

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access (DVHA)

SUBJECT: Resource Based Relative Value System (RBRVS) and Outpatient Prospective Payment System (OPPS) – State Plan Amendment (SPA) 12-001 and 12-003

Response to Public Comments received as of December 27, 2011:

The DVHA received 27 unique comments related to SPA 12-001 (RBRVS). We received no comments related to SPA 12-003 (OPPS). We are making no changes to SPA 12-003 related to changes to OPPS payments from what was proposed.

The DVHA appreciates all of the thoughtful comments submitted related to the proposed RBRVS methodology changes. We have numbered each comment received within this document. Comment #1 addresses multiple aspects of the RBRVS methodology and our response is shown below. Comments #2 through #26 relate specifically to the proposed reduction in payments for radiology services. The DVHA has provided one response to these comments as a group shown below. Comment #27 relates specifically to behavioral health services. Our response to this comment is also shown below.

The DVHA believes that it has effectively addressed the comments submitted and has taken action to address many of the commenters' concerns. As such, we do not believe it is necessary to conduct a public meeting at this time.

Our response to the comments appears at the front of this document followed by the individual comments themselves. Also as part of our response is an attachment which appears after page 22 of this document and is incorporated by reference. Our adjusted language to SPA 12-001 has also been posted to the DVHA website.

It is the DVHA's intent to implement the RBRVS methodology as described in the December 29, 2011 version of the SPA 12-001 for services with dates of service on or after January 1, 2012.

Response to Comment #1:

The DVHA appreciates the thoughtful comments from the Vermont Medical Society. With respect to the recommendation to utilize one conversion factor, we concur that it would be optimal for DVHA to do so in the same manner as implemented by Medicare. The DVHA is limited in its ability to pay providers based on the appropriation from the state Legislature. Absent the legislative appropriation to implement the single Medicare conversion factor of \$33.9764, we considered one conversion factor for all services that would be affordable under current appropriations (\$26.6375, or 78.4% of Medicare). We determined that in order to ensure accessibility to high-volume services used by Medicaid beneficiaries, we needed to implement three conversion factors.

With respect to the recommendation related to the Geographic Practice Cost Indices (GPCIs), we believe that it is important for the SPA to be explicit as to the GPCIs that DVHA is using in a rate year. Therefore, we do not agree that the reference to the GPCIs should be removed from the state plan amendment. We are aware that the Medicare Modernization Act of 2003 established the floor of 1.00

for the Work GPCI. This has been extended through February 29, 2012 by the Temporary Payroll Tax Cut Continuation Act of 2011 passed on December 23, 2011. Because the DVHA does not want to be dependent upon Congressional action for the remainder of 2012, we have set our Work GPCI at 1.00 for all of Calendar Year 2012. We have set the Practice Expense GPCI at 1.008 and the Malpractice Insurance GPCI at 0.554 as defined for Vermont in Medicare's Final Rule for RBRVS for Calendar Year 2012. Because of the increase to the Work GPCI from 0.977 as originally proposed to 1.00, we are required to lower all of the conversion factors slightly in order to maintain payments neutral in the aggregate.

With respect to the change in radiology rates proposed for 2012, last year we felt an adjustment was necessary in radiology rates since the rates that had been paid by DVHA prior to 2011 were at 104.2% of the 2011 Medicare rates while all RBRVS services, on average, were paid at 73.2% of the 2011 Medicare rates. With a limited budget, we felt it was necessary to align Medicaid radiology payments more closely with other professional services as a percentage of Medicare. This year, we proposed a further reduction in an effort to further align radiology payments with other professional services paid in our RBRVS system.

Upon further consideration, the DVHA has decided to change its proposed conversion factor for both radiology and chiropractic services. For these services, we will use a conversion factor of \$27.98 which is the same conversion factor that will be used for E&M and maternity-related services. This policy is similar to the policy put in place by DVHA effective January 1, 2011. Refer to the revised fiscal impact that accompanies this position statement for additional details.

With respect to the recommendation for DVHA to have an overall strategy related to the reimbursement for professional services under DVHA's RBRVS, we concur that DVHA's goal for setting rates for all professional services should be at or above the prevailing Medicare rate. In light of V.S.A. Title 32, § 307(d)(6) and Act 48, the DVHA is ready to work with our partners in other state leadership roles to enhance funding for professional service rates paid by the DVHA. Ultimately, however, we are dependent upon the appropriation given to us by the Legislature and must meet our obligation to contain spending within that appropriation. The commenter referenced recommendations for the Green Mountain Care Board and the Vermont Department of Labor. Since the recommendations to these state agencies are outside of DVHA's jurisdiction, we have passed on the comments to the appropriate representatives at each agency.

In summary, in light of the comments received from all commenters, the DVHA has changed its proposal for RBRVS payments for Calendar Year 2012 as originally proposed as follows:

Feature	Originally Proposed	Final Decision
Work GPCI	0.977	1.000
Practice Expense GPCI	1.008	1.008
Malpractice Insurance GPCI	0.554	0.554
Conversion Factor: Well Child Visit codes	\$29.20	\$29.08
Conversion Factor: Behavioral health codes	\$29.20	\$29.08
Conversion Factor: E&M codes	\$28.09	\$27.98
Conversion Factor: Maternity-related codes	\$28.09	\$27.98
Conversion Factor: Radiology codes	\$22.60	\$27.98
Conversion Factor: Chiropractic codes	\$22.60	\$27.98
Conversion Factor: All Other codes	\$22.60	\$21.28

Response to Comments #2-26:

The DVHA appreciates the concerns expressed by commenters that the rate reduction that we proposed for radiology services would be significant. We also understand that it would be optimal that the rates that DVHA pays for services under the RBRVS methodology be set at or above Medicare's rates. The DVHA is limited by the funds appropriated to it by the Legislature. Therefore, at this time, we are not able to pay any services under our RBRVS system at Medicare's rates. We have considered the comments we received and have decided to change our proposed conversion factor from \$22.60 to \$27.98 as stated above.

Response to Comment #27:

The DVHA appreciates your comment and has not proposed any changes for behavioral health services from what was originally proposed on December 16, 2011.

Public Comments received as of December 27, 2011:Comment #1

In response to notice posted by the Department of Vermont Health Access (DVHA) on its website on December 16, 2011, the Vermont Medical Society (VMS) is providing these comments regarding DVHA's proposed Vermont Medicaid State Plan Amendment (SPA) #12-001 to implement changes to the Resource Based Relative Value Scale (RBRVS) methodology to pay for professional medical care services as specified in the State Plan.

While the VMS strongly supports the Department's efforts to improve its fee schedule methodology, the VMS opposes the Department's proposed SPA #12-001 for a number of policy reasons, as well as serious concerns regarding the lack of due process in the SPA adoption process and the SPA's inconsistency with Act 48 – Vermont's health care reform legislation. In outlining the VMS's specific policy and adoption process concerns, the VMS also provides recommendations for improving the Department's fee schedule and its amendment process.

Due to the extremely limited comment period and the lack of a public hearing, the VMS believes DVHA has unduly restricted its ability to receive adequate physician and hospital input on the SPA.

DVHA's public announcement related to the SPA was available on its website the morning of December 16th and the announcement indicated that DVHA would accept written comments by no later than 4:30 p.m. December 27th. The public announcement also indicates that there are no public meetings scheduled at this time. The department is therefore only providing interested parties seven business days over the intervening holidays for the development and submittal of comment on a highly technical and a significant public policy issue that represents an early indication of the state's approach to health care reform.

Recommendation: In order to provide a reasonable amount of time to provide informed written comments on the proposed SPA, the VMS requests that the comment period be extended to allow for a comment period of at least 30 days from the date of the original announcement. In addition, the VMS requests that a public hearing be held.

The VMS believes that the State of Vermont should lead by example as it implements Act 48 – Vermont's health care reform legislation.

Under Act 48, 18 V.S.A. § 9371, fourteen principles are adopted as the framework for reforming health care in Vermont. Principle 12 states that the system must enable health care professionals to provide, on a solvent basis, effective and efficient health services. In addition, 18 V.S. A. § 9376 charges the Green Mountain Care Board (GMCB) with setting reasonable rates for health care professionals, and it states "it is also the intent of the general assembly to eliminate the cost shift between the payers of health services."

According to a DHVA budget adjustment analysis: "(T)hree of our largest category of service expenditures ~ outpatient, physician, and pharmacy ~ have a 6-year average growth rate of 9.1%, 8.7%, and .3% respectively. In state fiscal year '11, our costs in all three categories were less than that spent in SFY '10. Had predictable growth trends carried through into SFY '11, our overall costs would have been \$22 million higher."¹ In conversations between the VMS and the key members of past administrations, linkages were made between improvements to Medicaid fee schedule and reductions in overall physician service-related spending growth trends.

It is also worth noting that Vermont physicians had the lowest level of spending per capita below Medicare's sustainable growth rate formula (SGR) target for the entire county. This is based on a recent article in the New England Journal of Medicine² on a scheduled cut in Medicare physician fees of 27.4% for 2012 due to the SGR. Since Medicare uses a single fee schedule, this measure of comparative efficiency is based on the conservative utilization and low intensity of services provided by Vermont physicians to their patients when compared to their national peers.

According to DHVA's proposed SPA analysis, the Medicaid fee schedule would reimburse most procedures at approximately 66.5 percent of Medicare, and it would reimburse office visits and maternity visits at approximately 82.7 percent of Medicare -- with an overall reimbursement level of 78.7 percent of Medicare. However, the analysis overstates its reimbursement percentages, since it does not reflect an additional 2.0 percent cut applied to all codes, except for the evaluation and management (E&M) codes. By way of contrast, DVHA reimburses federally qualified health centers (FQHCs) on a cost basis at 125 percent of Medicare, and the VMS estimates that private health insurance companies reimburse professional services at rates in excess of 132 percent of Medicare. Therefore, DHVA is reimbursing most physician services at half the rate of private insurance companies, and it pays non-FQHC primary care physicians at two-thirds the rate paid for similar primary care services in FQHCs.

In addition to the Medicaid fee schedule, the other state-administered fee schedule for professional services is the Vermont Department of Labor's (VTDOL) Rule 40 relating to workers' compensation. When Rule 40 was initially adopted on April 1, 1995, the CPT reimbursement amounts were based on the amounts paid by Blue Cross Blue Shield of Vermont (BCBSVT). The Rule 40 professional procedure amounts were last *revised* by the VTDOL in 2006 after an 11-year period of time had passed. *However*, the 2006 update did not update the conversion factor for anesthesia *services*, and the payment for these *services* has not changed since 1995 -- *over 16* years ago. Given the complex nature of the worker's compensation system, making timely updates to its fee schedule is an important aspect of ensuring access to appropriate medical care for injured workers.

As the state's health care reform website indicates: "cost shifting is a term used to describe the costs that one group is paying for another's use of *services* ... when certain payers (such as Medicare or Medicaid) set reimbursement at less than the provider's cost of *services*, costs are shifted to commercial plans and are reflected in commercial health insurance premiums."³

The multiple state officials involved in implementing Vermont health care reform legislation *have* made it clear that they anticipate major changes in the way physicians and other health care providers are reimbursed in the future. The VMS believes it reasonable to ask state *government* to also end the long-standing practice of underpayment by the reimbursement systems they control.

Recommendation: With respect to payment reform, the Green Mountain Care Board should ensure that reimbursement amounts paid or established by DVHA and the VTDOL are consistent with the principles of Act 48 and are therefore sufficient to "enable health care professionals to provide, on a solvent basis, *effective* and efficient health *services*." The VMS believes that the GMCB's charge also includes helping to achieve "the intent of the general assembly to eliminate the cost shift between the payers of health *services*."

The VMS believes that the proposed state plan amendment is inconsistent with the Resource Based Relative Value Scale (RBRVS) as a pricing methodology.

The RBRVS Payment Methodology was implemented in Medicare in 1992 and is based on a formula that includes geographically adjusted relative value units (RVUs) for each procedure (CPT/HCPCS) and a single conversion factor (CF). The 2011 conversion factor for Medicare is \$33.9764. Therefore, Medicare's reimbursement for CPT 99213, the most common office visit in Vermont = \$67.90 (\$33.9764 (CF) x 2.00 (RVU)).

The RVU for each CPT code is determined using three separate factors: physician work, practice expense, and malpractice expense. Physician work RVU is based on the relative level of time, skill, training and intensity to provide a given *service*. On average, the work component comprises 52.466% of the total relative value for a *service*, the practice expense component comprises 43.669%, and the PLI component comprises 3.865%. *Over* time, CMS has placed greater value on the work related to the evaluation and management codes (E&M). This is demonstrated by the fact that payment for the E&M codes using the 2011 conversion factor and the 2012 RVUs would increase by \$862,804 or 2.1 percent over the 2011 level.

When DVHA adopted its current RBRVS-based system on January 1, 2011, in contrast to Medicare's single conversion factor, DVHA adopted two conversion factors. In the proposed SPA, DVHA is proposing three different conversion factors for different ranges of procedure codes that will result in Medicaid payment at three different percentages of Medicare, as opposed to the RBRVS methodology design's single percentage.

The proposed SPA's three conversion factors are calculated to be at 85.9 percent, 82.7 percent and 66.5 percent of Medicare (see attached chart). It is also important to note that DVHA's calculations do not reflect an additional 2.0 percent reduction that DVHA applies to all codes except for E&M codes.

DVHA's use of three different conversion factors -- instead of Medicare's use of a single conversion factor -- fundamentally undermines the rationale of the RBRVS system and destroys the integrity of the RBRVS Payment Methodology as a means to establish appropriate reimbursement amounts. As a consequence, the multiple conversion factors debase the work and practice experience values for many of the procedure RVUs established by CMS by as much as 23 percent.

Also included in Act 48's fourteen principles, is principle (4) which states that "primary care must be enhanced so that Vermonters have care available to them." The VMS would add to the principle the need to improve access to psychiatric care.

Recommendation: The VMS recommends that DHVA adopt a single conversion factor for its proposed RBRVS fee schedule and the conversion factor should be the one used by Medicare. This recommendation is consistent with the requirements of V.S.A. Title 32, § 307(d)(6) which calls for the governor's proposed financial plan for the Medicaid budget to include "recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement."

Absent the use of a single conversion factor, DVHA should not further compromise its RBRVS Payment Methodology by moving away from the current two conversion factors to three conversion factors. As noted above, one consequence of the proposed SPA's new conversion factor will be a reduction in payment for E&M codes of \$862,804 from CMS's rebased RVUs. Since E&M codes are typically used by primary care physicians, the VMS recommends that the conversion factor be at a sufficient level to allow for the increased reimbursement appropriate to the increased value of the E&M codes' RVUs.

The SPA's adoption of specific Vermont Geographic Practice Cost Indices (GPCIs) will cause the DVHA fee schedule to further deviate from Medicare's RBRVS methodology.

The geographic adjustments to the RVUs are made using Geographic Practice Cost Indices (GPCIs). There are three GPCIs, corresponding to the three components of the payment schedule: work, practice expense, and professional liability insurance (PLI). Three sets of GPCIs are defined for each of the 89 Medicare physician payment localities that currently exist.

The Medicare Modernization Act of 2003 (MMA) established a floor of 1.00 for the work GPCI in 2004, and the provision has been extended through December 31, 2011. Absent Congressional action, on January 1, 2012, the current work GPCI floor of 1.00 for Vermont physicians was scheduled to *revert* back to approximately 0.968. *However*, the recent two-month agreement on the payroll tax bill reauthorizes the work GPCI floor of 1.00 from January 1, 2012 to February 29, 2012. Since the work component comprises 52.466% of the total relative *value* for a *service*, the SPA's use of 0.977 for the work GCPI would represent an additional reimbursement cut of 1.21 percent (0.23×52.466) from the amount otherwise paid, using the RBRVS formula based on Congress' reauthorization of the 1.00 work floor.

Recommendation: DVHA should delete reference in the SPA to specific GPCIs and instead rely on the GCPIs established by CMS each calendar year for Vermont.

The VMS believes that the proposed 21.4 percent reduction in payment for the radiological codes in 2012, in combination with the 25.3 percent reduction in payment for these same procedure codes in 2011, is excessive and it could have an adverse impact on Medicaid beneficiaries' access to radiological services in Vermont.

The two-year cumulative 46.7 percent cut in Medicaid reimbursement for radiology procedures is *even* greater than the 27.4 percent Medicare sustainable growth rate (SGR) cut that was scheduled to take place on January 1, 2012 and was recently delayed by Congress until March 1, 2012. The VMS

believes the two-year 46.7 percent cumulative radiology payment cut is probably the largest Medicaid payment reduction in the country and that it borders on being confiscatory in nature.

Under 42 U.S.C. § 1396a.(30) (A) a state Medicaid program must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and *services* are available under the plan at least to the extent that such care and *services* are *available* to the general population in the geographic area."

The VMS is concerned that the proposed 21.4 percent reduction in payment for radiological *services* could result in independent community-based radiology practices having to limit the number of Medicaid beneficiaries they treat in order to meet the costs of operating their practices. These reductions will also place further financial strains on the hospital-based practices.

The Medicaid budget for state fiscal year 2011 (SFY11) included \$2 million of anticipated *savings* that would be achieved by requiring prior authorization for selected radiology services. The *savings* were based on an anticipated reduction of the utilization of high-tech imaging *services* for Medicaid beneficiaries of 20 percent.

With respect to Computed Tomography (CT) use in Vermont, the state has one of the lowest rates in the country. The January 15, 2010, Act 49 report from the Vermont Department of Banking, Insurance, Securities and Health Care Administration on *Recommendations to Improve Utilization and Variation in Health Care Services in Vermont* states on page 23 the following: "Between the years of 2003-2007, the rate of CT *events* increased nationally (7.3% growth rate), in the New England region (7.5%), and in the state of Vermont (5.7%). While the rates of CT events increased in Vermont over 5 years, the state has much lower rates than the nation and the adjoining HRR's. The national average for CT events was 63.8 events per 100 people while the Vermont state average was just 41.8."⁴

During the course of the legislature's consideration of the department's high-tech imaging prior authorization request, the VMS repeatedly raise concerns that the anticipated 20 percent reduction in imaging services in a state with one of the lowest rates the country could result in Medicaid beneficiaries experiencing inappropriate denial of access to diagnostic services.

At 22.5 percent in 2009, Vermont's Medicaid program is the second highest in the country as a percentage of a state's total personal health care spendings.⁵ The proposed 21.4 percent reduction in Medicaid reimbursement on top of last year's 2S.3 percent reduction in reimbursement for radiology services, coupled with high Medicaid enrollment and the anticipated 20 percent decrease in utilization through the newly instituted Medicaid prior authorization requirements, could create "a perfect storm" effect and significantly harm the state's ability to attract and retain community-based and hospital-based radiologists.

Recommendation: In order to avoid a two-year cumulative 46.7 percent cut in Medicaid reimbursement for radiology procedures, DHVA should retain radiology procedures under the higher conversion factor. If it is necessary to find additional resources to achieve this recommendation and other recommendations, the VMS suggests using a part of the \$22 million in savings attributable to decreased physician services identified in the aforementioned DVHA budget adjustment document. Due to the federal government sharing in the cost of the Medicaid program, Vermont would pay approximately 42 percent of any added cost.

The VMS recommends that DHVA develop a strategy to fully adopt Medicare's Part B RBRVS reimbursement methodology with a single conversation factor, based on the Medicare level.

V.S.A. Title 32, § 307(d)(6) calls for the governor's proposed financial plan for the Medicaid budget to include "recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement."

As stated earlier, under DHVA's proposed SPA analysis, the Medicaid fee schedule would reimburse most procedures at approximately 66.5 percent of Medicare, and it would reimburse office visits and maternity visits at approximately 82.7 percent of Medicare -- with an overall reimbursement level of 78.7 percent of Medicare. In addition, the analysis does not reflect an additional 2.0 percent cut applied to all codes, except for the evaluation and management (E&M) codes. Under such low reimbursement levels, Vermont cannot hope to attract and retain the necessary primary care and specialty physician workforce to provide health care services to an increasingly aging population and 47,000 additional Vermonters with health insurance coverage.

Under section 1202 of the amended federal Patient Protection and Affordable Care Act (PPACA), Medicaid reimbursement to primary care practitioners who practice family medicine, general internal medicine, and internal medicine for evaluation and management codes and some immunization administration codes will be increased for 2013 and 2014 to 100 percent of the Medicare rate (using July 1, 2009 as a base year).

Using the attached chart's amount of \$24.3 million in payments to primary care physicians at a level of 82 percent of Medicare, the section 1202 increase will result in approximately \$5.3 million in additional federal funds for Medicaid reimbursement of primary care physicians for 2013 and 2014.

Recommendation: In anticipation of the additional federal funds under section 1202, DVHA should submit to the General Assembly recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement based on the RBRVS methodology.

¹ <http://dvha.vermont.gov/budget-legislative/sfy12-baa-12-S-11-.pdf>

² The Sources of the SGR "Hole"; Ali Alhassani, M.Sc., Amitabh Chandra, Ph.D., and Michael E. Chernew, Ph.D.;

December 21, 2011 (10.10S6/NEJMp11130S9)

³ http://hcr.vermont.gov/contain_costs/decrease_cost_shift

⁴ http://www.bishca.state.Vt.us/sites/default/files/Act-49-Process-Recommendations-1-15-10_O.pdf

⁵ Health Spending by State of Residence, 1991-2009; Medicare & Medicaid Research Review 2011: Volume 1, Number

4; Cuckler, G. et al; pages E12-E13.

Comment #2

The Vermont Radiological Society (VRS), a professional organization representing Vermont's more than 50 actively practicing radiologists in addition to radiation oncologists, medical physicists, and radiology residents and fellows, would like to comment on the proposed SPA #12-001. We support the comments and recommendations set forth in the letter of response from the Vermont Medical Society. The VRS opposes the proposed drastic cuts in Medicaid Reimbursement for diagnostic imaging services due to begin on January 1, 2012. The proposed reduction in payments for radiological services of 21.4% in 2012, on top of the 25.3% reduction in the same codes in 2011, is

excessive and represents the most dramatic aggregate cut of any healthcare provider class. As the Vermont Medical Society points out, "the two-year 46.7 percent cumulative radiology payment cut is probably the largest Medicaid payment reduction in the country " and "borders on being confiscatory in nature." We are concerned that the proposed fee schedule changes will have the potential to devastate access to appropriate imaging to vulnerable citizens in Vermont. An additional reduction in reimbursement could jeopardize the ability of Vermont to recruit and retain high quality community-based and academic radiologists.

As you know, Vermont has the lowest utilization of advanced imaging of all 50 states, and some have even considered us to be "best practice" for imaging utilization. This is not a position that happened by chance. Despite the rural location of many of our community-based radiologists, Vermont radiologists communicate well with each other and work together in order to provide the highest quality, safe and appropriate imaging for our patients. For example, just in the last year, Vermont radiologists from all over the state have collaborated with success in an effort to reduce repeat CT scan imaging for trauma patients who are transferred to a Level 1 Trauma Center for definitive diagnosis and treatment. To our knowledge, an effort like this among radiologists in any state is unprecedented. Although initiated at Fletcher Allen Health Care, this project has the active participation of all of the state's radiologists and hospitals as well as The Vermont Program for Quality in Health Care. As a group, Vermont radiologists continually work together with the benefit of the patient in mind.

Underscoring our commitment to appropriate patient imaging care for the citizens of Vermont, earlier this year the Vermont Radiological Society published the following Position Statement:

- Vermont's Radiologists are a dedicated group of physicians with advanced and specialized training in the tailoring and interpretation of medical imaging and the performance of image-guided minimally-invasive diagnostic and therapeutic procedures. As such, Radiologists in Vermont typically possess an M.D. degree and subsequently complete a five year residency program. Many Radiologists pursue up to two further years of fellowship training as well.
- Radiologists in Vermont are committed to the provision of the highest quality imaging-based diagnosis and treatment available founded on the steadily improving art and science of our specialty. We embrace the concept of life-long learning.
- The Radiologist's payment for the interpretation of an exam is known as the "professional component" of an imaging charge and generally is about one tenth the "technical component" administered by the hospital for the acquisition of the exam. Practice income across Radiology groups throughout the State has been flat or declining over the past five years.
- Nearly all of Vermont's Radiologists work at hospital-based practices. In this capacity, we do not own imaging equipment, order imaging tests or self-refer. This practice model prevents the inherent conflict of interest and utilization bloat that may occur when non-Radiologist office-based physicians refer their patients to imaging equipment that they own in order to capture both the professional and technical components of the charge.
- Vermont's Radiologists are proud of our contribution to the health of Vermonters and the fact that Vermont has been identified as the healthiest state in the nation for four years in a row.
- Vermont's Radiologists are committed to appropriate availability and utilization of advanced medical imaging in this State. Our efforts are reflected by the fact that Vermont has the lowest utilization rate of advanced medical imaging of any state in this nation.
- Vermont's Radiologists are committed to advancing the knowledge and sophistication of referring physicians and providers (those who order the imaging studies that we interpret). By assisting these ordering providers to better understand outcomes-oriented imaging guidelines such as the American College of Radiology's Appropriateness Criteria, we can help assure that

patients get the most appropriate imaging test when imaging is indicated and avoid unnecessary or redundant testing that does not benefit the patient.

- Vermont's Radiologists understand that accessible high-quality medical imaging relies on highly advanced equipment operated by highly-trained technologists on a 24/7 basis. We are committed to utilize this expensive resource judiciously and understand that appropriate use of advanced medical imaging improves patient outcomes, prevents unnecessary surgery and is highly cost-effective.
- Vermont's Radiologists are dedicated to safe-guarding the future health of our patients though our commitment to radiation exposure minimization according to the principle of ALARA- As Low As Reasonably Achievable.
- Vermont's Radiologists are aware of the economic forces that influence local, state and national practice environments. We are concerned that below market-cost reimbursement for imaging services in Vermont would result in inadequate maintenance and replacement of medical imaging equipment and would severely undermine physician recruitment and retention in the field of Diagnostic Imaging. The resulting degradation of the infrastructure of Diagnostic Imaging might take a few years to develop but would result in diminished quality and accessibility to image-based medical services for all Vermonters for decades to come.

Vermont's Radiologists understand the pivotal role that diagnostic imaging plays in the preservation and maintenance of the health of all Vermonters (including our families, friends and neighbors). We feel that this role must be well understood by you and those fashioning Vermont's healthcare financing paradigm in order to prevent erosion of the quality and accessibility of this vitally important healthcare resource. With our expertise, we are in a unique position to educate and inform changes in healthcare in a way that quality imaging care for all Vermonters is preserved.

The VRS believes that the extremely short comment period and lack of public hearing afforded to the Department's SPA #12-001 is unreasonable. Since the proposed actions may erode our ability to make quality and appropriate imaging services accessible to the most vulnerable populations in Vermont, we respectfully request a public hearing.

Comment #3

I am writing to request an open hearing regarding the proposed 21.4% reduction of professional compensation to Vermont's radiologists.

The Commissioner of the Department of Vermont Health Access (DVHA), has cut Medicaid reimbursement for diagnostic imaging services by 30 percent in 2011 and has proposed to further cut it by an additional 21 percent in 2012. At the same time, the State has allowed rate increases to some VT hospitals by as much as 9.2 percent. The State also has promised the largest health insurance company in the State the opportunity to become the de facto administrator of the new single payor system.

These actions all must be understood within the broad context of healthcare reform in Vermont. The State of Vermont is pursuing drastic reductions in compensation for the provision of diagnostic imaging services, while simultaneously raising hospital reimbursement rates with the intent of forcing Vermont radiologists out of private practice and into employment by hospitals and other health care institutions.

These actions undermine the doctor-patient relationship and tortiously interfere with radiologists' existing contractual, business, and professional relationships.

It is imperative that an open hearing occur to explore the collusionary forces in our State among the DVHS, hospitals, and health insurance companies that, in the name of health care reform, are applying economic blackmail to Vermont radiologists.

Comment #4

As you know, the Commissioner of the Department of Vermont Health Access (DVHA), has cut Medicaid reimbursement for diagnostic imaging services by 25 percent in 2011 and has proposed to further cut it by an additional 21 percent in 2012. I was notified of this proposal for 2012 on 12/16/11 with only 8 working days to comment given the holiday. I am concerned that this fee cut of 46% total over two years plus an additional 20% in volume loss due to prior authorization requirements makes this untenable for practicing radiologists in a state with one of the highest percentages of enrolled citizens in Medicaid.

I am asking you to hold a public hearing in January before any rushed decisions are made.

Comment #5

I am writing to request a public hearing to respond to the Medicaid fee schedule changes that will become effective January 1, 2012. Being notified of the proposed cuts to reimbursement on 12/16/11 gave us only 8 working days to comment given the upcoming holidays. This fee cut of 46% total over 2 years plus the additional 20% in volume loss due to prior authorization requirements makes this untenable for practicing radiologists in a state with one of the highest percentages of enrolled citizens in Medicaid. I am a pediatric radiologist at Fletcher Allen Health Care, and as such deal with a high volume of Medicaid patients. These are the most vulnerable patients, and require a high level of skill and subspecialized training to appropriately diagnose and treat. If fee cuts continue, Vermont will drive away the specialists caring for these patients.

Please consider this request for a hearing and the full discussion of what these cuts may do the children of Vermont.

Comment #6

I am a diagnostic radiologist practicing in Burlington, VT at Fletcher Allen Health Care. I would like to request a public hearing for the new Medicaid fee schedule cutting diagnostic imaging reimbursement. Notification to healthcare providers about significant changes to occur in only 8 working days is unfair.

This fee cut of 46% total over two years plus an additional 20% in volume loss due to prior authorization requirements makes this untenable for practicing radiologists in a state with one of the highest percentages of enrolled citizens in Medicaid. This affects not only the radiologists, but the hospitals providing the services. Jobs in imaging may be lost.

Imaging is an important part of current medical care. If imaging is limited, the health of some of our most vulnerable members of society will surely be impacted.

Comment #7

I am writing because of concern regarding the recent announcement by the Department of Vermont Health Access regarding the filing of State Plan Amendments which propose to cut physician reimbursement for providers who participate in the Medicaid program. I would like to address my concerns specifically regarding the proposed cuts to radiology services.

First, I must say that it is very disingenuous at the eleventh hour, and right before the holidays to publically release these amendments which in addition to the 25% reimbursement cut that occurred last year, cuts reimbursement an additional 21%. This allows very limited time and effort to properly reply to these proposed changes, and further alienates the relationship between administrators of state/federal medical programs and the providers that participate in these programs. We are all part of the same team, and in particular regarding the Medicaid program, we are all trying to do the right thing for the Vermonters covered by this program. I know an increasing number of my colleagues are not willing to participate in this program, not only because of the fee schedule which is not sustainable for practice, but because of the rather draconian way in which these decisions appear to be presented without appropriate time for feedback.

The proposed fee schedule reduces the Medicaid payment rate to radiologists to approximately two thirds of the Medicare rate. The effect of this reduction will be to force many radiologists to no longer accept Medicaid patients. I know through our correspondence through the Vermont Medical Society and the Vermont chapter of the American College of Radiology, that this is a certainty rather than a possibility, particularly for the many private practice physicians in the state. A secondary effect of this is the strong possibility of radiologists leaving this state to practice elsewhere in the country. This would severely limit access to care throughout the state which is a federal mandate of this program (“assure that [Medicaid] payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”). Furthermore, it is not clear to me that the few sites that would be able to continue to accept Medicaid patients would be able to absorb the additional work. For instance, the 30 University of Vermont Medical Group radiologists interprets approximately 280,000 exams per year, and in my area of thoracic radiology, 2.6 radiologists interpret 33,000 exams.

It is my hope that these comments are viewed within their intention of trying to preserve a program that provides medical care to a vulnerable population. As an increasing number of Vermonters are covered by Medicaid, it is imperative that we work together to ensure that it continues in the spirit in which it was created and mandated.

Comment #8

As a concerned radiologist practicing at Fletcher Allen in Vermont since 1988, I am very concerned about and very much opposed to the proposed 21 % Medicaid fee schedule cut in 2012. Not only will this cause radiologists to consider other job alternatives outside the state but, if implemented, many non-physician jobs will be lost at hospitals throughout the state, especially if such cuts continue unchecked. Sub specialty trained and experienced physicians such as radiologists contribute critical diagnostic and treatment skills to all Vermonters in need of medical care. I would strongly urge that a public hearing take place so that all concerned individuals might be allowed to express their concerns about this most important issue.

Comment #9

This is the first letter I have ever written to a political figure. I am writing because I believe that a public hearing is needed to respond to the Medicaid fee schedule changes that will become effective January 1, 2012. Being notified of the proposed cuts to reimbursement on 12/16/11 gave us only 8 working days to comment given the upcoming holidays. This feels unfair and rushed.

Also a fee cut of 46% total over 2 years, plus the additional 20% in volume loss due to prior authorization requirements, makes it impossible for practicing radiologists in a state with one of the

highest percentages of enrolled citizens in Medicaid to practice. I am a Gastrointestinal radiologist at Fletcher Allen Health Care, and I perform a large number of procedures on Medicaid patients. Taking care of these vulnerable patients requires a high level of skill and sub specialized training to appropriately diagnose and treat. If fee cuts continue, Vermont will drive away the specialists and subspecialists who do there best caring for these patients, and the rest of Vermont population.

Please consider this request for a hearing and the full discussion of what these cuts may do to the people of Vermont.

Comment #10

Please immediately suspend plans for a Vermont Medicaid fee schedule change, scheduled to become effective on January 1, 2012, until this can be thoroughly discussed by all parties, rather than sprung on the medical field at the 11th hour.

This will have catastrophic results affecting the provision of quality health care to Vermonters. I am activating my out of state licenses and have begun the process of finding another job out of state. This endangers the well being of the hospital as well as already stressed medical practices and is completely unreasonable.

Please call an immediate suspension of this plan and rethink how we can achieve a fair single payer system in Vermont.

Comment #11

As a physician practicing the specialty of radiology in Brattleboro, Vermont, I am dismayed at your recent announcement of arbitrary fee cuts to physicians rendering services to Medicaid patients. The additional 21% cuts for 2012, added to 25% cuts enacted in 2011, amount to a nearly 50% pay cut for Vermont radiologists serving one of the most vulnerable populations in our state, a group which can ill afford to lose access to quality radiology services and other general medical services. Yet I fear that this proposal, coupled with 27% cuts to Medicare provider services also due to take effect on January 1st (barring unlikely action by Congress), may well have the effect of decreasing access to health services for Medicaid patients -- and, indeed, the entire population of Vermont. Further, if Medicaid reimbursement is tied by formula to Medicare reimbursement, the simultaneous Medicare cuts may result in even greater Medicaid cuts.

Those physicians who can do so may be forced to stop serving the Medicaid population, while those who for contractual reasons cannot while still practicing in Vermont, may be forced to consider leaving the state of Vermont. Other physicians who are nearing retirement age but had intended to work a few years longer, may find the latest cuts the straw that broke the camel's back, rendering it more attractive to take early retirement than continue to practice. Whether Vermont radiologists are lost by emigration to other states or by earlier retirement prompted by inadequate reimbursement, the net effect will be to diminish the supply of board-certified radiologists (and other providers facing cuts) available to serve all of Vermont's population, and it will most certainly make it nearly impossible to attract new physicians to this state for so long as Vermont compares adversely to other professional opportunities.

Vermont cannot rely on a beautiful landscape alone to attract and retain skilled health professionals. It will not make any difference whether Vermont eventually implements a new system of health care delivery if the most essential component of that system, Vermont physicians, are an endangered species.

In conversation with my colleagues, I find total agreement with the above views. The Vermont radiology community as organized through the Vermont chapter of the American College of Radiology is unanimously opposed to this serious threat to the viability of Vermont healthcare. I urge you to suspend these cuts and to hold appropriate public hearings rather than rushing these changes through at the eleventh hour during the holiday season.

If you believe it is important to have well-trained board-certified radiologists available in Vermont to find early breast cancer on mammograms, don't enact these cuts. If you think it is important to maintain the ability of Vermonters, including yourself and your loved ones, to have access to diagnostic imaging services for the diagnosis and management of thousands of different ailments through x-rays, ultrasound, CT scanning, nuclear medicine, and magnetic resonance imaging, then you should reconsider your actions before it is too late. Significant damage to the medical profession in the Green Mountain State can be achieved quickly by inappropriate government action. To rebuild a seriously compromised corps of Vermont physicians will take years or decades.

Comment #12

I am a radiologist in Rutland and on the staff at RRMC since 1985. I agree there is a clear need to contain the rising costs in imaging. The correct way to do it is to curtail inappropriate use which would require tort reform and limiting the number of providers able to order expensive tests. The present downward spiral in reimbursement will only limit the number and quality of radiologists in VT as I know several who are actively seeking jobs elsewhere and will be difficult to replace.

Utilization in VT is still less than national averages. Even if the medicaid reimbursement was kept at a nationally competitive level it would not be adequate due to the large numbers enrolled in medicaid in Rutland.

I strongly suggest enrolling all physicians to work with the state to bring about meaningful reform rather than allowing a voice only to those touting the party line of the present administration. The public also should have a voice in this process as most are ignorant of the fact that the state places such low values for physician services.

I encourage you to at least keep fees in the present range while we transition through some difficult times.

Comment #13

I am writing to you to express my concerns regarding the proposed additional 21% cuts in Medicaid reimbursement for diagnostic imaging services. As a practicing radiologist at Fletcher Allen Health Care, the combination of diagnostic imaging tests and my expertise in interpreting these studies have been crucial in helping to manage patients. Very often, imaging tests are the only means to determine the cause of a patient's problem. Imaging tests help to diagnose diseases early in their course, and to guide the treatment of patients. It is our imaging tests that help determine whether the patient should be treated medically or surgically.

We are already one of the states with the lowest utilization of imaging tests, and a further cut in Medicaid reimbursement for diagnostic imaging services will only negatively affect the health care of Vermonters.

I strongly feel that there should be a public hearing to discuss the proposed cuts in Medicaid reimbursement for diagnostic imaging services. It will be in the best interest of Vermonters and health care providers in this state to hold a public hearing.

Comment #14

I have reviewed the proposed change for payment rates which are scheduled to occur on January 1, 2012. The radiologists appear to be targeted for a significant impact for the 2nd year in a row. I would advise against this. Attracting physicians to a rural state remains a challenge, but it becomes increasingly difficult in Vermont with reimbursements that are well below national averages. Our payer mix is very unfavorable, and this change just adds to the burden. I fear that there may be unintended consequences of this change.

Comment #15

- Vermont's Radiologists are a dedicated group of physicians with advanced and specialized training in the tailoring and interpretation of medical imaging and the performance of image-guided minimally-invasive diagnostic and therapeutic procedures. As such, Radiologists in Vermont typically possess an M.D. degree and subsequently complete a five year residency program. Many Radiologists pursue up to two further years of fellowship training as well.
- Radiologists in Vermont are committed to the provision of the highest quality imaging-based diagnosis and treatment available founded on the steadily improving art and science of our specialty. We embrace the concept of life-long learning.
- The Radiologist's payment for the interpretation of an exam is known as the "professional component" of an imaging charge and generally is about one tenth the "technical component" administered by the hospital for the acquisition of the exam. Practice income across Radiology groups throughout the State has been flat or declining over the past five years.
- Nearly all of Vermont's Radiologists work at hospital-based practices. In this capacity, we do not own imaging equipment, order imaging tests or self-refer. This practice model prevents the inherent conflict of interest and utilization bloat that may occur when non-Radiologist office-based physicians refer their patients to imaging equipment that they own in order to capture both the professional and technical components of the charge.
- Vermont's Radiologists are proud of our contribution to the health of Vermonters and the fact that Vermont has been identified as the healthiest state in the nation for four years in a row.
- Vermont's Radiologists are committed to appropriate availability and utilization of advanced medical imaging in this State. Our efforts are reflected by the fact that Vermont has the lowest utilization rate of advanced medical imaging of any state in this nation.
- Vermont's Radiologists are committed to advancing the knowledge and sophistication of referring physicians and providers (those who order the imaging studies that we interpret). By assisting these ordering providers to better understand outcomes-oriented imaging guidelines such as the American College of Radiology's Appropriateness Criteria, we can help assure that patients get the most appropriate imaging test when imaging is indicated and avoid unnecessary or redundant testing that does not benefit the patient.
- Vermont's Radiologists understand that accessible high-quality medical imaging relies on highly advanced equipment operated by highly-trained technologists on a 24/7 basis. We are committed to utilize this expensive resource judiciously and understand that appropriate use of advanced medical imaging improves patient outcomes, prevents unnecessary surgery and is highly cost-effective.

- Vermont's Radiologists are dedicated to safe-guarding the future health of our patients though our commitment to radiation exposure minimization according to the principle of ALARA- As Low As Reasonably Achievable.
- Vermont's Radiologists are aware of the economic forces that influence local, state and national practice environments. We are concerned that below market-cost reimbursement for imaging services in Vermont would result in inadequate maintenance and replacement of medical imaging equipment and would severely undermine physician recruitment and retention in the field of Diagnostic Imaging. The resulting degradation of the infrastructure of Diagnostic Imaging might take a few years to develop but would result in diminished quality and accessibility to image-based medical services for all Vermonters for decades to come.
- Vermont's Radiologists understand the pivotal role that Diagnostic Imaging plays in the preservation and maintenance of the health of all Vermonters (including our families, friends and neighbors). We feel that this role must be well understood by those fashioning Vermont's new healthcare financing paradigm in order to prevent erosion of the quality and accessibility of this vitally important healthcare resource.

Comment #16

I am a diagnostic Radiologist at Porter Hospital in Middlebury and I am deeply disturbed to hear the very recently acquired news of a 21% cut in Medicaid reimbursement for Vermont's Radiologists. This comes on top of a 25% cut last year in addition to institution of a pre-approval process that reduced Medicaid reimbursement to Vermont Radiology practices up to a total of 35%. This cut directly threatens the infrastructure that currently provides timely and local access to high-quality effective and efficient medical imaging care to the very Vermonters your agency has charge of. This is a very grave and serious situation that clearly can not be managed reasonably by an unannounced eight-day commentary period over the holidays. I share the position of the Vermont Radiological Society which is that a public hearing is warranted in order that the ramifications of this proposal are appropriately explored and understood.

Comment #17

I am writing on behalf of Southwestern Vermont Medical Center (SVMC) to oppose the drastic cuts in Medicaid reimbursement for diagnostic imaging services that will take place on January 1, 2012. We are seriously concerned that cutting reimbursements an additional 21 percent in 2012 on top of this year's 25-percent reduction will jeopardize the ability of our radiologists, who already receive one of the lowest reimbursement rates in the nation for radiology services, to provide care for the state's most vulnerable people.

High quality radiology services are crucial to the success of medical specialties from primary care to surgical services. In fact, hospitals could not exist without strong imaging capabilities. The United States is experiencing a physician shortage, and radiology remains one of the most sought-after specialties. We are concerned that further cuts to Medicaid reimbursements will erode Vermont radiologists' confidence in the state and lead them to seek opportunities elsewhere.

Please reconsider these cuts and take the time to hear from Vermont's physician community and affected constituents through a public hearing process to examine how the proposed reductions will affect the ability to provide quality radiological care for all Vermonters. I ask that the proposed changes to Medicaid reimbursement for imaging services be postponed until all effects of this decision are explored and evaluated.

Comment #18

Vermont Radiologists are deeply troubled by the sudden unexpected news that DVHA plans a second drastic cut in Medicaid reimbursement to Vermont physicians engaged in the interpretation of diagnostic images. Our concerns are well expressed by Dr. Biebuyk in his letter to Ms. Rader Wallak included below. Also include is my request to Mr. Larson at DVHA for a public hearing on this matter.

Radiologists in this State are hospital-based physicians who are justifiably proud of our contribution to this State's fine healthcare delivery system. We have the healthiest State in the nation for four years running. Vermont also has the lowest rate of utilization of advanced medical imaging (i.e. CT and MRI) in the nation as well. This is evidence that many things are right and correct in our current system. Multiple keystones of this highly functional and effective system are under attack by DVHA's policy of repeated, drastic, unjustified and unsustainable cuts to the physicians in the trenches who interpret the imaging studies that help make modern healthcare so effective. These cuts destroy good faith between Vermont physicians and their government and erode infrastructure, physician recruiting and retention and accessibility before we even begin to tackle the challenges of single-payer in this State.

If it is the State's goal to reign-in healthcare costs by dismantling our existing high-quality, accessible and effective system; in effect, to ration healthcare by diminishing accessibility to services, then we are well on our way. If this is not the goal, then action is required immediately to provide reimbursement to physicians commensurate to the value of the work done and on a scale that is comparable to the rest of the nation. It disturbs me greatly that many of my Radiologist colleagues in Vermont are considering out-of-state practice opportunities. It disturbs me even more to find myself amongst their number.

For additional information regarding the identity and role of Radiologists in Vermont, please see the attached enclosure.

Comment #19

I am a radiologist and have practiced in Rutland for over 10 years. DVHA recently acted to decrease reimbursement for radiologists caring for Medicaid patients. I am writing to bring your attention to several related issues.

There's a common lack of understanding about what a radiologist does. In addition to interpreting images and rendering reports of the imaging findings, we frequently perform invasive procedures. These procedures are a vital part of medical care and include biopsies, drainages, angioplasties, foreign body removal, and localization for surgical reference in the O.R. These invasive procedures are particularly poorly reimbursed by Medicaid. Radiologists also perform the following functions which are usually not reimbursed at all:

- consultation with primary care and specialty physicians regarding the best imaging test to use for problem-solving on individual patients
- discussion with referring providers, making sense of the imaging findings in the context of the patient's condition. It is during these discussions that a unifying diagnosis is often first suggested. These discussions commonly assess response to treatment and are the basis for determining future medical and surgical treatment.
- discussion with the patient, explaining the imaging findings and what they mean
- consultation with patients and providers regarding radiation safety

- quality control of the imaging process, assuring consistent high quality imaging, supervising technical staff, participating in accreditation processes
- design of the imaging examinations, optimizing parameters for scanning and minimizing radiation exposure
- consultation with hospital administration, advising on equipment purchases, technologist performance, policies and procedures

In 2011, my practice in Rutland saw a 36% decrease in reimbursement from Medicaid. This was due to the 2011 rate cut combined with utilization restrictions. Further cuts in reimbursement will make life-saving imaging and image-guided procedures less accessible to our most vulnerable patients. This will have the effect of rationing care away from people who can least afford to pay.

Vermont has one of the highest percentages of enrolled population in Medicaid in the country, and Rutland has one of the highest proportions of Medicaid patients in the State. We have very little ability to cost shift our Medicaid losses onto private payors. Radiologists are not able to self-refer, so we cannot exert control over our work volume. The abrupt loss of revenue and the expectation of continued loss of revenue has led to much discussion in my group about our future in Vermont. We have decided that when we lose a radiologist due to relocation or retirement, we will not replace him. We do have radiologists in our group who have begun to actively inquire about opportunities in other states. Losing a radiologist will necessitate a decreased level of access. Many image-guided procedures will no longer be available in Rutland. Scheduling for non-emergent care will be less timely. Many of our Medicaid patients can barely afford the gas to travel to Rutland, and telling them they have to go to Burlington, Dartmouth or Albany for a procedure will mean that they simply won't have access to that type of medical care. The people in our area who can afford to travel and take time off work will still get the care they need at tertiary centers. The less advantaged portion of the population will not have access.

I am requesting a public hearing to discuss this issue.

Comment #20

I am a practicing radiologist at Southwestern Vermont Medical Center in Bennington. I am writing to urge your reconsideration of the proposed cut to Medicaid reimbursement for 2012.

As you know, the Department of Vermont Health Access (DVHA) has cut Medicaid reimbursement for diagnostic imaging services by 25 percent in 2011 and has proposed to further cut it by an additional 21 percent in 2012. The proposed changes may have a significant impact on the ability of radiologists in the state to provide imaging care to the most vulnerable populations.

With Vermont having one of the highest percentages of Medicaid enrollment in the country, these cuts have a disproportionate effect on reimbursement and consequently our ability to continue to provide for Vermont's poorest citizens.

I realize that imaging utilization is an consideration in limiting healthcare spending, but these continued cuts to radiologists in particular seem unfair. As a practicing radiologist, I am prevented by law from ordering almost all imaging studies with few exceptions. While lowering our payments may save a small amount in the short term, it does little to curb the number of studies ordered or performed. Our professional reimbursement is but a small percentage of the overall charge for imaging compared to the technical component which is not targeted for revision. These cuts have an air of "shooting the

messenger". I am not arguing to take money from someone else's pocket, but the proposed cuts will do little to solve the larger utilization issue.

I would also urge that there be a public hearing to discuss this matter. This proposal was announced with only 8 business days allowed for written response given the approaching holiday. This issue is too important to be glossed over in this fashion. The physicians and the patients of Vermont deserve more.

I am hopeful that this issue can be favorably settled following more thoughtful discourse. Thank you for your time.

Comment #21

I am a diagnostic radiologist who has practiced at Springfield Hospital for nearly thirty years and have done some filling at multiple other VT hospitals from time to time.

Many folks do not understand our current key role in health care. With powerful technologies as CT and MRI, we have moved into a central position where we daily (and nightly) determine, for example, who needs emergency surgery, and who does not. Who needs hospitalization ASAP for diverticulitis, or who only has a "stomach bug". Who has cancer, does the biopsy, and evaluate its spread. Who has only a bad migraine, or who might have a ruptured brain aneurysm.

I agree wholeheartedly with comments you've received from my colleague JC Biebuyck, about how radiologists could diminish (even more than we do now) inappropriate imaging utilization. Daily now, i'm frequently discussing with our primary care docs which test to order for some clinical problem. Then they don't order a whole battery of unnecessary tests.

Part of over ordering is clearly due to medical legal concerns, this is a huge and important issue too, which hopefully will be addressed at some near date.

I am very concerned by the proposed medicaid cuts. New England in general has historically underpaid radiologists compared to much of the country. In our Springfield practice, VT medicaid is, at 18 percent of our charges, our second highest patient group, second only to medicare (36 percent). Though comprising 18 percent of our charges, it represents only 12.7 percent of payments, quite a discount. And of course, Windsor County has many, many uninsured folks with minimal ability to pay.

As I move toward retirement, I fear that moves like these will make it harder to find a replacement radiologist. As you know, folks entering the physician workforce often have massive school debts to pay off. Many of my colleagues at Springfield have had added expenses for private schools for their children, they being dissatisfied with quality of public schools. I've loved living and working in VT but it does not appeal to everyone; the cold, the limited social and cultural resources, if you're used to the Boston suburbs, say. Some colleagues have come here with fantasies about VT, but then left when they and/or their spouses learned the realities. I'm just trying to say that filling a radiology opening here is not a "slam dunk", and declining reimbursement makes it that much harder.

I would request a public hearing on this issue which hopefully could take place after the holiday season.

Comment #22

I am writing to you to express my concern regarding the proposal by the Department of Vermont Health Access to further reduce Vermont Medicaid reimbursement for diagnostic imaging services. I am a board certified radiologist working at Springfield Hospital in Springfield, VT. As you are aware, the Springfield population has one of the highest rates of Medicaid enrollment in the state. Reducing reimbursement for imaging this vulnerable population threatens to diminish my ability to continue providing high quality care for these patients. It is true that many imaging exams are expensive and they are an obvious target for reducing health care costs. However, imaging plays a crucial role in early detection of diseases, diseases that can prove far more costly in terms of dollars and quality of life if not caught early. Studies have shown that CT and MRI scans performed on patients are associated with a decrease in other costs of hospitalization, such as length of stay, in those patients requiring admission. Evidence suggests that greater use of inpatient imaging improves patient outcomes without significantly impacting hospitalization costs. It is clear that judicious use of imaging is both cost effective and potentially life saving. We as a society must not target insurance coverage for the populations least able to pay for these exams.

At Springfield Hospital, we employ three full-time radiologists, one of whom will retire in six months. I am very concerned we may not successfully recruit a replacement for this radiologist because Vermont is no longer an attractive place for specialists to practice medicine. If we do not find a replacement, the ratio of workload to income will undoubtedly become so unbalanced that I will have to consider other locations in which to practice medicine and raise my young family. Please consider that your decisions may drive away the most skilled and qualified physicians to other states. If that happens, all Vermonters will lose out.

Thank you for your consideration on this critical issue.

Comment #23

As a radiologist who has practiced in the state since 1995, I am writing to express my concern over the proposed Medicaid cuts to Vermont radiologists. This proposal if it takes effect has the potential to significantly impact the imaging evaluation of patients in our state. In the interests of all Vermonters I urge you to hold a public hearing on the issue so that the issues raised in this proposal are properly explored before implementation.

Comment #24

I am a board certified radiologist at Springfield Hospital in Springfield, VT. and I am contacting you to express serious concern over the recent proposal by Department of Vermont Health Access to again make significant cuts to Vermont Medicaid reimbursement for diagnostic imaging procedures.

As you are aware, Medicaid cut reimbursement for diagnostic imaging services by 25 percent in 2011 and has proposed to further cut it by an additional 21 percent in 2012. These changes significantly jeopardize the ability of the state's most vulnerable population, Medicaid recipients, access to radiologic services.

Diagnostic radiology is an integral component of patient care and frequently directs the ultimate care of the patient. Imaging studies, while expensive, frequently determine who may need emergency surgery versus who may simply need a follow up visit with their primary care physician. While it is true that imaging expenditures have significantly increased, it also remains true that imaging guided care is the standard of care in medicine today. Costly and higher risk procedures such as exploratory abdominal surgeries are nearly a thing of the past, thanks to the incredible advances in imaging

technology. However, the Medicaid cuts seriously endanger our ability to offer the current medical technology to those who need it the most.

My practice in Springfield, VT services many uninsured patients, and nearly 20% of our charges are Medicaid patients, for which we are paid approximately 12.7%. New England historically has paid radiologists below the national average, and with these proposed cuts it will only worsen. I fear with further cuts, I will be forced to leave the area and move with my physician husband (who also provides care to patients regardless of ability to pay) and four young children to a location with more reasonable cost containment measures.

Additionally, as my senior partner retires in 6 months, I fear that I will not be able to recruit a replacement to the state of Vermont where reimbursements are continually declining. At this point, the work will become too much for myself and my only remaining partner, forcing us to either eliminate Medicaid patients all together, as is happening in certain areas in New Hampshire, or close my practice all together.

The Vermont chapter of the American College of Radiology and the American Chapter of Radiology historically have worked tirelessly to maintain the strictest quality assurance measures, in turn doing our part to help with cost control. This has been achieved through accreditation programs for use of the technology as well as the implementation of appropriateness criteria to assist clinicians in ordering the appropriate test, ultimately limiting the amount of imaging the patient needs and cutting out wasteful spending.

While the field of radiology has done much to help with cost containment, it has been incredibly frustrating to observe utilization be driven up by other medical specialists who set up expensive imaging equipment in their practices and continually, in what most consider a conflict of interest, self refer to pay off their machines and drive their own profits. Additionally many clinicians have become so ingrained with defensive medicine tactics that radiology services are overused to avoid lawsuits. Tort reform should be vital in the battle to contain medical costs.

While I do not have the ability to generate referrals, I do have a role in limiting the execution of imaging procedures that are not clinically indicated, significantly reducing health care costs in the process. I respectfully request that DVHA reconsider further significant widespread cuts to imaging that will threaten high quality medical care for the most vulnerable Vermonters, and instead consider other methods of cost containment such as stricter implementation of self referral regulations, tort reform and containment of inappropriate utilization by referring physicians.

We were notified of this proposal on 12/16/11 with only 8 working days to comment given the holiday. I respectfully request a public hearing on this issue to take place after the holiday season.

Comment #25

I have been a Radiologist at Southwestern Vermont Medical Center since 1979 after residency at Medical Center Hospital of Vermont. I am part of a five person independent group practice proudly providing full Radiologic services to the people of Southwestern Vermont regardless of their ability to pay. My colleagues and I are deeply disturbed at the recently announced prospect of another draconian cut to the Medicaid reimbursement rates by DVHA for professional Radiologic services. The proposed 21% cut, following on the heels of last year's 25% cut and a pre-approval process which has had the effect of a further 35% reduction, threatens our ability to recruit and retain qualified physicians and thus likely impacts our long range ability to continue to provide necessary services. This proposed

cut may seem like an expedient way to save or redistribute money but will likely contribute to dismantling our current high quality system and result in negative unintended consequences for us, our hospital, our patients and ultimately for the State of Vermont.

As you are well aware, Vermont has the lowest rate of use of advance medical imaging (eg CT and MRI) in the nation, in no small part due to the efforts and vigilance of its' committed Radiologists. The Radiologist community wishes to work collaboratively with the state and with other physicians to continue to reduce unnecessary healthcare costs. Radiologists work only by referral from other physicians and are thus in a unique position to be able to help reduce inappropriate utilization. This is a much more appropriate approach than to continue targeting the reimbursement for our professional services. Our hospitals and our communities depend on our ability to continue to provide critical services for patient care and wellness.

We feel that the precipitous announcement of the cut, without prior notification, discussion or appropriate time for input and comment and announced just before the holidays, is an inappropriate way to proceed and risks sending the message to Vermont's physicians that their opinion is not valued. We, the Radiologist community, need the opportunity of a public hearing to address and discuss the issue and for us to have the opportunity to present our position and for stakeholders to understand the ramifications of the proposed cut. I support the American College of Radiology and the VSMS and in this request.

Comment #26

I am writing to let you know that we support VMS' concerns around the Medical Fee Schedule amendments and in particular, support their request for an extension of the comment period and a public hearing. This issue is extremely important for our members and we will need some time to properly understand the impact on each of our hospitals.

Comment #27

The Vermont Psychiatric Association Executive Committee has reviewed your proposal for new conversion factors in DVHA RBRVs for calendar year 2012 and strongly urge you to use scenario #3 which minimizes the reduction in spending for Behavioral Health services. As discussed with Mr. Larson recently, the crisis in access to outpatient psychiatric care continues to be a major problem in the state due in large part to the very low reimbursement rates and associated difficulty recruiting and retaining psychiatrists. Anything the DVHA can do to limit further cuts is critical to prevent loss of essential outpatient psychiatric services.

Thank you for your effort regarding this urgent matter.

No public meetings are scheduled at this time.

To get more information about the RBRVS and OPPS State Plan Amendments go to
<http://dvha.vermont.gov/administration/draft-versions-of-state-plan-changes>.

**FINAL Model for New Conversion Factors in DVHA's RBRVS for Calendar Year 2012
Using CY 2010 Data (Date of Service) for Modeling**

Procedure Code Group	Scenario #1 Using 2011 RVUs		Original Proposal (Scenario #3) Using 2012 RVUs & DVHA 2012 CFs				Final Decision Using 2012 RVUs & DVHA 2012 CFs				DVHA 2012 Payments as Pct of Medicare 2012 Payments*
	Conversion Factor	Modeled Payments	Conversion Factor	Modeled Payments	Change from Scenario #1	Pct Change	Conversion Factor	Modeled Payments	Change from Scenario #1	Pct Change	
All Codes		\$92,354,513		\$92,387,489	\$32,976	0.0%		\$92,354,808	\$295	0.0%	78.4%
Well Child Visit Codes	\$33.9764	\$2,511,583	\$29.2000	\$2,511,894	\$311	0.0%	\$29.0800	\$2,511,210	(\$373)	0.0%	85.6%
E&M Codes	\$28.6797	\$40,812,050	\$28.0900	\$40,817,953	\$5,903	0.0%	\$27.9800	\$40,812,603	\$553	0.0%	82.4%
Maternity-Related Codes	\$28.6797	\$3,728,624	\$28.0900	\$4,047,316	\$318,692	8.5%	\$27.9800	\$4,059,768	\$331,144	8.9%	82.4%
Behavioral Health Codes	\$28.6797	\$22,322,448	\$29.2000	\$22,031,672	(\$290,776)	-1.3%	\$29.0800	\$21,994,140	(\$328,308)	-1.5%	85.6%
Chiropractic Codes	\$28.6797	\$691,852	\$22.6000	\$550,410	(\$141,442)	-20.4%	\$27.9800	\$683,471	(\$8,381)	-1.2%	82.4%
Radiology	\$28.6797	\$4,577,483	\$22.6000	\$3,599,143	(\$978,340)	-21.4%	\$27.9800	\$4,471,965	(\$105,518)	-2.3%	82.4%
All Other RBRVS Services (shown below)	\$21.3420	\$17,710,475	\$22.6000	\$18,829,101	\$1,118,626	6.3%	\$21.2800	\$17,821,651	\$111,176	0.6%	62.7%
Integumentary	\$21.3420	\$1,181,738	\$22.6000	\$1,266,366	\$84,628	7.2%	\$21.2800	\$1,198,760	\$17,022	1.4%	62.6%
Musculoskeletal	\$21.3420	\$2,663,872	\$22.6000	\$2,797,719	\$133,847	5.0%	\$21.2800	\$2,649,527	(\$14,345)	-0.5%	62.6%
Respiratory	\$21.3420	\$385,567	\$22.6000	\$413,609	\$28,042	7.3%	\$21.2800	\$391,410	\$5,843	1.5%	62.6%
Cardiovascular	\$21.3420	\$946,572	\$22.6000	\$989,889	\$43,317	4.6%	\$21.2800	\$937,431	(\$9,141)	-1.0%	62.6%
Digestive	\$21.3420	\$1,989,079	\$22.6000	\$2,122,465	\$133,386	6.7%	\$21.2800	\$2,009,471	\$20,392	1.0%	62.6%
Urinary	\$21.3420	\$375,167	\$22.6000	\$384,031	\$8,864	2.4%	\$21.2800	\$363,320	(\$11,847)	-3.2%	62.6%
Genital Systems	\$21.3420	\$984,782	\$22.6000	\$1,032,931	\$48,149	4.9%	\$21.2800	\$977,588	(\$7,194)	-0.7%	62.6%
Delivery Services	\$21.3420	\$138,110	\$28.0900	\$136,104	(\$2,006)	-1.5%	\$27.9800	\$136,440	(\$1,670)	-1.2%	82.4%
Endocrine and Nervous	\$21.3420	\$962,559	\$22.6000	\$1,030,229	\$67,670	7.0%	\$21.2800	\$975,540	\$12,981	1.3%	62.6%
Eye and Ocular	\$21.3420	\$514,594	\$22.6000	\$547,297	\$32,703	6.4%	\$21.2800	\$517,989	\$3,395	0.7%	62.6%
Pathology	\$21.3420	\$557,179	\$22.6000	\$585,599	\$28,420	5.1%	\$21.2800	\$552,780	(\$4,399)	-0.8%	62.6%
Medicine	\$21.3420	\$6,841,382	\$22.6000	\$7,344,665	\$503,283	7.4%	\$21.2800	\$6,943,049	\$101,667	1.5%	62.6%
All Other	\$21.3420	\$169,874	\$22.6000	\$178,197	\$8,323	4.9%	\$21.2800	\$168,346	(\$1,528)	-0.9%	62.6%

Provider Group	Conversion Factor	Modeled Payments	Conversion Factor	Modeled Payments	Change from Scenario #1	Pct	Conversion Factor	Modeled Payments	Change from Scenario #1	Pct	DVHA 2012 to Medicare 2012
Primary Care Physicians	various	\$24,077,568	various	\$24,282,492	\$204,924	0.9%	various	\$24,231,147	\$153,579	0.6%	81.5%
Primary Care Nurse Pract.	various	\$2,949,290	various	\$2,970,545	\$21,255	0.7%	various	\$2,966,675	\$17,385	0.6%	81.8%
OB/GYN Providers	various	\$6,613,385	various	\$6,790,092	\$176,707	2.7%	various	\$6,887,092	\$273,707	4.1%	79.6%
Psychiatrists	various	\$4,988,216	various	\$4,956,550	(\$31,666)	-0.6%	various	\$4,946,999	(\$41,217)	-0.8%	84.8%
PhD Psychologist	various	\$2,744,434	various	\$2,697,271	(\$47,163)	-1.7%	various	\$2,692,446	(\$51,988)	-1.9%	85.6%
MS Psychologist	various	\$12,096,716	various	\$11,885,647	(\$211,069)	-1.7%	various	\$11,864,272	(\$232,444)	-1.9%	85.6%
Specialists	various	\$23,776,034	various	\$24,132,056	\$356,022	1.5%	various	\$23,686,586	(\$89,448)	-0.4%	73.2%
Chiropractors	various	\$679,203	various	\$541,305	(\$137,898)	-20.3%	various	\$671,137	(\$8,066)	-1.2%	82.3%
Radiologists	various	\$3,756,296	various	\$3,136,528	(\$619,768)	-16.5%	various	\$3,676,015	(\$80,281)	-2.1%	77.8%
Therapists	various	\$2,302,176	various	\$2,504,215	\$202,039	8.8%	various	\$2,367,992	\$65,816	2.9%	62.9%
Optometrists/Opticians	various	\$1,303,230	various	\$1,356,889	\$53,659	4.1%	various	\$1,296,539	(\$6,691)	-0.5%	65.5%
Podiatrists	various	\$334,307	various	\$344,155	\$9,848	2.9%	various	\$337,427	\$3,120	0.9%	72.8%

*The comparison of DVHA and Medicare payments assumes that Medicare will retain the 2011 Conversion Factor of \$33.9764 and the GPCI for Work at 1.000 throughout 2012.