Medicaid Reimbursement Report

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History of the cost shift

- The hospital cost shift has been examined since the late 1980's
- The legislature established a Cost Shift Committee to prepare a report in 2006
- The report provided information about the magnitude and trends of the cost shift
- The report provided recommendations including that the information be reported annually
- Examination of the effect of the cost shift continues as part of the annual hospital budget reviews

Purpose of this Report

- An alternative approach to measuring the Medicaid cost-shift
  - Difference between Medicaid and Medicare reimbursement rates of hospitals and
  - An appropriate measurement developed for other health care providers after looking at Medicare rates

- Note: different methodology than used for GMCB cost-shift section of their Annual Report

What did you ask us to do for this Report?

- Provide
  - the amount of State funds needed to bring Medicaid reimbursements up to Medicare;
  - the projected impact on health insurance premiums;
  - whether premium reductions would likely result in a decrease in the aggregate amount of federal premium tax credits for which Vermont residents would be eligible and
  - specific timing considerations for the increase as it relates to Vermont's application for a Waiver for State Innovation pursuant to Section 1332 of the Patient Protection and Affordable Care Act (ACA).

Which rates did we analyze?

- 3 primary categories of service contribute to the cost shift:
  - Inpatient hospital facilities
  - Outpatient hospital facilities
  - Professional services
    - Primary care is a subset, but we pulled it out
    - These also flow to hospitals who have affiliated practices

Medicaid Categories of Service Compared to Medicare in CY2013

Category of Service	Providers Included in Calculation	DVHA Payments	Total Increase up to Medicare Amounts	Rates as a % of Medicare
Inpatient Hospital (facility services only)	In-State Hospitals	$92 M	n/a	> 100%
Outpatient Hospital (facility services only)	In-State Hospitals	$76 M	$29 M	72%
Professional Services (delivered in office setting and hospital setting)	In-State and Out-of-State Professionals	$86 M	$22 M	80%
Total			$51 M	
Primary Care ONLY (duplicative of above)	*In-State & Out-of-State Primary Care Professionals*	*$28 M*	*$7 M*	*80%*

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Funds Necessary to Increase Medicaid Rates to Medicare in 2016

Category of Service	Estimated DVHA Payment 2016	Total Increase up to Medicare Amounts	Estimated 2016 Rates as a % of Medicare
Inpatient Hospital	$146 M	n/a	> 100%
Outpatient Hospital	$116 M	$45 M	72%
Professional Services	$100 M	$25 M	80%
Total		$70 M	
Enrollment Increase		$30 M	

Estimated DVHA 2016

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How to Estimate Impacts on Private Premiums

- 341, 077 Vermonters have commercial insurance (VHHIS)
- Estimated average annual premium = $4,900 (GMCB)
- Projected total annual premium = $1.67 billion
- If $80M is passed through annually, premiums reduce to $1.59M or 5% impact

Is it $$ or trend?

- Trend! Paying less than you would have otherwise paid.
  - THERE WILL BE LOWER COSTS and premiums will be lower than they otherwise would be. Will have to delineate that clearly because most premium payers will not see actual $ decrease from 2015 premiums otherwise.

- Why? Health care costs rise faster than the economy grows.

What are the mechanisms for ensuing cost shift if passed on?

- GMCB hospital budget process
  - Includes affiliated physician practices, about half
  - Does not include out of state hospitals, so targeting **instate** outpatient reimbursement maximizes regulatory authority
- GMCB insurance premium reviews
  - Premiums include all providers (in and out of state)
  - Blunter instrument

What are the mechanisms for ensuing cost shift if passed on?

- Hospital and Medical Service Corporations
  - Statutory entity
  - Can direct them to pass this onto their customers
    - GMCB can check when they do premium review process
  - Use one fee schedule for ALL customers, including employer plans.
- Bully pulpit
  - Provide tools to employers for negotiation if they are not in regulated market
  - Voluntary participation by other insurers

Target Reimbursement to Maximize Regulatory Authority

- Maximize hospital budget process
  - Apply reimbursement increases to in-state hospital services (inpatient or outpatient)
- Estimate about 75% return for other services
  - Factors in Blue Cross/Blue Shield is dominant payer, hospital budget impacts, premium reviews
- Leave some room for “leakage”

Impacts on Federal Funding

- Lower premium trend reduces the amount of premium tax subsidies Vermonters would otherwise have received given a higher trend
- Since we are talking trend, actual $$ do not decrease
- Increasing reimbursements, however, bring in additional Medicaid federal funds. This offsets reduction in premium tax credit $.
- NOT ALL FEDERAL FUNDS ARE CREATED EQUAL – DOLLARS TOWARD COST SHIFT HELP LOWER PRIVATE PREMIUMS. DOLLARS TOWARD PRIVATE PREMIUMS JUST PAY FOR THE OVERPAYMENT…

Impact on Individuals and Families

- The federal premium tax credit is adjusted annually
  - excess of the rate of premium growth over the rate of income growth for the preceding year
  - The percentage of income paid by the individual increases with premium increases
  - Reducing the premium growth rate reduces the amount of Vermonters' individual contributions
- In addition, only about 65% of Vermonters receive premium tax credits