Draft text from 2016 Budget, re Blueprint; Cost Shift

Sec. E.307.3 BLUEPRINT FOR HEALTH: PAYMENT INCREASES
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall:
(1) increase payments to the Blueprint for Health's community health teams under section 705 of Title 18 by $541,078 in Global Commitment Funds;
(2) adjust payments for community health teams under section 705 of Title 18 to reflect revised patient attribution and market share of insurers and Medicaid. Payments may be modified as set forth in section 702(b) of Title 18 and insurers shall participate in the new payment amounts as required by section 706 of Title 18. The Department shall increase its payments to reflect increased enrollment in Medicaid by an amount up to $467,833 in Global Commitment Funds.
(b) Beginning January 1, 2016, the Department of Vermont Health Access shall increase payments to primary care medical homes under 18 V.S.A. § 704 by $3,500,000 in Global Commitment Funds.
EXPLANATION: Invests in Blueprint for Health to support primary care, support delivery reform in primary care, and improve health outcomes. Increases payments to Blueprint for Health's community health teams and primary care medical homes. Also, has DVHA adjust insurer payments to reflect new market share, including Medicaid.

Sec. E.307.4 HOME HEALTH: PAYMENT INCREASES
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall modify reimbursement methodologies and amounts to home health agencies as defined in 8 V.S.A. § 4095 to provide prospective payments and to include a quality component and increasing available funding by $1,250,000 in Global Commitment Funds.
EXPLANATION: Begins a payment reform for home health agencies and increases Medicaid reimbursement to home health agencies to invest in better health outcomes.

Sec. E.307.5 HEALTH HOME INVESTMENT
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall increase health home funding by $5,000,000 in Global Commitment Funds to invest in delivery system reform.
EXPLANATION: Invest in better health outcomes through increased funding for health care delivery reform.

Sec. E.307.6 COST SHIFT: INCREASE REIMBURSEMENT TO MEDICARE LEVELS
(a) Beginning January 1, 2016, the Department of Vermont Health Access shall increase reimbursement as follows to address the Medicaid cost shift:
(1) for in-state outpatient services as defined in 42 U.S.C. § 1396d(a)(2) by $10,000,000;
(2) for primary care services by $5,000,000;
(3) for inpatient hospital services as defined in 42 U.S.C. § 1396d(a)(1) for Dartmouth Hitchcock Medical Center by $1,500,000;
(4) for non-primary care professional services as defined in 42 U.S.C. §1396d by $9,000,000.
(b) Beginning July 1, 2015, the Department of Vermont Health Access is appropriated $29,768,988 to account for an increase in Medicaid caseload. This appropriation is included in Sec. B.307 of this act.
EXPLANATION: Increase Medicaid reimbursement and support increased caseload to help address Medicaid cost shift and invest in better health outcomes.

Sec. E.307.7 COST SHIFT ACCOUNTABILITY
(a)(1) In fiscal year 2016 the amount of $25,500,000 in Global Commitment Funds is appropriated in this act to the Agency of Human Services to address health care inflation and reduce costs shifted to private insurers due to the underpayment of health care providers by Medicaid. This amount annualizes to approximately $51,000,000.
(2) In fiscal year 2016 the amount of $29,768,988 in Global Commitment Funds is appropriated in this act to the Agency of Human Services to address Medicaid enrollment and a reduction in the uninsured, which will reduce uncompensated care and bad debt assumed by health care providers. This amount reflects a full year cost.

(3) The Green Mountain Care Board (GMCB) shall account for the impact on the cost shift of these investments through its regulatory authority over hospital budgets and health insurer rates. The GMCB shall include its assessment of the impacts in its annual report as required by 9375(d) of Title 18.
(4) Any hospital service corporation established under chapter 123 of Title 8 and medical service corporation established under chapter 125 of Title 8 shall adjust their reimbursement to health care providers and premiums or administrative fees charged to account for the impact of investing funds in Medicaid provider reimbursement in order to ensure the cost shift is reduced to the fullest extent possible.
EXPLANATION: Directs the Green Mountain Care Board to ensure that the increases in Medicaid reimbursements and for a reduction of the uninsured are accounted for in hospital charges and in private insurance premiums.

Sec. E.307.8 REPEALS
(a) 2000 Acts and Resolves No. 152, Sec. 117b, as amended by 2013 Acts and Resolves No. 79, Sec. 42 is repealed July 1, 2015.
EXPLANATION: Repeals report required by the Department of Vermont Health Access on the cost shift, because the Green Mountain Care Board is required to report on the cost shift by 18 VSA 9375(d).

Sec. E.308 CHOICES FOR CARE; SAVINGS, REINVESTMENTS, AND SYSTEM ASSESSMENT
(a) In the Choices for Care program, "savings" means the difference remaining at the conclusion of fiscal year 2015 between the amount of funds appropriated for Choices for Care, excluding allocations for the provision of acute care services, and the sum of expended and obligated funds, less an amount equal to one-percent of the fiscal year 2015 year total Choices for Care expenditure. The one-percent shall function as a reserve to be used in the event of a fiscal need to freeze Moderate Needs Group enrollment. Savings shall be calculated by the Department of Disabilities, Aging, and Independent Living and reported to the Joint Fiscal Office.
(1) It is the intent of the General Assembly that the Department of Disabilities, Aging, and Independent Living only obligate funds for expenditures approved under current law.
(b)(1) Any funds appropriated for long-term care under the Choices for Care program shall be used for long-term services and supports to recipients. In using these funds, the Department of Disabilities, Aging, and Independent Living shall give priority for services to individuals assessed as having high and highest needs and meeting the terms and conditions of the Choices for Care waiver.
(2)(A) First priority for the use of any savings from the long-term care appropriation after the needs of all individuals meeting the terms and conditions of the waiver have been met shall be given to home- and community-based services. Savings may also be used for quality improvement purposes in nursing homes but shall not be used to increase nursing home rates under 33 V.S.A. § 905.
(B) Savings either shall be one-time investments or shall be used in ways that are sustainable into the future. Excluding appropriations allocated for acute services, any unexpended and unobligated State General Fund or Special Fund appropriation remaining at the close of a fiscal year shall be carried over to the next fiscal year.
(C) The Department of Disabilities, Aging, and Independent Living shall not reduce the base funding needed in a subsequent fiscal year prior to calculating savings for the current fiscal year.
(c) The Department, in collaboration with Choices for Care participants, participants' families, and long-term care providers, shall conduct an annual assessment of the adequacy of the provider system for delivery of home- and community-based services and nursing home services. On or before October 1, 2015, the Department of Disabilities, Aging, and Independent Living shall report the results of this assessment to the House Committees on Appropriations and on Human Services and the Senate Committees on Appropriations and on Health and Welfare in order to inform the reinvestment of savings during the budget adjustment process.
(d) On or before January 15, 2016, the Department of Disabilities, Aging, and Independent Living shall propose reinvestment of the savings calculated pursuant to this section to the General Assembly as part of the Department's proposed budget adjustment presentation.
(e) Concurrent with the procedures set forth in 32 V.S.A. § 305a, the Joint Fiscal Office and the Secretary of Administration shall provide to the Emergency Board their respective estimates of caseloads and expenditures for programs under the Choices for Care Medicaid Section 1115 waiver.
EXPLANATION: Same provision as in 2014 Act 179 Sec. E.308.