Physician Practices Report Update

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VERMONT
HEALTH CARE REFORM

Legislature's Question

- Should the state prohibit health insurers from reimbursing physicians in independent practices at lower rates than those at which they reimburse physicians in hospital-owned practices?

- Focus of this question is on *ownership*, but there are multiple factors contributing to price variation.

What are the factors driving variation?

- Commercial insurance
  - Negotiating power (or lack of) between insurer and a specific provider entity
  - Differences in negotiating power among providers compared to each other (size; volume)
  - Network design
  - Academic medical centers
- Public payers (Medicare; Medicaid)
  - Place of service (office versus hospital outpatient dept)
- Both
  - Payment mechanism itself

Variation - Public Payer analysis

- There is payment variation based on site of service
  - Not on *ownership* status
  - Physician office setting (hospital-owned or independent): fee for professional services; fee for practice expense
  - Outpatient hospital department: fee for professional services; facility fee
- Professional service fee is the same across both settings
- Practice fee & facility fee does vary
- Hospitals bill both ways, depending on the place the service is received

Medicare & Medicaid

Payment System	Office	Outpatient
Relative Costs	Based on national physician practice data on the direct costs of clinical labor, supplies and equipment for each service as well as survey data on the indirect costs of operating physician practices across different types of physician specialties. Referred to as “Practice Expense”; also includes costs associated with malpractice insurance.	Based on national Medicare cost report data on the departmental costs and two year historic utilization data.
Payment Unit	One service = One payment	Ambulatory Payment Classifications (APCs) Bundles the cost of ancillary services into the major procedure

Variation – Commercial analysis

- There is payment variation based on whether the practice was affiliated with an academic medical center
  - Not on *ownership*
- Analysis is limited to:
  - Primary care practices that participate in the Blueprint for Health
  - 10 most frequent CPT codes – average across all carriers
    - 60% of all professional services in VHCURES

Variation in Top 10 Codes

Average Allowed Price by Practice Ownership, Top 10 Procedure Codes, Excluding Services with Modifier

Services rendered during calendar 2012

			Hospital-Owned		
CPT Code	FQHC-Owned	Independent	Non-Academic	**Academic**	Number of Services
99213	$73.82	$80.68	$75.66	**$98.71**	142,203
99214	$111.45	$120.03	$112.80	**$148.77**	84,684
90471	$22.11	$26.82	$22.44	**$38.41**	66,184
99396	$139.72	$142.77	$141.57	**$180.44**	26,364
36415	$7.24	$7.37	$7.11	**$10.28**	27,534
90460	**$45.41**	$34.60	$33.54	$33.50	27,667
90658	$15.36	$19.74	$18.07	**$27.09**	15,011
90472	$15.39	$20.04	$18.16	**$29.89**	12,317
99395	$127.38	$129.59	$128.66	**$163.17**	9,556
87880	$21.87	$23.52	$21.31	**$49.70**	6,628
					418,148

Draft AOA Recommendation

- Continued focus on payment variation in the context of moving toward a new, unified payment system and all payer waiver based on the following principles:
  - Transparency
  - Adequacy and sufficiency of reimbursement
  - Address the cost-shift among payers

Notes on Table – Slide 7

CPT Code	Definition
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient, visit typically 25 minutes
90471	Administration of 1 vaccine
99396	Established patient periodic preventive medicine examination age 40-64 years
36415	Insertion of needle into vein for collection of blood sample
90460	Admin. of first vaccine or toxoid component through 18 years of age with counseling
90658	Vaccine for influenza for injection into muscle, patient age 3 years and older
90472	Administration of vaccine
99395	Established patient periodic preventive medicine examination age 18-39 years
87880	Strep test (Streptococcus, group A)

Practices are limited to those participating in the Blueprint for Health. Identification of ownership by the Blueprint.

Selection and ordering of codes is based on all occurrances, including those with modifiers. Average price is calculated only for those services with no reported modifier.

Allowed price is the sum of payer and patient payments and excludes any subsequent payments

Bold indicates highest allowed price for that service