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To: Health Reform Oversight Committee
From: Green Mountain Care Board
Date: October 1, 2017
Re: Payment Differential and Provider Reimbursement Report, Act 85 (2017) § E.345.1

Introduction

The Green Mountain Care Board respectfully submits this memorandum to the Heath Reform Oversight Committee in response to the charge in Act 85 of 2017, Section E.345.1.

> Act 85 (2017) Sec. E.345.1 FAIR REIMBURSEMENT REPORT
> Utilizing funds appropriated in Section B.345 of this act, the Green Mountain Care Board shall report to the Health Reform Oversight Committee by October 1, 2017 describing what substantial changes have been put into effect to achieve the site-neutral, fair reimbursements for medical services as envisioned in 2014 Acts and Resolves No. 144, Sec. 19, 2015 Acts and Resolves No. 54, Sec. 23, and 2016 Acts and Resolves No. 143, Sec. 5.

Overview

In a series of mandates since 2014, the Legislature has highlighted the payment differential between hospital-acquired practices and independent practices as a target for policy intervention.[1] The primary concern has been that the payment differential between hospital-owned practices (most specifically, the academic medical center) and their independent counterparts has led to the decline of independent providers in the state and to increased consolidation of the state's health care system. Board actions to achieve site neutral, fair reimbursement for medical services can be found on page 12 of this report.

Relevant legislation, 2014-2016

In 2014, the legislature first mandated that the Agency of Administration evaluate whether the State should prohibit reimbursement differentials based on practice setting and/or ownership type. In its "Independent Physician Practices Report," the Agency found that differentials in commercial payment rates largely existed between the academic medical center and other practice settings.[2] The Agency recommended that the State continue to pursue payment and delivery system reform while ensuring the pay differential remains an important part of the discussion.

[1] The issue of payment differentials among providers by practice ownership is often referred to as "pay parity" or "fair and equitable reimbursement."
[2] Other practice settings include community hospitals and independent providers, who are reimbursed at roughly the same levels.

In 2015, the Legislature mandated that Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Healthcare (MVP) submit implementation plans to ensure "fair and equitable reimbursement amounts for professional services provided by academic medical centers and other professionals." In July 2016, the carriers submitted plans to the Green Mountain Care Board for review.[3] Although each carrier proposed a different methodology reducing the differential between the academic medical center and other practice settings, it is important to note that neither carrier proposed an increase in rates to independent providers. The Board reviewed the carriers' plans but concluded that neither plan offered a sufficient analysis of the consequences—whether intended or unintended—of changing how they reimburse providers. On February 1, 2017, the Board submitted a comprehensive report to the Legislature with its own set of recommendations for "fair and equitable reimbursement."[4]

February 2017 Board recommendations and insurer responses

In the February 1, 2017 report, the Board first recognized that the payment reform efforts outlined in the All-Payer Accountable Care Organization Model Agreement (All-Payer Model or APM) transition the State from a fee-for-service reimbursement model toward value-based payments, and that such a transition should alleviate concerns about payment differentials. However, the Board recognized that the transition would take time and recommended several steps to narrow the gap in the short term.

Noting that there are cost-related justifications for differential reimbursements between the academic medical center and other settings for some services, the Board decided to focus its attention on those services deemed to be "site-neutral"; that is, services for which there is no underlying difference in the cost required to deliver the care, no matter the setting. The Board looked to work performed by the Medicare Payment Advisory Commission (MedPAC), which had recently examined the issue of disparities in provider reimbursements and issued recommendations on site-neutral services and payment methodologies.[5] The Board recommended that physician practices newly acquired by the academic medical center should not be allowed to switch to the (generally higher) academic medical center fee schedule, but must remain on the (generally lower) community fee schedule upon their acquisition. This recommendation aligns with 2017 adjustments to Medicare provider reimbursements, and was supported by the University of Vermont Medical Center (UVMMC).[6] For existing hospital-affiliated practices, the Board asked the carriers to outline a plan for achieving greater equity in reimbursements for E/M codes and for procedures MedPAC had identified as site-neutral.

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[3] All reports are available on the Green Mountain Care Board website at: http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports.

[4] Ibid.

[5] Site-neutral services are defined by the MedPAC as services that 1) do not require emergency stand-by capacity 2) do not have extra costs associated with higher patient complexity in the hospital, and 3) do not need the additional overhead associated with services that must be provided in a hospital setting. MedPAC identified Evaluation and Management (E/M) codes and a set of ambulatory services as site-neutral. Medicare Payment Advisory Commission, *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. Due to the complexity of adjusting fee-for-service rates and with input from stakeholders, the Board focused its actions on E/M codes only.

[6] Presentation to the Board by the University of Vermont Health Network, *Act 54 and Act 143: Fair and Equitable Payments and Site Neutrality* (April 27, 2017), *available at* http://gmcboard.vermont.gov/sites/gmcb/files/UVMHN%20presentation%20on%20fair%20and%20equitable%20payments%20%204-27-17.pdf.

The Board's February 1, 2017 recommendations are summarized below:

Recommendations
GMCB Report February 1, 2017

- Implement site-neutral payments for newly acquired physician practices for certain services
- For currently affiliated practices, carriers directed to formulate plans to align fee schedules for site-neutral services
- Carriers should propose effective date for implementing site-neutral reimbursement plan, and provide analysis of plan impacts on 2018 insurance rates and plan design, and implementation of All-Payer ACO Model
- GMCB will review the revised plans in a public process
- GMCB will explore additional longer term recommendations for measuring and aligning payments across providers and care settings

Both carriers were asked to submit responses to the Board's report no later than March 15, 2017. In its response, BCBSVT stated that the recommendation to keep newly acquired practices on the same fee schedule would have little impact on premiums and could "be done with moderate administration modifications to BCBSVT processes;" however, the recommendation to lower reimbursements for existing hospital-based practices had the potential to lead to higher premiums if hospitals shifted costs to inpatient services.[7] MVP's response included a request that the Board "issue a regulatory requirement governing the appropriate billing practice for services provided by hospital owned physicians" and require that newly acquired and currently owned practices convert to a Medicare fee schedule, regionally adjusted for Vermont. MVP also anticipated hospital cost-shifting to other services to offset the reduction.[8]

In the end, both carriers agreed that the Medicare site-neutral approach is a rational strategy for that specific payer, but raised concerns about implementing site neutrality in the commercial market with its complex array of fee schedules and negotiated contracts.

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[7] *Blue Cross and Blue Shield of Vermont Implementation Plan for Providing Fair and Equitable Reimbursement Amounts for Professional Services Provided by Academic Medical Centers and Other Professionals* (March 2017) *available at* http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/BCBSVT%20Act%20143%20revised%20Reimbursement%20Plan%20Final%203-15-17.pdf.

[8] *Addendum to MVP's July 1, 2016 Report to the GMCB Regarding Fair and Equitable Physician Reimbursement* (March 2017) *available at* http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/GMCB%20March%2031%202017-MVP%20submission%20merged.pdf.

Board Review, March 2017-present

Since its February report and the submission of carrier responses, the Board took a step back to more thoroughly understand the issues driving the legislative charge and consider new avenues towards fair and equitable reimbursement.

First, in an effort to better understand the pressures facing physicians and the factors affecting health care consolidation, the Board embarked on a "clinician landscape" study. In addition to reviewing national trends in vertical consolidation (independent physicians joining with larger hospital systems), the Board analyzed data on provider employment trends in Vermont and conducted both a state-wide survey and a series of focus groups with Vermont clinicians.

Second, in order to evaluate the reimbursement differential, its implications and potential solutions, the Board reviewed a claims-based analysis performed by Onpoint Health Data, analyzed all plans and responses provided by the insurers, and convened a stakeholder workgroup to define and outline how to achieve a more "fair and equitable reimbursement" system. The workgroup included representatives from MVP, BCBSVT, UVMMC, Rutland Regional Medical Center, the Vermont Association for Hospitals and Health Systems, OneCare Vermont, Vermont Medical Society, HealthFirst, individual independent primary care and specialty providers, Bi-State Primary Care Association, Vermont Program for Quality in Health Care, and legislators. The workgroup met on May 24 and June 20, 2017, and additional sub-group meetings were held in between the workgroup sessions. Having all stakeholders in the room allowed for a robust discussion on the complexity of the issues. The workgroup did not come to consensus on a path forward, but the discussions helped to frame the options before the Board.

Several key points emerged:

> **Key Point #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 healthcare.

> **Key Point #2:** Multiple factors explain the trend toward more hospital-based employment including the growing costs, challenges and risks associated with running a business, Affordable Care Act (ACA) incentives to integrate, and provider preferences for consistent schedules and predictable salaries. Commercial reimbursement rates do not appear to be a primary reason that physicians are choosing employment in hospital and health systems. Salaries are also not likely to be higher in hospital-based settings.

Timeline

2016

July – BCBSVT and MVP implementation plans for fair and equitable reimbursement
November – GMCB stakeholder meetings
December 1 – GMCB update to legislature

2017

February 1 – GMCB report to legislature
March – BCBSVT and MVP modified reports submitted to GMCB
April 27 – GMCB public meeting
May – GMCB legislative testimony
May 24 – Work group meeting
June 20 – Work group meeting
August/September – GMCB clinician landscape survey and focus groups
August 28 – GMCB public meeting
September 14 – Hospital budget vote on UVMMC "pay parity" adjustment
October 1 – Report to Health Reform Oversight Committee

Key Point #3: Fee-for-service rate differentials exist between hospital-based practices and independent settings for professional services. In Vermont, the greatest differential is between the academic medical center and other providers.

Key Point #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.

This memorandum addresses each point in turn.

Key Point #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 healthcare.

Our review of the literature makes clear that many of the trends facing Vermont are not unique. Over the past decade, our national healthcare system has transformed from one characterized by a diverse network of largely independent hospitals, clinics and physician practices, to a 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. Evidence indicates that overall market concentration in the U.S. hospital sector has increased 40 percent 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). Nationally, hospital ownership of physician practices increased from 24 percent of practices to 49 percent from 2004-2011.[9] A more recent analysis suggests that 37 percent of practices were independent in 2013, down from 57 percent in 2000, and the number was projected to drop to 33 percent for 2016.[10] The 2016 Survey of America's Physicians also reports that "only 33% of physicians identify as independent practice owners or partners, down from 48.5% in 2012."[11]

In Vermont, identifying trends in vertical consolidation has been hampered by the lack of a complete and historical database tracking the employment status of clinicians. The Board has heard anecdotal claims that as few as 15 percent of Vermont clinicians now practice independently, but such claims have not been verified with data. Nor have there been any attempts to quantify the degree to which this has changed over time. The Board supports efforts to include employment status information in Vermont Department of Health's physician census data collection.

The Board acquired data from SK&A, a third-party market research firm whose dataset and extensive physician database is used by federal agencies and academic researchers to analyze hospital and provider

[9] Cutler and Morton, *Hospitals, Market Share, and Consolidation*, Vol. 310, No. 18, Journal of the American Medical Association (Nov. 13, 2013).
[10] Accenture, *The (Independent) Doctor Will NOT See You Now* (May 2015), *available at* https://www.accenture.com/t20160601T222041Z__w__/us-en/_acnmedia/PDF-2/Accenture-The-Doctor-Will-Not-See-You.pdf#zoom=50.
[11] *2016 Survey of America's Physicians: Practice Patterns & Perspectives*, conducted on behalf of The Physicians Foundation by Merritt Hawkins (September 2016) at 8, *available at* http://www.physiciansfoundation.org/uploads/default/Biennial_Physician_Survey_2016.pdf.

market conditions.[12] Although the data may not be all-inclusive, it provides one estimate of the trends in physician consolidation over time. The data in Table 1, below, suggests that overall, 31 percent of Vermont physicians are practicing independently in 2017, down from 47 percent in 2011, in alignment with the national data discussed above. The data also suggests that more Vermont specialists than primary care providers moved from independent to hospital-employed status between 2011-2017; 46 percent of primary care providers in Vermont are still independent, compared to only 23 percent of specialists.

Table 1: Number of primary care providers and specialists in Vermont, % employed and independent (SK&A data set, 2017)

	2011	***2013***	***2015***	***2017***
Primary Care (No.)	481	517	521	528
% Employed	*46%*	*46%*	*51%*	*54%*
% Independent	*54%*	*54%*	*49%*	*46%*
Specialist (No.)	1,033	1,072	1,080	1,006
% Employed	*56%*	*64%*	*75%*	*77%*
% Independent	*44%*	*36%*	*25%*	*23%*
TOTAL (No.)	1514	1589	1601	1,534
% Employed	53%	58%	67%	69%
% Independent	47%	42%	33%	31%

It should be noted that there are advantages and disadvantages associated with increased consolidation of the health care system.[13] While there is the potential for higher prices in a more concentrated market, there is also the potential for greater care coordination and cost savings through economies of scale. As Vermont moves towards value-based payment reform and greater care coordination, a more integrated market—with state regulatory oversight—may help achieve the health reform goals outlined in the All-Payer ACO Model.

[12] The SK&A data set, originally compiled for commercial purposes, is highly regarded and has been used in several health services research studies, including MedPAC's June 2017 Report to the Congress (Chapter 10: Provider consolidation: The Role of Medicare policy). The MedPAC Report is available at http://medpac.gov/docs/default-source/reports/jun17_reporttocongress_sec.pdf?sfvrsn=0. The SK&A physician database is updated semi-annually. *See SK&A Data: How We Acquire It*, http://www.skainfo.com/about/data-collection.

[13] Cutler and Morton, note 8, *supra*.

Key Point #2: Multiple factors explain the trend toward more hospital-based employment including the growing costs, challenges and risks associated with running a business, ACA incentives to integrate, and provider preferences for consistent schedules and predictable salaries. Commercial reimbursement rates are not the primary reason that physicians are choosing employment in hospital and health systems. Salaries are also not likely to be higher in hospital-based settings.

Although the legislative charge puts the focus on commercial reimbursement rates, the national literature highlights many other factors driving providers to seek employment or affiliation with larger institutions: the high costs associated with EMR implementation, increasing measurement and payment driven reporting requirements, the growing costs, challenges and risks associated with running a business, ACA incentives to integrate, and provider preferences for consistent schedules and predictable salaries. A survey conducted by the Board, described in more detail below, shows consistent findings for Vermont clinicians.

GMCB Clinician Landscape Survey

During August and September 2017, the Green Mountain Care Board fielded an electronic survey of Vermont clinicians and conducted three focus groups to launch discussion around experiences with being independent or employed practitioners, how practices have changed over time, the impact of healthcare reform initiatives on practices, and thoughts about the future of healthcare in Vermont. Specifically, we were interested in learning what clinicians find most rewarding, the stressors they face in their practices, the factors that drive their employment choices, and their outlook on the profession in Vermont. The full Vermont Clinician Landscape Study Report accompanies this Report (Attachment A).

After reviewing over 400 survey respondents, we identified the following key takeaways:

- Independently practicing clinicians cite strong patient relationships, the opportunity to run their own practice as well as flexibility and choice over work schedules as the factors most satisfying about their work.

- Independent clinicians are most frustrated by billing, paperwork and other administrative burdens, the uncertainty of their income, and the burdens associated with running their own practice and accessing costly technology.

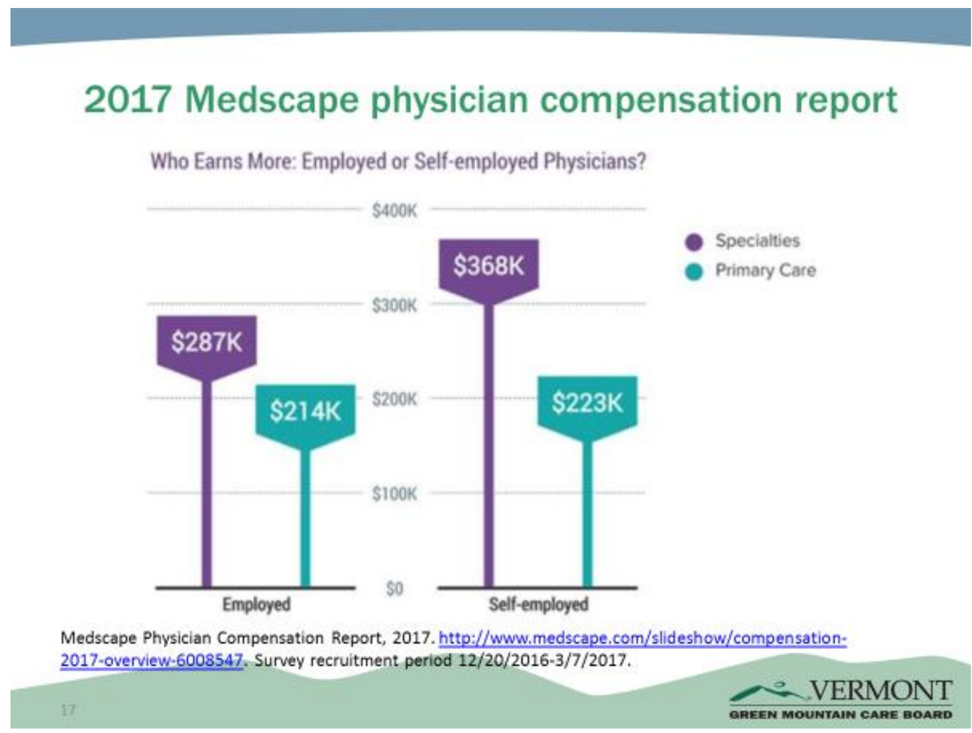
- Employed clinicians are most satisfied about not having to run their own business, not being responsible for high practice costs, the opportunities to work with colleagues, and the **certainty** of their income in an employed setting.

- Like independent clinicians, employed clinicians find administrative burdens frustrating. They also identify as frustrations the limited control they have over practice management, lack of control over their work schedule, and **level** of their income.

- The top three most commonly cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement. The same top three threats apply to employed clinicians.[14]

Despite frustrations, the majority of clinicians, whatever their employment setting, are generally optimistic about their current employment and anticipate continuing to practice as they are today.

It is worth noting that *certainty of income,* rather than the *level of income*, is the more likely driver of hospital-based employment choices. National data from the 2017 Medscape Physician Compensation Report shows independent physicians tend to make higher salaries than employed physicians.[15] The salary gap is larger for specialists ($81k) than for primary care providers ($9k). The Board was unable to obtain comparative Vermont data on employed vs. independent physician salaries. All fourteen Vermont hospitals, the Brattleboro Retreat and Dartmouth Hitchcock Medical Center complied with the Board's request for their IRS Form 990, which includes some physician salary information. For comparative purposes, the Board requested salary information for independent physicians through HealthFirst, Vermont's independent practice association, which declined the request. However, we have no reason to believe that the national findings, summarized in the figure below, are not generalizable to Vermont.



Key Point #3: Fee-for-service rate differentials exist between hospital-based practices and independent settings for professional services. In Vermont, the greatest differential is between the academic medical center and other providers.

[14] The fourth most commonly cited threat for independent clinicians was commercial reimbursement and for employed clinicians was Electronic Health Records.
[15] The Medscape Report is available at http://www.medscape.com/slideshow/compensation-2017-overview-6008547.

Several researchers have attempted to quantify the impact of growing consolidation on prices in the healthcare sector. For example, one study showed that metropolitan areas with greater vertical integration experienced faster growth in prices and spending for outpatient services, and little impact on inpatient prices and spending.[16] Another study finds that hospital acquisition of physician practices is associated with an overall increase in physician prices of 14 percent, and an increase in primary care spending of about 5 percent[17].

In Vermont, the data suggests that the largest differential exists between the academic medical center and other physicians.[18] An analysis done by Onpoint Health Data using Vermont's All-Payer Claims Database serves to quantify this differential for primary care practices. Table 2 provides information about the primary care charges and total care costs incurred by patients attributed to the Vermont Blueprint for Health practices in various practice settings for commercial payers only.[19]

Table 2. Average allowed amount, utilization and allowed per-member-per-month (PMPM) for commercial payers

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

For commercial payers, the data suggests that the $168 "Average Allowed Amount"[20] for a primary care service at the academic medical center is significantly more than the amount for the same service at community hospitals ($103), independent practices ($100), and FQHCs/RHCs ($96). It is important to note, however, that the academic medical center provides fewer services per patient than the other providers, narrowing the differential on a PMPM basis.

For combined public and private payers (commercial, Medicare, and Medicaid) the differential is less pronounced. FQHCs/RHCs receive enhanced payments for providing care and wrap-around services to

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[16] Neprash *et al.*, *Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices*, JAMA Intern Med. (Dec. 2015).

[17] Capps *et al.*, *The effect of hospital acquisitions of physician practices on prices and spending* (Jan. 2017), *accessed at* http://economics.mit.edu/files/12747.

[18] Vermont Agency of Administration, *Report on Payment Variation in Physician Practices* (Nov. 26, 2014), *available at:* http://legislature.vermont.gov/assets/Legislative-Reports/303323.pdf; *see also MVP Implementation Plan for Fair and Equitable Reimbursement* (July 1, 2016) and *BCBSVT Implementation Plan for Fair and Equitable Reimbursement*, (July 1, 2016). Both reports are available at: http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports.

[19] Onpoint data table is provided in Attachment C.

[20] The average allowed amount is the maximum amount a plan will pay for a covered health care service, i.e., the negotiated rate.

underserved populations, resulting in higher allowed reimbursements. As shown in Table 3 below, when combined payer mix is taken into account, the PMPM payments for independent practices and FQHC/RHCs are only slightly different, while community hospitals receive the lowest PMPM.

Table 3. Average allowed amount and PMPM for COMBINED (public/private) payers

COMBINED (public/private)	Blueprint practices	Avg. allowed amount	Allowed PMPM
FQHC/RHC	41	$120.39	$24.51
Academic Medical Center	10	$112.51	$26.27
Independent	47	$91.57	$23.79
Community Hospital	34	$80.34	$19.41

A significant caveat is that this analysis is done for Blueprint primary care practices only, and for a defined set of codes. Different patterns may emerge for specialty practices and services.

It is also worth noting that both carriers' July 2016 implementation reports recommend closing the reimbursement differential between the academic medical center and other practices. Specifically, BCBSVT's proposal includes reducing academic medical center professional fees for E/M codes (i.e. office visits), would take into account graduate medical education payments and disproportionate share hospital payments, and would be accomplished over the course of three years. Importantly, BCBSVT expects that there would be a commensurate increase in negotiated reimbursements for inpatient services, and cautions that the reimbursement changes could impact consumer insurance premiums. MVP reported that it reimburses UVMMC at a higher rate than other tertiary care providers in its network, and independent providers at a higher rate than other independently contracted physicians in its network. MVP recommends an across-the-board downward adjustment to the academic medical center fee schedule over two years, with no upward adjustment in independent rates.

Key Point #3: 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.

This point was the focus of the provider reimbursement workgroup convened in the spring and summer of 2017. The workgroup provided a venue for discussion among stakeholders and enabled the Board to collect input on options for addressing fee-for-service price differentials. The Board presented the following challenge to the workgroup:

A path toward "fair and equitable" reimbursement…

The challenge for the work group:

How might we move to a consistent, transparent, and easily operationalized reimbursement system based on the resource costs of delivering high quality care in the least cost setting?

Consequences that need to be addressed in any proposed approach:

- Impact on independent practices
- Impact on hospitals
- Impact on premiums and out of pocket costs for consumers
- Impact on access and quality of care
- Operational implications for payers
- Regulatory impact

Although the workgroup did not come to consensus on either the definition of fair and equitable reimbursement or how to achieve greater equity, the discussions were lively, informative and thought-provoking. One theme emerged: there are complexities and unintended consequences associated with changing one aspect of a very complex fee-for-service reimbursement system. The system is built like a "house of cards" and removal of one card, without a deep understanding of the implications, can have significant financial and operational consequences.

Many, but not all, of the stakeholders agreed that value-based payment reform can address reimbursement differentials based on practice setting and/or ownership type. The Vermont All-Payer Accountable Care Organization Model deemphasizes fee-for-service reimbursement, and moves the system toward capitated and global payments tied to quality. Accountable Care Organizations participating in the model can choose to receive All Inclusive Population Based Payments (AIPBP) instead of fee-for-service reimbursement. The AIPBP is based on the historical health care expenditures of attributed Vermonters, and will be provided to the ACO for distribution among participating providers. This pre-paid model creates an opportunity for an ACO to reward participating providers for high quality, high value care and to invest more in those services that keep patients healthy as opposed to those that have the most favorable reimbursement. In its 2018 budget submission, OneCare Vermont allocated dollars for a comprehensive payment reform pilot program, for independent primary care providers, that includes $1.8 million in supplemental investment to develop a multi-payer, blended capitation model for primary care services.

Additionally, on September 1, 2017, UVMMC advised the Board that ACO investments

> are effectively being redirected from participating hospitals to primary care and other community providers. Looking at primary care practices alone, OneCare Vermont has estimated that UVM Medical Center will be funding about $2.5 million of those payments in 2018. If you look at

> payments flowing to both primary care and continuum-of-care providers, UVM Medical Center's share rises to $3.2 million.[21]

The Board has been charged by the Legislature to oversee successful implementation of the All-Payer ACO Model Agreement between the state and the federal government.[22] The Agreement requires the majority of Vermont residents to be attributed to a value-based payment model, rather than traditional fee-for-service, by the end of 2022. Additionally, the Legislature charged the Board with continuing to monitor the effects of reimbursing providers differently when providing the same service, and reducing or eliminating the differential as appropriate through all-payer model implementation.[23] With the last charge in mind, the following section outlines Board Actions.

Board Actions to Achieve Site Neutral, Fair Reimbursement for Medical Services

Successful implementation of the All-Payer ACO Model Agreement is the Board's payment reform priority. If implemented and regulated properly, it can help address pay parity concerns. To address legislative concerns over fee-for-service price differentials in the immediate short term, the Board has exercised its regulatory authority to reduce payment differentials and move closer to "fair and equitable reimbursement" for providers.

Hospital budget review. At its publicly-held board meeting on September 14, 2017, the Board voted unanimously to approve UVMMC's fiscal year 2018 (FY18) budget with a condition that it reduce payment differentials for a set of well-established site-neutral services, consistent with the Board's prior recommendations concerning payment differentials. The condition directs UVMMC to reallocate an $11.3 million proposed reduction in professional fees to E/M codes (both primary and specialty care), and to implement the reallocation in a manner that does not result in any increase in rate beyond the 0.72 percent approved by the Board or net patient revenue growth above 3.39 percent. The Board instructed the hospital that implementation of the reduction cannot negatively impact its participation in the ACO.[24]

Specifically, the Board included in its order:

> The Hospital is directed to apply the entire $11.3M reduction in professional fees to E&M codes (99201-99499) in the FY18 budget to address provider reimbursement differentials. The reduction should not negatively impact the Hospital's ACO participation or target.[25]

The Board included within its findings the hospital's calculation of the impact of reallocating a reduction in provider fees to enumerated E/M codes, stating that "the Hospital has estimated the gap in reimbursement levels is reduced to approximately 10%."[26] In a letter to the Board, BCBSVT confirmed that the differential will be reduced by approximately 34 percent for these specific codes, and that by

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[21] *See* Letter to Kevin Mullin, Chair, from Todd Keating, Chief Financial Officer, University of Vermont Health Network (Sept. 1, 2017), available at: http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports. See Attachment D.

[22] Act 113 (2016), Sec. 2.

[23] Act 54 (2015), Sec 23.

[24] Due to the complexity of adjusting fee-for-service rates, and taking into consideration input from stakeholders, the Board focused its actions on E/M codes only. *See* f.n. 5.

[25] Fiscal Year 2018 UVMMC Hospital Budget Order (Sept. 28, 2017), ¶ C, *available at* http://gmcboard.vermont.gov/content/fy18-individual-hospital-budget-information.

[26] *Id*. at ¶ 14. The remaining differential is approximate and does not account for the provider tax (independent practices do not pay the tax) or differences in payer mix between providers.

aligning reimbursement rates between providers, consumers will experience lower out-of-pocket costs for E/M services at UVMMC, and "will no longer be surprised by dramatically different reimbursement for the same fundamental healthcare practices."[27]

Although the Board ordered that UVMMC direct its proposed rate reductions to specific E/M codes, the Board has declined to recommend a commensurate increase in rates to independent providers. The assertion that inadequate commercial reimbursement rates for Vermont's independent physicians is the primary driver of their financial struggles or key reason they seek hospital-based employment has not been verified by data, cannot be gleaned from information provided by the carriers, and is contrary to the results of our clinician survey. Moreover, given that the Board does not regulate independent practice budgets and has no access to their financial information or data, the Board declines to recommend that their reimbursements be increased. Rather, any difference in reimbursements among providers that does not reflect increased services or a heightened level of care should be addressed by the site-neutral policy promoted by the Board, and implemented through our regulatory authority, as discussed in this memorandum.

Rate review. In addition to adjusting UVMMC's budget, the Board ordered a substantial reduction in the insurers' medical trends in the 2018 Vermont Health Connect (VHC) Qualified Health Plan rate filings. These reductions were intended, among other things, to encourage the insurers to negotiate rates with providers in a way that promotes reimbursement parity between academic medical centers, community hospitals, and independent providers for site-neutral services. The Board's decision regarding 2018 BCBSVT's VHC filing states: "[W]e 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." The 2018 MVP rate decision included substantially similar language.[28]

Increased Transparency. The Board remains committed to the premise that the public should have access to important information regarding health care costs and pricing. The Board recently requested and received tax information from each of the fourteen Vermont hospitals, the Brattleboro Retreat and Dartmouth Hitchcock Medical Center and published on its website the names and salaries of the hospitals' highest earners, including physicians.[29] For comparative and contextual purposes, the Board requested similar salary information from independent physicians through HealthFirst. HealthFirst declined the request.

Conclusion

As described in this report, the Board took substantial action to achieve site-neutral, fair reimbursements for medical services. The Board ordered that UVMMC, Vermont's academic medical center, reallocate $11.3 million in rate reductions to address the differential, cutting fees for E/M services and reducing out-of-pocket costs for consumers. The Board formed a workgroup of stakeholders to focus on the issue of pay parity, and generate possible solutions that could be implemented. The Board conducted a survey and

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[27] *See* Letter to Kevin Mullin from Sara Teachout, Director, Government, Public and Media Relations, BCBSVT (Sept. 28, 2017), *available at* http://gmcboard.vermont.gov/publications/legislative-reports/provider-reimbursement-reports, and included with this report as Attachment E.

[28] The 2018 VHC rate decisions are available on the Board's rate review website at http://ratereview.vermont.gov/.

[29] Based on information taken from each of the fourteen Vermont hospital's (regulated by the Board) 2016 Schedule H, Form 990s, the Board compiled and posted a list of hospital salaries exceeding $400k. *See* http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/Hospital%20Salary%20Info.pdf.

garnered useful information from a significant segment of providers in independent practices. Although the Board continues to focus on the transition from a fee-for-service reimbursement model to population-based payments, the Board's recent orders and recommendations, including those relating to transparency, will narrow the gap between providers, and move the State closer to a site-neutral reimbursement structure.

This memorandum satisfies the charge put forth by the legislature in Act 85 of 2017.

Attachments

A. Clinician Landscape Study Report
B. Payment Differential and Provider Reimbursement Reports: Update and Discussion
C. Onpoint Health Data Blueprint primary care analysis data table
D. Letter to Kevin Mullin from Sara Teachout, Director, Government, Public and Media Relations, BCBSVT (Sept. 28, 2017)
E. Letter to Kevin Mullin, Chair, from Todd Keating, Chief Financial Officer, University of Vermont Health Network (Sept. 1, 2017)