Honorable Janet Ancel
Chair, House Ways and Means Committee
Vermont House of Representatives
State House
Montpelier, VT 05602

January 21, 2015

RE: Vermont Medicaid 2016 Reimbursement for Professional Services

Dear Representative Ancel,

The Vermont Medical Society (VMS) is providing these comments to the House Ways and Means Committee in support of the Administration's SFY2016 Appropriations Bill Section E.307.6 COST SHIFT: INCREASE REIMBURSEMENT TO MEDICARE LEVELS (attached).

The Department of Vermont Health Access (DHVA) budget narrative for SFY2014 indicated: "[I]t is a fairly well-known fact that Medicaid rates of reimbursement have not kept up with the rate of inflation. In order to providers to cover their costs, they have had to negotiate disproportionately higher rates of reimbursement with other insurers resulting is a cost shift."

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." Subsection (d) was enacted in 2002 and to the best of the VMS' knowledge this is the first time an Administration has complied with its requirements.

DHVA uses Medicare's Resource Based Relative Value Scale (RBRVS) methodology in establishing its Medicaid reimbursement for the services provided by physicians and other health professionals. 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).

Effective January 1, 2015, DVHA pays for Medicaid professional medical care services using a single CF of $28.71.The conversion factor for Medicare until March 31, 2015 is $35.8013. Therefore, DHVA's Medicaid professional reimbursement for 2015 as a percentage of Medicare equals 80.19 percent (28.71/35.8013).

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 was increased for 2013 and 2014 using new federal funds to 100 percent of the Medicare rate (using July 1, 2009 as a base year). Primary care physicians in Vermont received more than $8 million in enhanced Medicaid payments each of the last two years through this program.

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With the expiration of this Enhanced Primary Care Program (EPCP) and the resulting loss of the federal funding, in 2015 Vermont primary care providers saw their Medicaid reimbursement reduced from 100 percent of Medicare to 80 percent of Medicare – a 20 reduction (this 20 percent cut does not apply to primary care physicians employed by FQHCs and RHCs, since DVHA reimburses federally qualified health centers (FQHCs) on a cost basis capped at 130 percent of Medicare and Rural Health Clinics (RHCs) on a cost basis capped at 110 percent of Medicare).

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 indicated to DHVA that the 20 percent reduction in payment in 2015 for primary care services could result in primary care practices having to limit the number of Medicaid beneficiaries they treat in order to meet the costs of operating their practices and undermine the critical role primary care physicians' play in reforming Vermont's health care delivery system. The lack of replacement funding was especially shortsighted, since under the Medicaid FMAP funding formula, the state would only pay 46 percent of the increased reimbursement and the federal government would pay the remaining 54 percent.

At 21.2 percent in 2014, Vermont's Medicaid program is the second highest in the country as a percentage of a state's total personal health care spending[1] and the percentage continues to grow. State governments' long-standing practice of Medicaid underpayment has a much greater impact on Vermont physicians, since their percentage of Medicaid patients is much greater compared to other states. This is especially true for pediatricians who have been disproportionately impacted by the 20 percent cut in 2015, due to the large number of Vermont children covered by Medicaid/Dr Dynasaur.

PPACA guidelines expand Medicaid coverage for most adults up to an income of 138% of federal poverty level (with income offsets). However, in Vermont, children (aged 0 to 18) are eligible for Medicaid or Dr. Dynasaur if their family's income is 317% of FPL or less (with income offsets). Out of the remaining 23,231 uninsured in Vermont (3.7 percent), only 1,298 (1.0 percent) are children.

Again, the VMS strongly supports the administration's SFY2016 proposal to increase Medicaid reimbursement to Medicare levels. Please let me know if you have any questions or suggestions.

Sincerely,

Paul Harrington

Paul Harrington
Executive Vice President, Vermont Medical Society

Attachments

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[1] Health Spending by State of Residence, 1991–2009; Medicare & Medicaid Research Review 2011: Volume 1, Number 4; Cuckler, G. et al; pages E12-E13. http://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Cost Shift related Language

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.

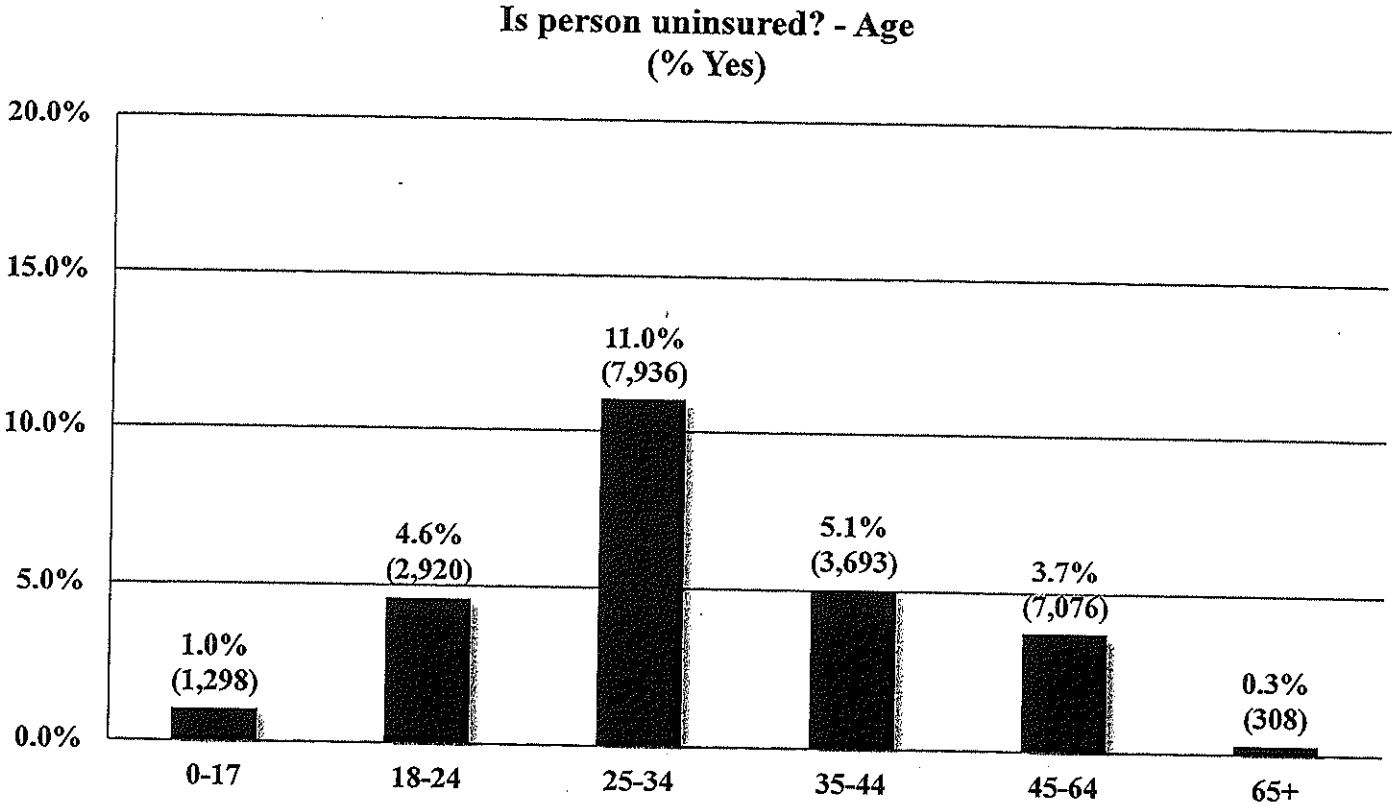
Trends in Primary Source of Health Insurance Coverage, 2000 - 2014

	Rate						Count					
	2000	2005	2008	2009	2012	2014	2000	2005	2008	2009	2012	2014
Private Insurance	60.1%	59.4%	59.9%	57.2%	56.8%	54.4%	366,213	369,348	370,981	355,358	355,857	341,077
Medicaid	16.1%	14.7%	16.0%	17.6%	17.9%	21.2%	97,664	91,126	99,159	109,353	111,833	132,829
Medicare	14.4%	14.5%	14.3%	15.3%	16.0%	17.7%	87,937	90,110	88,915	95,182	100,506	110,916
Military	0.9%	1.6%	2.4%	2.2%	2.5%	3.0%	5,626	9,754	14,910	13,917	15,478	18,578
Uninsured	8.4%	9.8%	7.6%	7.6%	6.8%	3.7%	51,390	61,057	47,286	47,460	42,760	23,231

Data Sources: 2000, 2005, 2008, 2009, 2012 and 2014 Vermont Household Health Insurance Surveys

Note: Primary type of health insurance coverage classifies residents with more than one type of insurance into a single category based upon the following hierarchical order; Medicare (except in cases where resident was over 64 and covered by a private insurance policy through an employer with 25 or more employees or person was covered by military insurance), private insurance, military, state health insurance and uninsured. Included in the category of private health insurance coverage are those covered through the Catamount Health Program.

More than one in ten (11%) adults aged 25 to 34 is uninsured.



Source: 2014 Vermont Household Health Insurance Survey