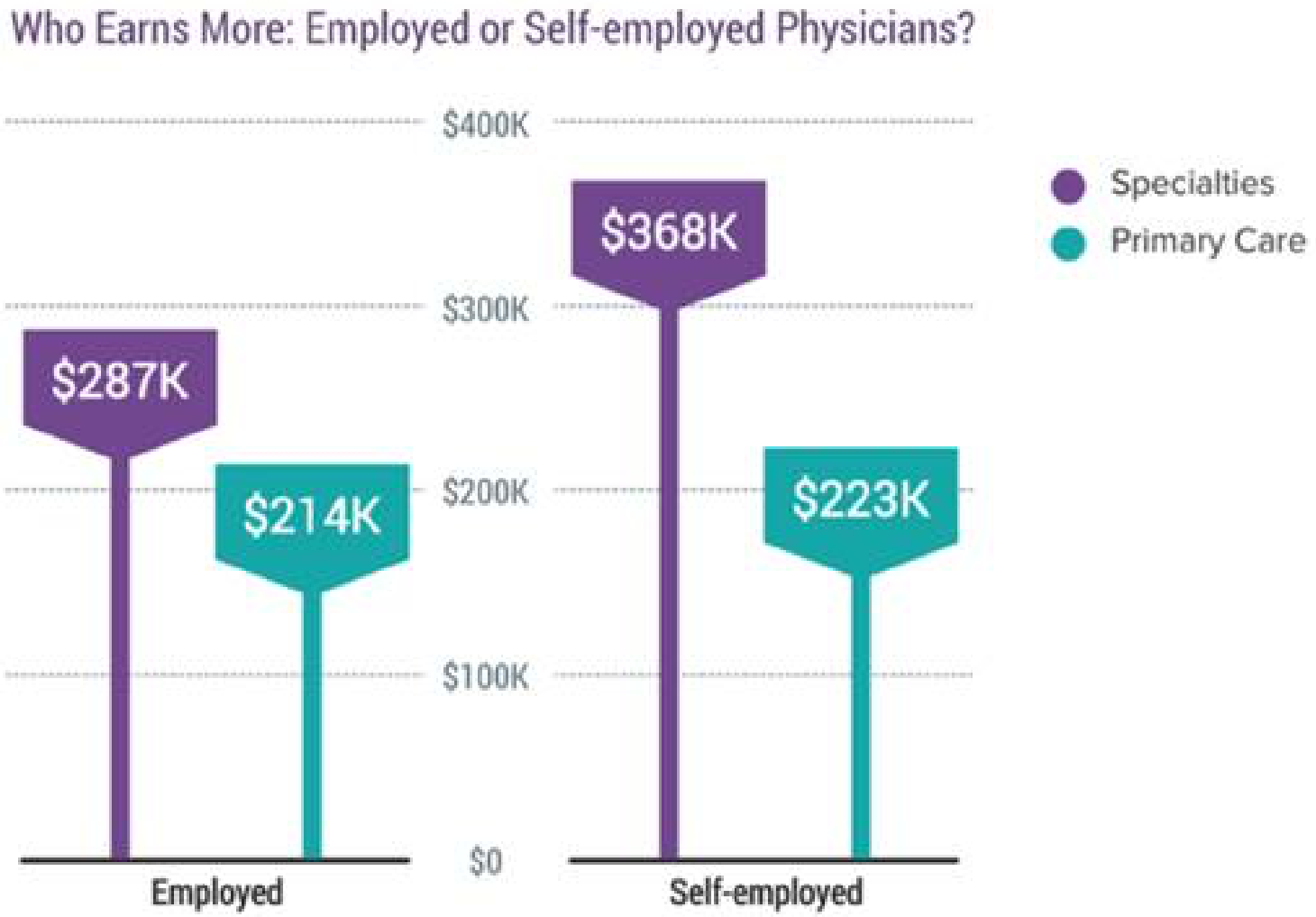
- Both independent and employed clinicians are frustrated by the administrative burdens.

- Independent clinicians identify the ***uncertainty*** of their income as a frustration whereas employed clinicians identify the ***level*** of their income as a frustration.

- Whether independent or employed, the greatest threats to practicing in Vermont are seen to be regulatory/administrative burden, health care reform payment models and Medicaid reimbursement.

- Even with these frustrations, most clinicians plan to continue practicing in the coming years as they are today.

2017 Medscape Physician Compensation Report



Medscape Physician Compensation Report, 2017. http://www.medscape.com/slideshow/compensation-2017-overview-6008547. Survey recruitment period 12/20/2016-3/7/2017.

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Average allowed amount per primary care service*, Vermont Blueprint practices, 2015

COMMERICAL payers	Blueprint practices	Avg. allowed amount	Services per patient	Allowed PMPM
FQHC/RHC	41	$95.66	2.06	$17.60
Academic Medical Center	10	$167.58	1.86	$27.32
Independent	47	$99.72	2.41	$21.29
Community Hospital	34	$103.31	2.09	$19.12

Source: Blueprint practice roster and VHCURES claims data, CY2015

*Primary care services as defined by primary care work group in 2015.

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3. Fee-for-service rate differentials exist between hospital-based practices and independent settings for professional services. In Vermont, the largest differential exists between the academic medical center and other providers.
4. **Adjusting fee-for-service rates piece-meal through regulation is complex and will have impacts on consumer premiums and out-of-pocket costs, hospital budgets, as well as access and quality of care.**

Achieving Site Neutral, Fair Reimbursement for Medical Services: Long Run Solution

- Vermont is moving away from fee-for-service payments toward system-wide value-based payment reform
    - One Care ACO model offers prospective, population-based payments, calculated using the historical expenditures of attributed members from all participating payers.
    - Reduces emphasis on fees for individual services (and the disparities therein)
    - Capitation/global budgeting gives flexibility to redirect pool of dollars to better support preventive, primary care and improve health care outcomes.

Regulatory Actions: Short Run

- **Hospital Budgets**: FY2018 budget order directed UVMMC to reallocate an $11.3 million proposed reduction in professional fees to site neutral services (~300 E/M codes in both primary and specialty care) in order to close the gap.
  - As a result, UVMMC "estimated the gap in reimbursement levels is reduced to approximately 10%."
  - BCBS confirmed that the Board's adjustment reduced the reimbursement differential by 34% for key E/M services and that consumers "will no longer be surprised by dramatically different reimbursement for the same fundamental healthcare practices".

Regulatory Actions: Short Run

- **Rate Review**: In 2018 QHP filings, the Board ordered reductions in the medical trend with the intention that the reduction would come from negotiating rates downward to promote parity in reimbursements and reflect actual cost of care rather than site of service. Specific language used:

"We reasonably expect that insurers will vigorously negotiate rates with the hospitals, including those that are outside our borders, in a way that promotes parity in reimbursements between academic medical centers, community hospitals and independent providers. Provider reimbursements should reflect actual costs of care rather than site of service."

Regulatory Actions: Short Run

- **ACO budget**: GMCB gave conditional approval contingent upon the following:
  - OneCare must submit a payment differential report that describes its Comprehensive Payment Reform Pilot's payment methodology and analyzes how the capitated payments for primary care services under its program compare to the payments hospitals make to primary care providers that are not participating in the pilot.
  - The report must also address how the Comprehensive Payment Reform pilot reduces administrative burden for primary care providers.

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1. Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. JAMA Intern Med 2015;**175**(12):1932-9 doi: 10.1001/jamainternmed.2015.4610published Online First.
2. Capps, C., Dranove, D. & Ody, C. (2017). The effect of hospital acquisitions of physician practices on prices and spending. Retrieved from http://economics.mit.edu/files/12747
3. Cutler DM, Scott Morton F. Hospitals, market share, and consolidation. JAMA 2013;**310**(18):1964-70 doi: 10.1001/jama.2013.281675published Online First.
4. Accenture. (2015) Independent Physicians: A Swiftly Shrinking Segment. Available: https://www.accenture.com/us-en/insight-clinical-care-independent-doctor-will-not-see-you-now.
5. Medscape Physician Compensation Report, 2017. http://www.medscape.com/slideshow/compensation-2017-overview-6008547. Survey recruitment period 12/20/2016-3/7/2017.

References

- Provider reimbursement report materials are available on the GMCB website:
    - http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports

- April 27, 2017 Board meeting materials:
    - UVMHN Presentation - Act 54 and Act 143: "Fair and Equitable Payments" and Site Neutrality
    - GMCB Presentation - Act 54 (2015) and Act 143 (2016) Payment Differential and Provider Reimbursement Reports: Overview of GMCB Process and Progress Update
    - GMCB Act 143 Update