

Vermont

Health Care Finance:

High-Level Overview

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January 2023



A QUICK NOTE ABOUT THE DATA IN THIS PRESENTATION

We attempted to use the most up to date available at the time of creating this presentation.

Some of the data are from BEFORE THE COVID-19 PUBLIC HEALTH EMERGENCY and may not fully reflect spending, coverage changes, additional assistance, etc. that may have occurred due to the COVID-19 pandemic.



Context: Insurance Coverage

Private / Commercial Insurance

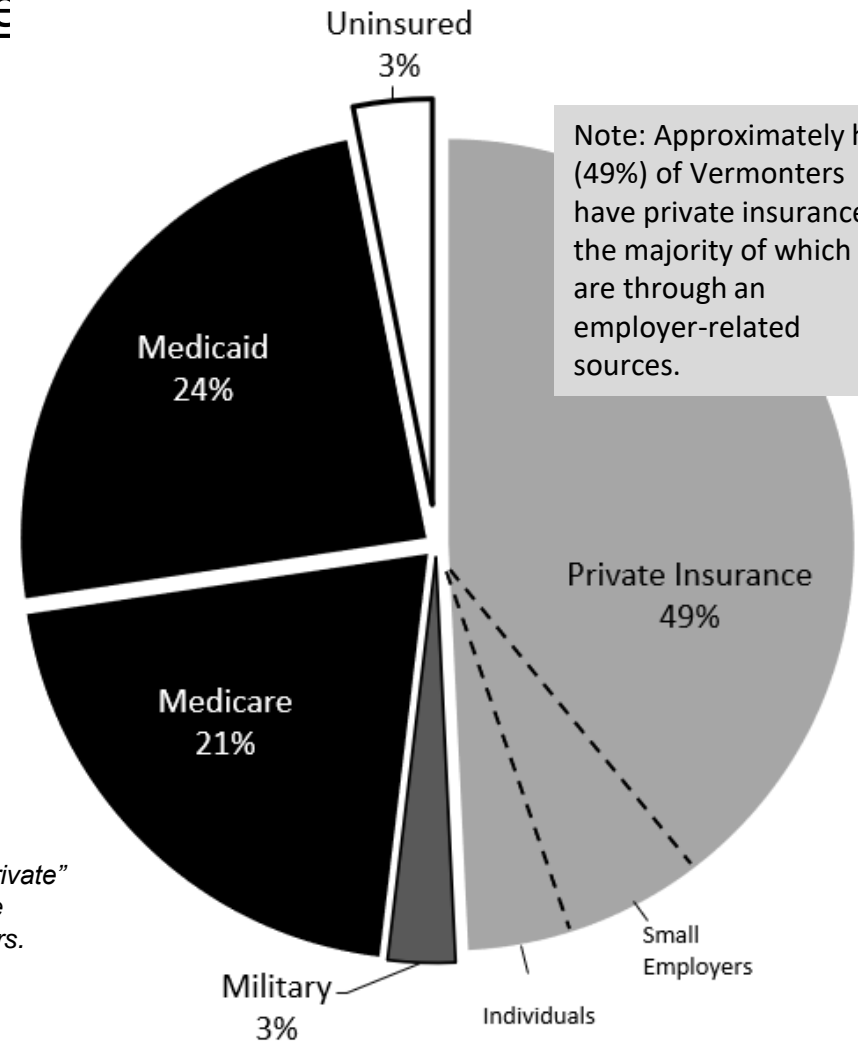
- Employer-based
- Individual Market

Government

- Medicare
- Medicaid

Military

Health Coverage by Source (2021)



Notes:

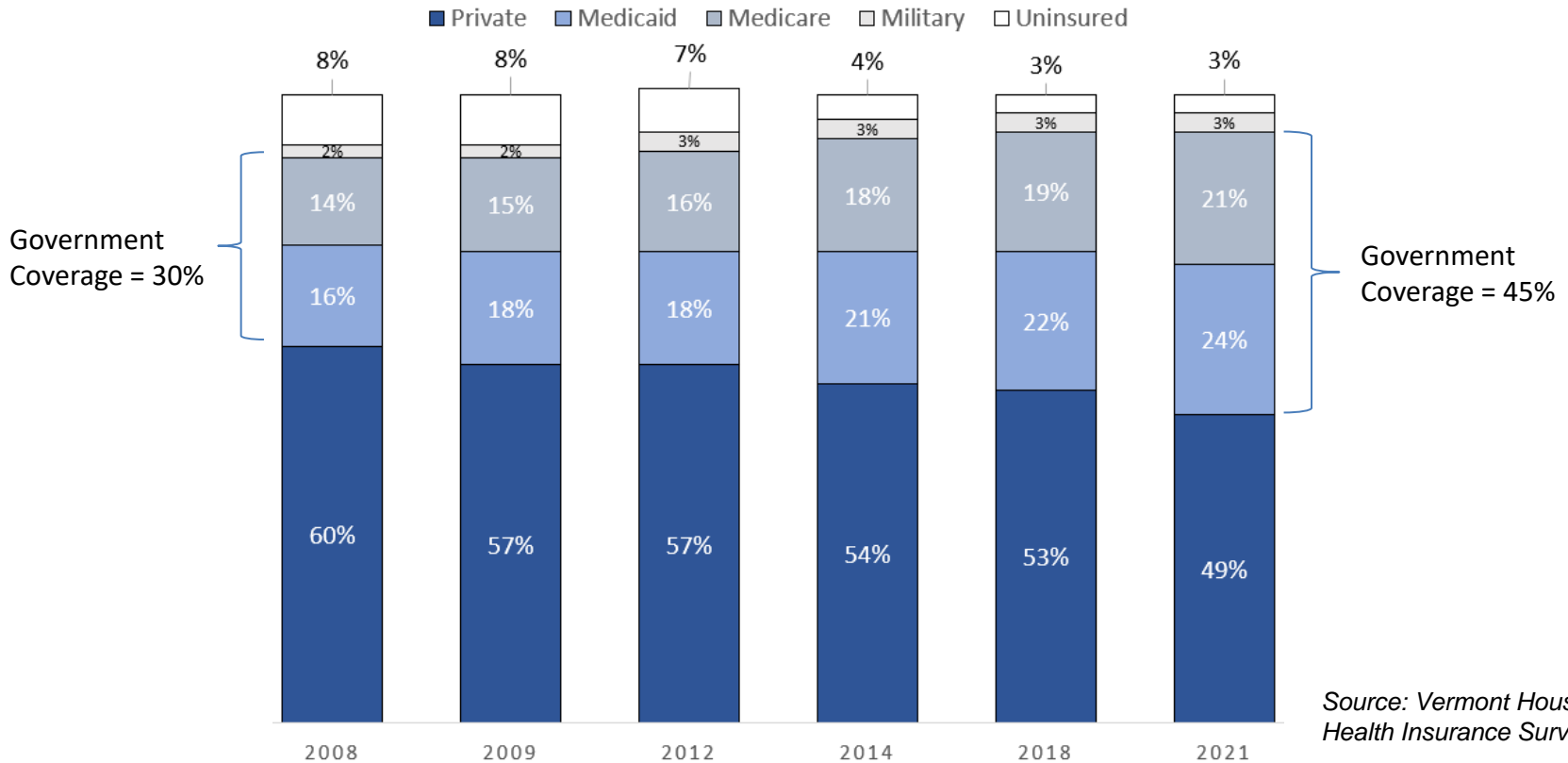
1) Chart = Primary source of health coverage by source (Vermont Household Health Insurance Survey, 2021)

2) Public employees (such as State employees and teachers) are treated as "private" insurance, not "public" insurance, in this and other documents because they are administered by private insurance companies acting as third-party administrators.



Context: Insurance Coverage

PRIMARY TYPE OF INSURANCE



Between 2008 and 2021:

- The rate of uninsured and commercially insured decreased
- The number of Vermonters with government insurance (Medicare and Medicaid) increased
- This trend can be found going back as far as 2000.



Context: Medicaid vs. Medicare

Medicaid

- State-federal program
- Low-income
- Children and adults
- 65 or older, blind, or disabled

Note: The list above is meant for illustrative purposes and does not include "Medicaid expansion" eligibilities which may differ from state to state.

Medicare

- Federal program
- All incomes
 - 65 or older
 - Any age with end stage renal disease
- Under 65 with certain disabilities



What is Medicaid?

- **Created in 1965 as Title XIX of Social Security Act**
- **Public health benefit program for low-income individuals and families and individuals with disabilities**
- **Financed through a federal-state partnership and administered by the states**
- **Each state designs and operates its own program within broad federal guidelines**

“If you’ve seen one Medicaid Program, then you’ve seen one Medicaid program.”

Vermont Medicaid

**VT Medicaid is administered by the
Department of Vermont Health Access (DVHA)**



*Green Mountain Care is the “umbrella” name
of all the State-sponsored health programs
under Vermont Medicaid.*



★ *Not to be confused with Green Mountain Care as laid out in
Act 48 (aka “single payer”) or with the Green Mountain
Care Board*

Context: Medicaid Coverage

(As of July 2022)

NATIONWIDE

Approximately 90 million individuals nationwide had coverage through Medicaid or CHIP (approx. 27% of Americans).

- CHIP = Children's Health Insurance Program.

VERMONT

Approx. 208,000 (1/3) of Vermonters received some form of assistance through Medicaid (including CHIP).

- Primary source of coverage:
 - Approximately **163,000** Vermonters (approx. 26%).
- Partial or supplemental assistance for approx. **45,000** Vermonters (approx. 7%)
 - e.g. premium assistance, Rx assistance, etc.

** These numbers have and continue to change due to the federal COVID-19 public health emergency declaration.*



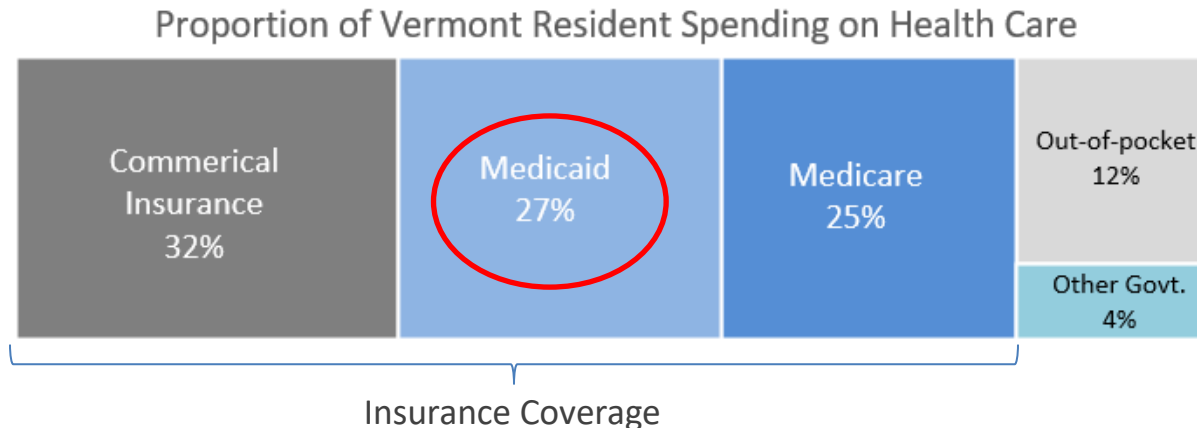
VERMONT

**MEDICAID
SPENDING**

Context: Overall Health Spending

IN 2020, VERMONTERS SPENT \$6.37 BILLION ON HEALTH CARE

- In 2019, Vermonters spent \$6.5 billion on health care.
- Spending decreased by 2.3% in 2020 due to the COVID-19 pandemic.
- **Medicaid** accounted for **27%** of Vermonters health spending in 2020.
 - This has state budget implications.

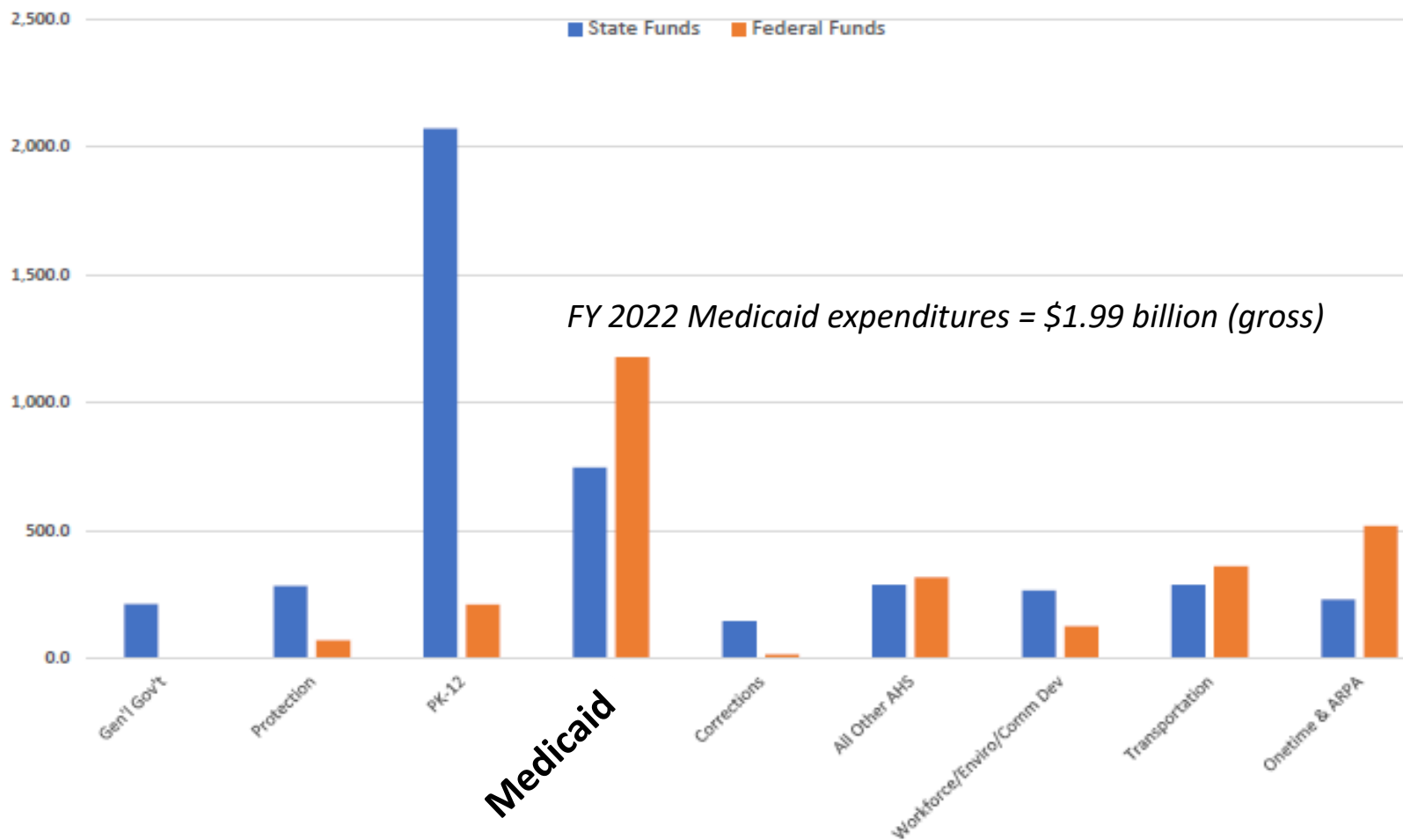


Source: 2020 Vermont Health Care Expenditure Analysis (published May 2022)



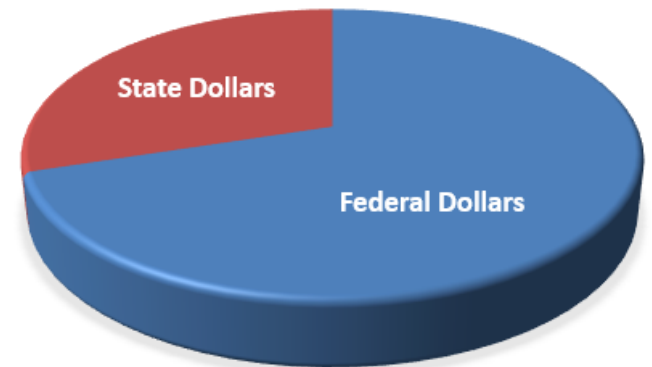
Context: State Budget (2022 illustration)

Where \$s Are Spent - FY22 Operating Budget
State Funds \$4.5B v. Federal Funds \$2.8B

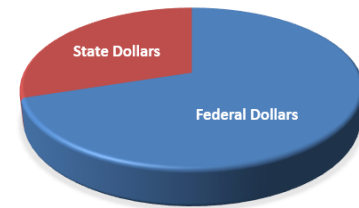


Medicaid Financing

- Overall FY 2022 Medicaid expenditures = \$1.9 billion (gross)
- Medicaid is funded through a combination of both State and Federal matching dollars.
 - In FY'22 total federal participation accounted for approximately 70% of overall Medicaid spending in Vermont.
 - Federal matching dollars range between 50% to 90% depending on the program and/or the expenditure.
- Most (not all) of the federal funds for the State's Medicaid program are from the FMAP (Federal Medical Assistance Percentage)



Federal Medical Assistance Percentage (FMAP)



- FMAP is the share of state Medicaid benefit costs paid by the federal government
- FMAP is calculated based on a 3-year average of state per capita personal income compared to national average
- No state can receive less than 50% or more than 83%

<i>COMPARISON OF FMAPs - Selected States (FFY 2024)</i>			
<u>New England States</u>	<u>Highest FMAP</u>	<u>Lowest FMAP (50% FMAP)</u>	
CT, NH, MA = 50%	Mississippi (77.27%) ↓	California	New Hampshire
RI = 55.01% ↑	West Virginia (74.10%) ↑	Colorado	New Jersey
Vermont = 56.75% ↑	Alabama (73.12%) ↑	Connecticut	New York
Maine = 62.65% ↓	New Mexico (72.59%) ↓	Maryland	Washington
		Massachusetts	Wyoming
↑ = Increased from previous year			
↓ = Decreased from previous year			

- States currently receive an additional 6.2% in FMAP as part of the federal Families First Coronavirus Response Act (2020)
- States also receive “enhanced FMAPs” for expansion populations under the ACA and for the *Children’s Health Insurance Program (CHIP)*



Federal Medical Assistance Percentage (FMAP)

SFY 2024 RATES*

Federal Medical Assistance Percentage (FMAP)

- 56.52% Federal / 43.48% State
- Applied to the majority Medicaid expenditures

STATE SHARE

\$1.00



GROSS

\$2.30



=

Enhanced FMAPs

Children's Health Insurance Program (CHIP)

- 69.57% Federal / 30.44% State
- Applied to Medicaid expenditures for approx. 4,700 low-income children

\$1.00



\$3.29



=

Childless New Adults

- 90% Federal / 10% State
- Applied to the Medicaid expenditures for approx. 47,000 childless adults

\$1.00



\$10.00



=

Note: These rates do not include the additional 6.2% FMAP states receive as part of the federal Families First Coronavirus Response Act

* The State fiscal year is different than the federal fiscal year. As such, the state uses a blended match rate to calculate SFY FMAP rates.



State Fiscal Year
(as used in state budget)

Year	State Share
------	-------------

2000	37.83%
2001	37.64%
2002	37.11%
2003	36.57%
2004	34.48%
2005	39.58%
2006	41.11%
2007	41.18%
2008	41.00%
2009	33.90%
2010	30.04%
2011	31.93%
2012	42.14%
2013	43.58%
2014	43.56%
2015	43.51%
2016	44.97%
2017	45.68%
2018	46.28%
2019	46.21%
2020	46.13%
2021	45.61%
2022	44.01%
2023	44.02%
2024	43.48%

Temporary fiscal relief to states

ARRA

Affordable Care Act (ACA)
"Leahy Bump"

+ 6.2% FMAP bump,
Families First
Coronavirus
Response Act

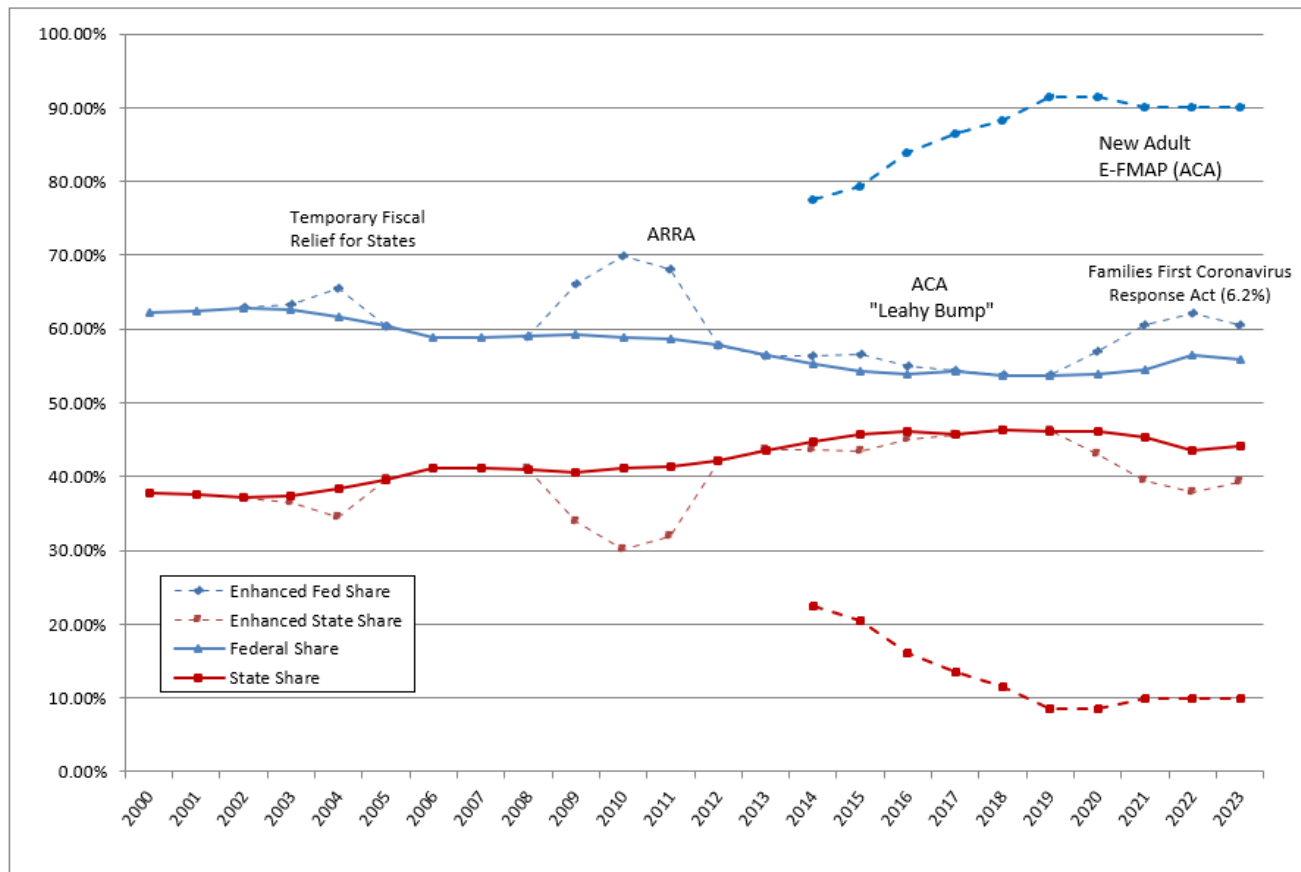
- Years where FMAP decreased
(and state share increased).

- Years where state received
enhancements to FMAP

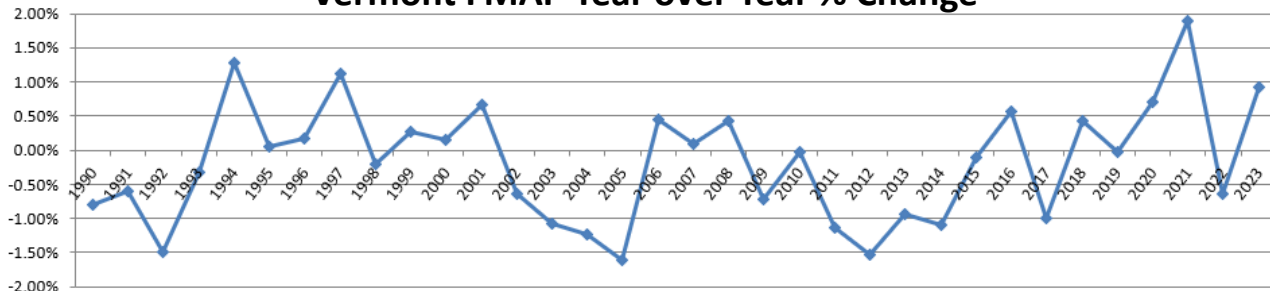
ARRA = American Recovery & Reinvestment Act

ACA = Affordable Care Act

FMAP History: Ups & Downs



Vermont FMAP Year over Year % Change



VERMONT

**GLOBAL
COMMITMENT**

GLOBAL COMMITMENT TO HEALTH

“If you’ve seen one Medicaid Program, then you’ve seen one Medicaid program.”

- Global Commitment to Health (“Global Commitment”) is the name of the 1115 Waiver Demonstration agreement between Vermont and CMS that is used to administer the majority of Vermont’s Medicaid program.
- As an 1115 Demonstration waiver, Global Commitment waives certain provisions of Medicaid law and give Vermont flexibility in administering the Medicaid program.
 - Must be budget neutral to the federal government.

Without a waiver:

- Medicaid is limited to what is approved by CMS in the Medicaid State Plan – mandatory and optional populations and services.
- Medicaid is strictly administered in compliance with Medicaid regulations (either FFS or Managed Care).



GLOBAL COMMITMENT TO HEALTH

Why does Vermont have a Waiver?

Vermont has had an 1115 waiver since 2005, allowing:

1. FFP for populations and services that are not authorized under the State Plan
 - Marketplace subsidy (up to 300% FPL)
 - Community Rehabilitation and Treatment (MH coverage above Medicaid limits)
 - VPharm
 - Choice for Care Moderate Needs
 - Global Commitment Investments
 - IMD payments
 - Cost-Effective alternatives
 - Children's palliative care service
 - SUD coverage above Medicaid limits (138%-225% FPL)*
 - Permanent Supportive House Services*

2. Flexibility to manage using a unique delivery model – Public Managed Care
Waivers of:
 - Payments outside of State Plan
 - State-wideness/Uniformity
 - Reasonable Promptness (CFC only)
 - Amount, Duration, and Scope (limits service array for some pops)
 - Freedom of Choice of Providers (allows restriction)
 - Upper Payment Limit (above Medicare amounts)

**Implementation planning is underway. Not yet operationalized.*



Medicaid Eligibility: Waiver Populations

Medicaid State Plan Eligibility Groups – Full State Plan Benefits

Aged, Blind, Disabled
Eligible for SSI or otherwise meet financial eligibility for ABD

New Adults
at or below 138% FPL who are:

- Not Pregnant
- Not 65 or older
- Not Receiving Medicare

Working Disabled
at or below 250% FPL

Pregnant Women
at or below 213% FPL

Children under 19
[Dr. Dynasaur]
at or below 317% FPL

Katie Beckett
Disabled children under 19 meeting institutional level of care. Parental income/resources not counted.

HCBS for Designated State Plan Populations – Full State Plan Benefits + HCBS

CFC Highest/High Needs - DAIL

Children under 21 with Severe Emotional Disturbance - DMH

Developmental Disabilities - DAIL

Traumatic Brain Injury - DAIL

Limited Benefit Waiver Groups – Not State Plan Eligible

VPharm
For Medicare beneficiaries with income 150 - 225% FPL.

Moderate Needs -DAIL
Below 300% of SSI benefit rate who meet clinical criteria and are at risk of institutionalization.

Marketplace Subsidy Program
For individuals at or below 300% FPL who purchase health care coverage in VHC.

Community Rehabilitation Treatment -DMH
For individuals with severe and persistent mental illness without income limit

Waiver Only Expenditures

Investments

IMD Payments

Cost-Effective Alternatives

Palliative Care for under 21 - VDH

Allowable without Waiver (WOW)

With Waiver Only (WW)

GLOBAL COMMITMENT TO HEALTH

Goals

- The terms and conditions layout how the program will be administered including who and what services are covered.
- Waiver agreements generally reflect a state's priorities and goals.
 - As goals, priorities, and leadership (at both the state and federal levels) have changed since 2005, so has Global Commitment.
- The stated goals in the current agreement are to:
 - Advance the state towards a population-wide comprehensive coverage
 - Implement innovative care models across the continuum that produce value
 - Engage Vermonters in transforming their health
 - Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports
 - Accelerate payment reform.



GLOBAL COMMITMENT TO HEALTH

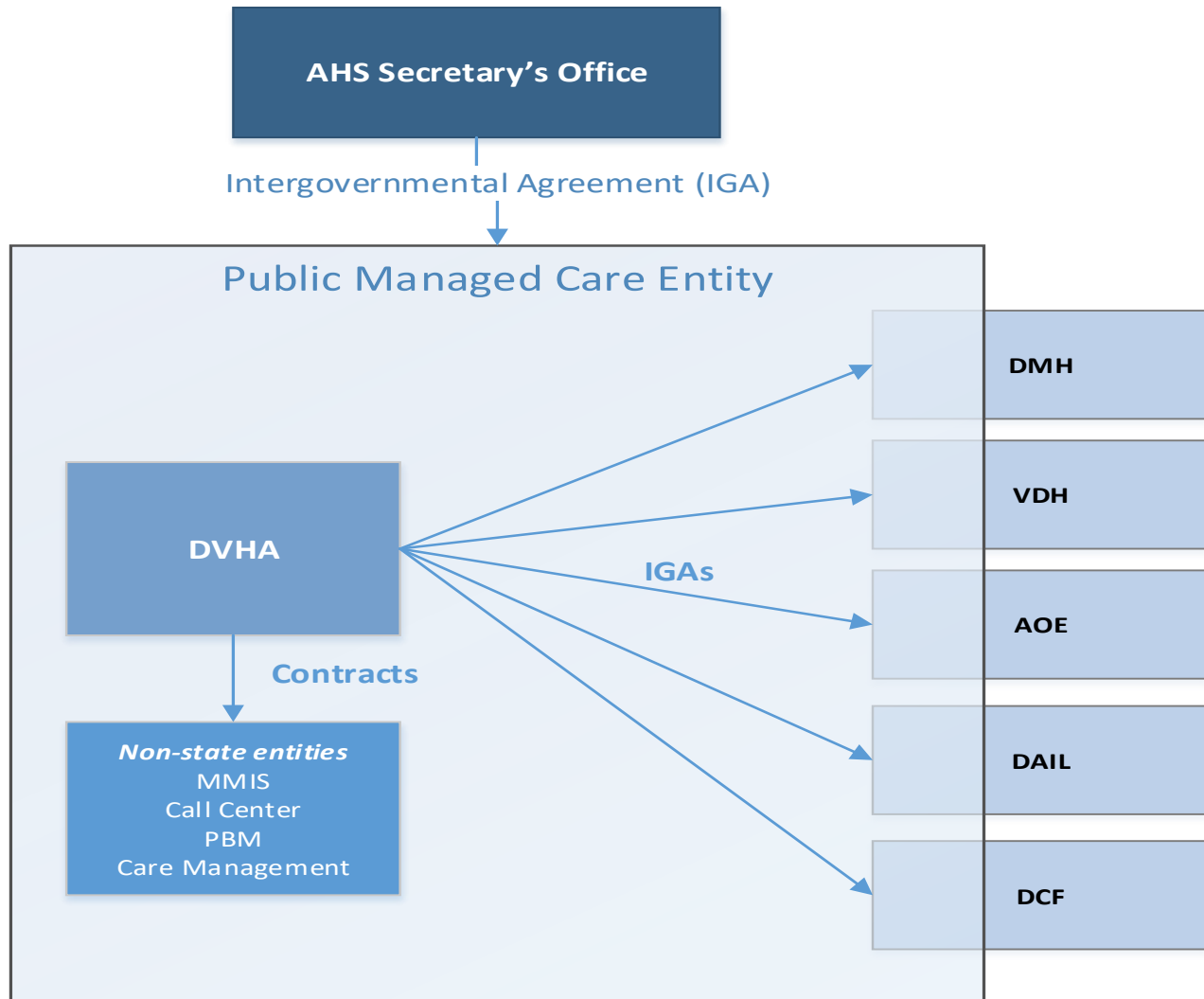
Investments

- Under the Global Commitment, DVHA operates in a managed care-like model.
 - In traditional managed care programs, achieved savings become profits. Under GC, savings are repurposed as “investments”.
 - These investment dollars can be spent on programs and initiatives that meet established criteria in the terms and conditions of the agreement and receive CMS approval.
 - In FY2022, Vermont had 67 investments worth \$106.7 million. Without the waiver, these would require all State funds only or be eliminated.
 - A list of investments can be found at:
<https://legislature.vermont.gov/assets/Legislative-Reports/Global-Commitment-Fund-Investment-Report-SFY22-10.12.22.pdf>



Waiver Delivery Model

[Public Non-Risk PIHP]



2022 FEDERAL POVERTY LEVELS (FPLs)

Monthly

Household Size	100%	138%	150%	200%	250%	300%	400%
1	\$1,133	\$1,563	\$1,699	\$2,265	\$2,831	\$3,398	\$4,530
2	\$1,526	\$2,106	\$2,289	\$3,052	\$3,815	\$4,578	\$6,103
3	\$1,919	\$2,648	\$2,879	\$3,838	\$4,798	\$5,758	\$7,677
4	\$2,313	\$3,191	\$3,469	\$4,625	\$5,781	\$6,938	\$9,250
5	\$2,706	\$3,734	\$4,059	\$5,412	\$6,765	\$8,118	\$10,823
6	\$3,099	\$4,277	\$4,649	\$6,198	\$7,748	\$9,298	\$12,397

Annually

Household Size	100%	138%	150%	200%	250%	300%	400%
1	\$13,590	\$18,754	\$20,385	\$27,180	\$33,975	\$40,770	\$54,360
2	\$18,310	\$25,268	\$27,465	\$36,620	\$45,775	\$54,930	\$73,240
3	\$23,030	\$31,781	\$34,545	\$46,060	\$57,575	\$69,090	\$92,120
4	\$27,750	\$38,295	\$41,625	\$55,500	\$69,375	\$83,250	\$111,000
5	\$32,470	\$44,809	\$48,705	\$64,940	\$81,175	\$97,410	\$129,880
6	\$37,190	\$51,322	\$55,785	\$74,380	\$92,975	\$111,570	\$148,760

<https://aspe.hhs.gov/poverty-guidelines>

