



State of Vermont
Agency of Administration
Health Care Reform
Pavilion Office Building
109 State Street
Montpelier, VT 05609-0201
www.adm.state.vt.us

[phone] 802-828-2316
[fax] 802-828-3320

Robin Lunge, Director

Report on Payment Variation in Physician Practices

Robin Lunge,
Director of Health Care Reform
Agency of Administration
On behalf of the Secretary of Administration

Kara Suter,
Director of Payment Reform
Department of Vermont Health Access

Steve Kappel,
Policy Integrity

November 26, 2014

Introduction

Act 144 of the 2013-2014 session of the Vermont Legislature charges the Secretary of Administration with recommending whether the State should prohibit health insurers from reimbursing physicians in independent practices at lower rates than those at which they reimburse physicians in hospital owned practices for providing the same services. To meet this charge, this report provides background information on why there are different payments for the same health care services in Vermont, known as price or payment variation, and summarizes earlier reports received by the Green Mountain Care Board on the topic.

The report describes how public payers determine prices, which includes a payment differential based on where the service is delivered, but not on ownership. In addition, the report discusses the available data, which is limited to primary care physician practices participating in the Blueprint, and determines that the current variation in commercial payment rates appears to be based on affiliation with an academic medical center, not based on hospital ownership.

Finally, the report recommends further analysis on this important topic in the context of pursuing payment and delivery system reform to ensure that a new payment system takes into account the current variation.

Process and Public Input

The Director of Health Care Reform received a number of letters from physician practices and others providing input into the issue. These letters are available by contacting the Agency of Administration.

The Director of Health Care Reform requested time on the agenda of the Green Mountain Care Board to share the analysis prior to its finalization, to hear questions and clarifications from GMCB members, and to allow for public input and questions. This public meeting was held on November 20, 2014. The Director's presentation to the GMCB is provided in Appendix A.

Background

Throughout the U.S. health care system there is wide variation in the amount paid for a specific health service. Multiple factors contribute to variation, both from the provider side and the payer side of a payment transaction. Major factors contributing to price variation in Vermont are identified below. There are differences in the influence of these factors between the Commercial and Public sectors:

1. Relative Power in Establishing Payment Rates

Medicare and Medicaid, or public payers, have the legal authority to unilaterally set payment rates. The next section of this report elaborates on how public payers determine payments to providers.

Commercial payers typically negotiate payment with health care providers, but the structure of these negotiations is strongly influenced by the relative market power of each party to the negotiation. As in any market-based system, providers with more volume or who are larger have a greater ability to negotiate with a payer than small or low volume providers. Smaller providers may be "price takers" even with payers with smaller market share; in other words, these

providers may not truly be able to negotiate, but may be expected to simply accept the proffered rate. On the other hand, in a small market like Vermont, a provider may have a monopoly in a given geographic area. In that case or in the instance where a specialty provider has a rare or unique skill, this may allow that provider to have more influence over the payment rate and allow for negotiation. These factors, among others, influence the market power of any specific provider with any given payer.

2. Product

Payments differ based on how a particular insurance product limits the provider network. For example, a health maintenance organization which has a closed or limited network, may be able to use that product design to negotiate lower provider reimbursement by only allowing the lowest priced providers inside the network.

3. Payment mechanism

Currently, payments may be based on provider costs (e.g. Medicare payments to Critical Access Hospitals), discounted charges, fee schedules, and prospective payment systems, such as Diagnosis Related Groups (DRGs), which establish payment for a hospital inpatient stay based on factors such as diagnoses and procedures, but are not affected by quantities of services provided or charges.

4. Provider Type

Some payers will pay less for the same service if it was provided by a different class of health professionals. For example, Medicare and Medicaid discount payments to master level psychologists compared to payments made to psychiatrists.

5. Place of service

Some payers will pay for the same service at different rates depending on where that service was provided.

Public Payers: Medicare and Medicaid

Prior reports have identified location of care as contributing to payment variation, but it is important to distinguish location from ownership. Public payers do not negotiate rates or distinguish payment by ownership status. As opposed to the commercial marketplace where size and volume may impact negotiated rates, public payers (Medicare and Medicaid) organize their payment systems by setting of care. The public payer ambulatory payment systems described within this report includes the physician office setting and outpatient hospital department (OPD) setting. Systems that set rates in these settings reflect the relative price of a service within each setting of care. Setting of care is determined by what “Place of Service” or “POS” is included on the bill for the service.

In Vermont, the Outpatient Prospective Payment System (OPPS) and the Physician Fee Schedule are used to pay for services in physician offices and in outpatient hospital departments.¹ There are federal rules for determining whether a physician practice is “part of” a hospital, which primarily relate to the location and administrative and financial relationships of the practice and

¹ In Medicare, Critical Access Hospitals are cost-based reimbursement and not OPPS. VT Medicaid reimburses all hospitals under OPPS, although sole community hospitals (SCHs) are adjusted slightly above non SCHs.

hospital provider. These rules can be found in 42 C.F.R. § 413.65.² Based on these rules, hospitals routinely bill Medicare and Medicaid services in both hospital outpatient department and physician office settings of care.

Payments to Physicians

Public payers do not distinguish payments to physicians by ownership status. Physician office practices are reimbursed for professional services the same regardless of ownership status. The component of payment for professional services—known as “physician work” is the same regardless of setting of care.

In the other most common ambulatory setting of care, hospital Outpatient Department (OPD), a separate payment is made for professional services (“physician work”) and facility fees—known as Ambulatory Payment Classifications (APCs). The professional service payment is the same across both settings of care; said another way, the component of payment associated with the work of the physician (or other allied health professional) is paid the same in both the office and outpatient hospital setting of care. In fact, most hospital systems bill both the physician office setting and the outpatient hospital settings, in accordance with Medicare regulations, in addition to the traditional acute setting.

Payments to Hospitals

Despite the congruence of professional payments across settings, the payments for facility fees do vary because they are based on different data and methodologies. Office practices receive payments for their relative “practice expense” while outpatient hospitals receive payments based on “ambulatory payment classifications,”³ Comparability between settings is a challenge because of the ability to distinguish hospital ownership in the data, differences in underlying data used to set rates, conversion factors, and differences in the amount of “packaging” in the outpatient setting. The main differences in the payment systems are summarized in the table below.

Payment System	Office	Outpatient
Relative Costs	<p>Medicare and Medicaid: 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.</p> <p>Referred to as “Practice Expense”; also includes costs associated with malpractice insurance.</p>	<p>Medicare and Medicaid: Based on national Medicare cost report data on the departmental costs and two year historic utilization data.</p>
Payment Unit	One service = One payment	<p>Ambulatory Payment Classifications (APCs) Bundles the cost of ancillary services into the major procedure</p>

² <http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol2/pdf/CFR-2013-title42-vol2-sec413-65.pdf>

³ In the office setting, practices also receive a payment for malpractice insurance costs, but this is very small relative to the payment for practice expenses.

Commercial Payers

Based on interviews described in the 2014 Price Variation Analysis Report⁴ produced for the Green Mountain Care Board in August 2014, most small physician practices are “price takers” – an offer is made by a payer and the provider either accepts or rejects the offer, without further opportunity for payment negotiation⁵. In contrast, large providers do engage in negotiations with payers. These negotiations are much more similar to classic contractual negotiations than to the “price taker” model.

Analysis

Efforts to explore the question of payment variation by ownership status in the commercial insurance market were hampered by the lack of a readily-available source that supports payment analysis by practice ownership. The one source for this information that we were able to identify is the Blueprint for Health’s practice roster. This roster identifies practice ownership type (FQHC, hospital-owned, independent / single site, and independent / multiple site). Analyses presented below relied on this information to classify practices. It is important to understand that this analysis is limited to primary care practices that participate in the Blueprint. While this is a large majority of primary care practices, between 75 to 80%, patterns may differ for specialty practices.

Analyses were conducted using data from VHCURES, Vermont’s all-payer claims database. Claims included in the analysis were for Vermont residents under 65 and were limited to primary payer. Analyses looked at average payment across ownership types for individual CPT codes. CPT (Current Procedural Terminology) is a coding system developed by the American Medical Association and universally used for billing of professional services. In addition to the basic 5 character code, CPT supports the use of “modifiers” which provide additional information. For example, modifiers are used for the two-part Medicare payments described above.

Findings

Looking at the 10 most frequent CPT codes, which accounted for just under 60 percent of all professional services performed by Blueprint practices in 2012, there was a clear difference in average payment between hospital-owned practices and all others. Conversations with payers suggested that the difference is not based on ownership, but instead on academic / non-academic status. We repeated our analyses separating out practices owned by the University of Vermont Medical Center, formerly Fletcher Allen, from all other hospital-owned practices and confirmed this. The table below illustrates the variation found in the commercial setting, which appears to be based on affiliation with an academic medical center. It is important to note that this could also be based on size or volume, since the state’s only academic medical center is also the largest hospital. Variations in prices could also be based on the commercial payer mix.

⁴ Available here:

http://gmcboard.vermont.gov/sites/gmcboard/files/Meetings/Presentations/Price_Variation_Analysis_GMCB1002_14.pdf

⁵ Other contractual terms may be negotiated with smaller providers

Average Allowed Price by Practice Ownership, Top 10 Procedure Codes, Excluding Services with Modifier⁶

Services rendered during calendar 2012

CPT Code	FQHC-Owned	Independent	Hospital-Owned		Number of Services
			Non-Academic	Academic	
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

As can be seen, with the exception of one code, variation is quite small, except for the variation between practices affiliated with academic medical center

⁶ Labels for CPT codes are provided in the second part of the table.

Discussion and Recommendation

The findings in this report illustrate that the majority of payers in Vermont do not reimburse hospital-owned office practices higher on average than physician-owned office practices for the 10 most common procedure codes for primary care services. The analysis found some variation in the commercial market attributable to academic medical center affiliation but not ownership status. Among public payers, the analysis found variation associated with differences in payment systems across settings of care rather than ownership status. This analysis provides a picture of payments to physician-owned practices in comparison to payments to hospital-owned practices, but it is important to note that rates for hospital-owned practices are a portion of a larger strategic revenue plan.

Whether these differences are legitimate reasons for differential payments is subject to debate with good arguments on all sides. Independent physicians will argue that smaller practices promote innovation, are more nimble, and could bring new ideas that reduce costs. Some will also argue that some practices are at the edge of sustainability and this must be considered in the price. Hospitals will argue that given the fixed costs of these institutions, that prices for services in outpatient settings should reflect the higher cost of these settings. Academic medical institutions will argue that supporting medical education through higher prices is important and that Vermonters benefit from having an academic medical center in the state, in part because of the research focus and in part because medical professionals tend to settle where they go to school, thus providing a needed workforce. Of course, in today's market-based system, these considerations while important, do not ensure leverage in price negotiation.

If the Green Mountain Care Board is to move forward with a regulatory system in lieu of today's market-based system, trying to determine the "right" price for a service should not be done in a one-off manner. The determination needs to be part of the larger payment and delivery system reform efforts that Vermont is engaging in. As Vermont begins its analysis and research on how to move forward with an all payer waiver, the state has an opportunity to look at these issues in the larger context and from multiple angles.. Our recommendation is that the administration and the GMCB continue to pursue payment and delivery system reform and to ensure that this issue remains an important part of that discussion

Appendix A

Physician Practices Report Update

Robin J. Lunge
Director of Health Care Reform

November 20, 2014

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	<p>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.</p> <p>Referred to as “Practice Expense”; also includes costs associated with malpractice insurance.</p>	<p>Based on national Medicare cost report data on the departmental costs and two year historic utilization data.</p>
Payment Unit	<p>One service = One payment</p>	<p>Ambulatory Payment Classifications (APCs) Bundles the cost of ancillary services into the major procedure</p>

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

CPT Code	FQHC-Owned	Independent	Hospital-Owned		Number of Services
			Non-Academic	Academic	
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 occurrences, 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

CPT® codes, descriptions and other data are copyright 1966, 1970, 1973, 1977, 1981, 1983-2014 American Medical Association. All rights reserved.

CPT is a registered trademark of the American Medical Association.