



State of Vermont
Agency of Administration
Health Care Reform
109 State Street
Montpelier, Vermont 05609

REPORT TO THE VERMONT LEGISLATURE

Medicaid Reimbursement Report

In accordance with Act 144 of 2014, Section 20

Submitted to
House Committees on Health Care and on Ways and Means
Senate Committees on Health and Welfare and on Finance

Submitted by
Robin Lunge, Director of Health Care Reform
Agency of Administration
&
Kara Suter, Director of Payment Reform and Reimbursement
Department of Vermont Health Access

In consultation with the Green Mountain Care Board

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Introduction

The general assembly requested several interrelated reports¹ on Medicaid reimbursement amounts and its impacts on private insurance plans. This report, in conjunction with the Green Mountain Care Board Annual Report, submitted separately, fulfills these requirements.

Specifically, the general assembly expressed its intent to measure the elimination of the Medicaid cost shift, defined as the difference between Medicaid and Medicare reimbursement rates for hospitals and, for other health care providers, an appropriate measurement developed after examining Medicare rates. The general assembly requested an analysis of the impact of increasing Medicaid reimbursement rates to eliminate the cost shift, as defined above, including:

- the amount of State funds needed to effect the increase;
- the projected impact of the increase on health insurance premiums; and
- to the extent that premium reductions would likely result in a decrease in the aggregate amount of federal premium tax credits for which Vermont residents would be eligible, whether there are 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).

This report determines that the state would need to invest approximately \$70 million in 2016 to increase Medicaid reimbursement rates sufficiently to come up to Medicare reimbursement in the aggregate. While there are many potential ways to invest these dollars, we recommend investing additional Medicaid dollars in payments for primary care, professional services, and hospital outpatient services.

As to the projected impact on health insurance premiums, investments in the cost shift will result in a reduction in premium increases which will benefit Vermonters. At this time, there are no timing considerations related to a Waiver for State Innovation under the ACA.

Cost Shift

The cost shift occurs when hospitals and other health care providers charge higher prices to patients who have private insurance or no insurance to make up for lower reimbursement from Medicare, Medicaid, charity care, or bad debt. The Green Mountain Care Board (GMCB, or Board) is responsible for reporting annually on the cost shift.

In 2006, the Legislature in Act 191 created the Cost Shift Task Force. This entity was charged with creating an annual report for the Legislature that describes the cost shift, quantifies its impact, and presents reporting recommendations that include:

- a standard reporting instrument;
- improvements to physician payer data;
- distinctions between the amount of Vermont Medicaid and non-Vermont Medicaid

¹ See Sec. 117b of No. 152 of the Acts of 2000, as amended by Sec. 42 of No. 79 of the Acts of 2013; Sec. E.345.1 of No. 50 of the Acts of 2013; Sec. 20 of No. 144 of the Acts of 2013 Adj. Sess. (2014); and 18 V.S.A. 9375(d).

- payments; and
- increased transparency in reporting on “disproportionate share”—the Medicaid payments to hospitals that serve populations with especially high coverage by Medicaid.

It is important to note that the cost shift methodology developed by the Cost Shift Task Force, and now used by the GMCB for its Annual Report, includes analysis of eliminating the cost shift from several sources other than Medicaid. In addition, because the GMCB analyzes the cost shift impacts from these various sources, the amounts included in its Annual Report will be greater than the amounts included in this report, which is focused on eliminating the Medicaid cost shift as defined by the general assembly to be increasing Medicaid reimbursement to Medicare reimbursement rates.

Differences in Medicare and Medicaid Rates

There are different payment systems underlying Medicaid reimbursement. Three categories of service (COS) comprise the majority of medical benefit spending likely to contribute to cost shifting. These COS include: 1) inpatient hospital facilities, 2) outpatient hospital facilities, and 3) professional services, which include both physician offices and professional fees across settings. In addition, we separately analyzed primary care reimbursement as a sub-set of professional services. Because many hospitals also have affiliated primary care and professional services, increases in these categories also flow through to hospitals.

As required by the general assembly, we analyzed Medicaid reimbursement across these three COS compared to Medicare reimbursement using the best available data and most feasible analytic design. All the estimates in Table 1, below, have unique caveats that should be considered when drawing conclusions. Appendix One to this report is a technical document that describes the assumptions and transformations used to compare the rates; Appendix Two describes the main sources of data used to derive the estimates presented in this report.

The findings of the analysis are represented in Table 1 on the following page:

Table 1. 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)	<i>In-State & Out-of-State Primary Care Professionals</i>	\$28 M	\$7 M	80%

In order to approximate the needed increase in the amount of Medicaid reimbursement in 2016, we need to account for recent growth in Medicaid enrollment as well. For purposes of the analysis in this report, we estimate \$30 million additional dollars would be necessary to cover current rates for newly enrolled Medicaid beneficiaries; without these new dollars, rates would have to decrease to compensate, hence widening the cost shift. To adjust for growth in service utilization, we are using proposed state fiscal year 2016 DVHA budget numbers as best available information as of the time of analysis.

Using the percentages calculated above applied to proposed DVHA budget numbers, we estimate that for 2016, approximately \$70M would be needed to bring Medicaid rates to parity with Medicare and an additional \$30 million would continue to be necessary to account for enrollment. Therefore, a total of approximately \$100 million is necessary to fully reimburse at Medicare levels.

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

In the Governor's state fiscal year 2016 budget, we include increases for outpatient hospitals, professional services, and a separate increase for primary care services, totally \$25M beginning January 1, 2016 (\$50 million annualized). In addition, the Governor's budget includes \$30M annually beginning July 1, 2015 to account for caseload increase. Because caseloads are not expected to decrease, this amount would be built into the base for future years. This is an annual investment of \$80 million.

While this investment does not fully bring all COS up to Medicare reimbursement levels, it makes significant progress towards that goal in a tight budget climate. The funds for this investment are raised through a .7% payroll tax on employers.

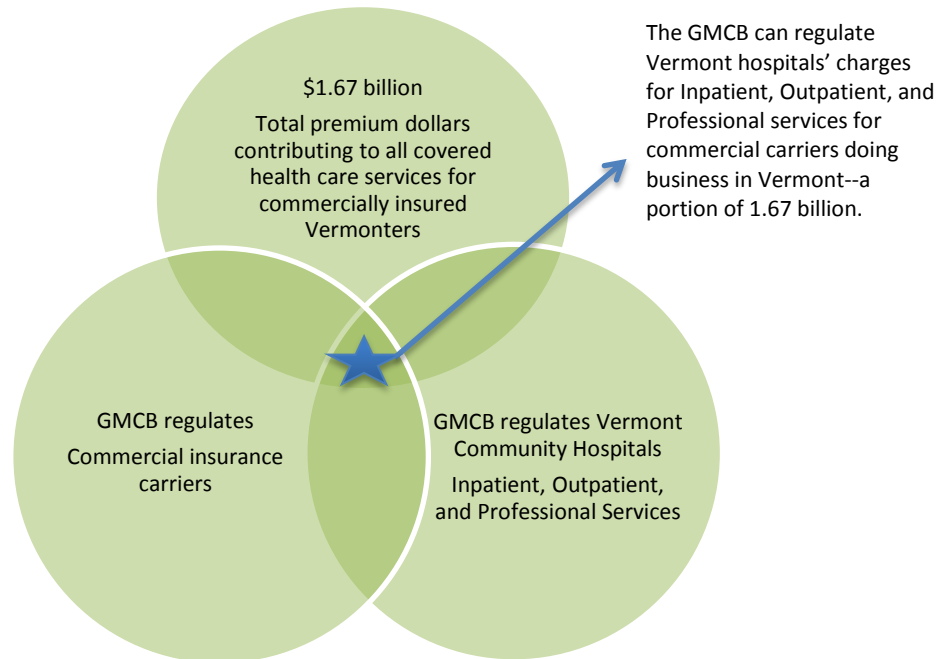
Impact on Private Premiums

We also analyzed the impact of increasing Medicaid reimbursement to Medicare levels on private premiums. According to the 2014 Vermont Household Health Insurance Survey, 341, 077 Vermonters have commercial insurance as their primary source of health care coverage. The projected amount of total annual premium paid for the commercially insured population, given an estimated average annual premium of \$4,900, is \$1.67 billion.

If health care providers fully pass through the Medicaid reimbursement increases through the rates charged to private insurance and employer plans, the amount invested into the cost shift should have an equivalent reduction in reimbursements under these other systems. Therefore, an investment of \$80 million in Medicaid could reduce the total amount of premium paid for commercial insurance to \$1.59 billion, or by approximately five percent.

Given that health care costs are rising faster than the economy is growing, it is unlikely that premium payers will see this as a dollar decrease in their 2015 premiums. Premium payers will however, see a smaller increase in health care premiums in 2016 than they otherwise would have seen, absent the increase.

Through its hospital budget process, the GMCB can ensure that Medicaid investments in the cost shift will impact the amount that Vermont community hospitals charge to private insurers and the uninsured for Inpatient, Outpatient, and Professional services. The Board also has the authority to ensure that the premiums charged by insurers doing business in Vermont reflect Vermont hospitals' charges for Inpatient, Outpatient and Professional services. Figure 1 below illustrates that the GMCB can regulate a portion of the total amount of commercial premiums paid by Vermonters.



We stress that the Green Mountain Care Board hospital budget process does not regulate all provider charges for every service covered by commercial insurance and Medicaid. However, Section 9376 of Title 18 of the Vermont Statutes Annotated specifies that the Board may set reasonable rates for health care professionals. The GMCB does not have authority to regulate premiums charged by insurers that are not doing business in Vermont. The Board also has no authority over the rates charged by out-of-state hospitals.

For the reasons described above and as Figure 1 illustrates, the exact amount that an increased investment in Medicaid will impact the total amount paid in insurance premiums for Vermonters can only be broadly estimated at this time. Vermont's hospitals and insurance carriers, facilitated by the GMCB, should begin discussing an appropriate process for determining precisely how Vermont hospitals can adjust their rates to maximize the benefit to all Vermonters from an increased investment in Medicaid.

In addition, because most insurers also act as third-party administrators for self-insured employers, and to the extent that the provider reimbursements are consistent across an insurer's business, the cost shift investments should be felt as reduced cost trends by businesses that choose to self-insure.² We encourage self-insured businesses to work with their third-party administrators to ensure that cost shift investments recommended by the Governor and passed by the general assembly are returned to them by their third-party administrators. We also encourage health care providers, insurers and other third-party administrators to ensure that the investments in the cost shift reduce the amounts paid in premiums.

² Due to the Employee Retirement Security Act of 1974, the state has no regulatory authority of self-insured employer plans and may not ensure that the cost shift investments are passed through to these employers.

Acknowledging all of the caveats above, we provide the following example calculation to demonstrate the potential return on investment from increased Medicaid rates. We assumed that 100 percent of the increased Medicaid dollars paid as rate increases for Outpatient Services would be recaptured as savings in premiums. We also assumed that approximately 75 percent of professional services payments could be recaptured. Using these assumptions, based on data from 2012-2013, we estimate just over \$46 million in premium relief that year. Similar logic applied to 2016 would yield premium relief of about \$94 million.

Impact on Federal Premium Tax Credits

The Affordable Care Act provides premium tax credits to some Vermonters who purchase insurance plans in the individual market through Vermont Health Connect. These credits are available to Vermonters whose household income is less than 400% of poverty, which is \$95,400 a year for a family of 4 or \$46,680 for an individual.³ In addition, these credits are only available if the individual or family does not have access to coverage through their employer.⁴ Vermont provides an additional state subsidy, which further reduces the family's premium costs.

The premium tax credit subsidy amount paid by the federal government is the difference between a set percentage of the individual's household income and the second lowest cost silver plan covering the individual's family. As a result, it is possible that a lower premium would reduce the amount of subsidy an individual would have otherwise received; however, there are two considerations that need to be taken into account. First, addressing the cost shift will reduce the rate of premium growth, so the federal subsidies themselves will not decrease from year to year. Second, even if premium rates were reduced and resulted in a reduced federal subsidy for an individual, it is difficult to quantify what this looks like in the aggregate. Reduced premiums could result in increased wages, which could make more Medicaid enrollees eligible for the premium tax credit. Furthermore, a reduction in premiums may not result in Vermont receiving less federal funding overall, because Vermont will be increasing federal contributions with the increase in its Medicaid payments. Economic modeling is needed to find out the exact effect on the aggregate amount.

In addition, under the ACA, the federal premium tax credit is adjusted annually based on the excess of the rate of premium growth over the rate of income growth for the preceding year.⁵ This means that the percentage of income paid by the individual increases with premium increases. Reducing the premium growth rate will go towards reducing the amount of Vermonters' individual contributions.

³ These numbers are from 2014 federal poverty levels, which are used to calculate 2015 eligibility.

⁴ There is an exception made when the employer's coverage is considered unaffordable, which is defined as when the employee contribution to the employer's plan for self-only coverage exceeds 9.5% of household income. I.R.C. § 36(c)(2)(C).

⁵ I.R.C. § 36B(b)(3)(A)(ii) & Rev. Proc. 2014-37.

Appendix One

Technical Appendix

Medicaid Payments

Medicaid payments reported in this report are those used to calculate the federal fiscal year (FFY) 2014 upper payment limit (UPL) test. For professional services, the total amount used was adjusted by eight million to adjust to account that the Enhanced Primary Care Program (EPCP), a program that provided enhanced federal funding for certain primary care services, was initiated 2013 and 2014 but is no longer. A full description of the UPL tests can be found in Appendix Two.

Medicare Payments

The best sources of comparative Medicaid rate information are the annual Upper Payment Limit (UPL) tests. The UPL uses an estimate of “total cost” of providing services compared to the Medicaid rate paid. Therefore, estimating the difference in payments between Medicare and Medicaid requires making assumptions and transforming the data contained in the UPLs. A summary of those assumptions and transformations are below; as with any estimates, there are caveats and limitations that should be considered when interpreting these findings.

Inpatient Hospitals

For this analysis, we first removed spending attributable to out of state hospitals, roughly accounting for 31% of inpatient spending (\$92 million). We then assume that Medicare payments were roughly equal to 80% less than costs for Medicare prospective payment system (PPS) hospitals which account for approximately 68% of inpatient hospital costs and that CAHs were paid at 100% of inpatient hospital costs. Based on these assumptions, the total Medicare equivalent therefore, for in-state inpatient hospitals is approximately \$98 million. Medicaid in-state inpatient rates are approximately 116% higher than this benchmark. Given the caveats below, the estimates in this report are reported as >100%.

Outpatient Hospital (facility services only)

Similar to the inpatient hospital analysis, we assume that Medicare outpatient payments would be 80% for PPS hospitals (\$66 million) and 100% for CAHs (\$39 million) for a total Medicare equivalent of \$105 million. The number in the UPL is for in-state only hospital outpatient departments, so no adjustment in total payments or spending were made.

Professional Services (delivered in office setting and hospital setting)

Unlike the inpatient and outpatient UPLs, Medicare and Medicaid rates can be compared using the ratio of the Medicaid Conversion Factor (CF) to the Medicare CF. The Medicare CF in 2013 was \$ \$34.0376 and Medicaid was \$27.1642 resulting in a ratio of 79.8%. Total Medicare payment benchmark therefore, was calculated by adjusting total payments (net of EPCP removed) by 20%.

Primary Care ONLY (duplicative of above)

In this analysis, the amount estimated for primary care, which is included in the estimates of professional services (i.e., this is a subset of the other number reported), includes both those evaluation and management services as well as other services provided by these primary care providers like procedures, laboratory tests and screenings, and drug administration services. We assumed that approximately 32% of the total professional services spend was attributable to primary care providers (physicians and nurses). This was derived based on 2013 financial models used for annual rate setting and reporting.

The table below summarizes the professional and primary care professional service rate comparison.

Adjusted Professional Services CY2013				
	Coverion Factor (rounded, in whole dollars)	Payments (rounded, in millions)	Medicaid as Percent of Medicare	Difference Medicaid from Medicare
Medicaid	\$ 27	\$ 87	80%	\$ 22
Medicare	\$ 34	\$ 109		
Adjusted Primary Care (32%) 2013				
	Coverion Factor (rounded, in whole dollars)	Payments (rounded, in millions)	Medicaid as Percent of Medicare	Difference Medicaid from Medicare
Medicaid	\$ 27	\$ 28	80%	\$ 7
Medicare	\$ 34	\$ 35		

Caveats

There are many limitations to this analysis. We have confidence about magnitude and direction of estimates, however, additional analysis would be warranted to obtain a more precise. Other spending outside of the UPL or more data to inform assumptions may also improve precision of estimates.

This report focused on comparative rate information based on CY2013 data. The estimates were not trended forward or adjusted for case-mix, volume or price changes. The only adjustment was to account for the end of the EPCP program. Since these estimates largely do not include the three percent rate increase effective on November 1, 2013, a separate column increased the percent of Medicare estimates to account for increase.

The most sensitive assumption used in the analysis is what percentage of cost would equal Medicare-equivalent payments. There is no precise source of this information and a percentage of 80% was chosen as a nationally discussed, reasonable estimate. However, Vermont has a higher proportion of CAHs and its academic medical center (AMC) is a large proportion of the total market.

The UPLs only consider a comparison on costs and rates paid under fee-for-service. The UPLs do not contemplate some supplemental payments like the disproportionate share hospital (DSH) payments or payments made under the Blueprint for Health. They also do not consider liabilities providers pay as a result of the provider tax.

Appendix Two

FFY14 Upper Payment Limit Tests for Hospital Services and Professional Services

As part of ongoing maintenance of Medicaid programs, the Centers for Medicare and Medicaid (CMS) require state Medicaid agencies to compute upper payment limits (UPLs) for certain categories of service. The UPL is defined as the maximum amount of payments that CMS will allow federal matching funds to be paid against. The test is run annually and uses a 12-month utilization baseline of data in the computations. The maximum amount allowed by CMS is compared to the actual amount that the state Medicaid agency pays out. In DVHA's case, the amount that DVHA paid out below the maximum is defined as the "room" below the UPL.

The table below shows the most recent UPL tests run for inpatient hospital and outpatient hospital services as well as professional services. The amount of room below the UPL varies significantly by category of service.

Category of Service	Time Period for Utilization in Study	Providers Included in Calculation	Source Data Used to Determine Maximum Payment	Maximum Payment	DVHA Payment	UPL "Room"	Pct of Max Payment in Rates
Inpatient Hospital (facility services only)	Discharges 10/1/11 – 9/30/12	In-State and Out-of-State Hospitals	Hospital costs as reported on each hospital's Medicare cost report year ending 9/30/12	\$149.0 M	\$132.7 M	\$16.3 M	89.1%
Outpatient Hospital (facility services only)	Dates of Service 10/1/12 – 9/30/13	In-State Hospitals only	Hospital costs as reported on each hospital's Medicare cost report year ending 9/30/13	\$122.0 M	\$75.6 M	\$46.4 M	62.0%
Professional Services (delivered in office setting and hospital setting)	Dates of Service 1/1/13 – 12/31/13	In-State and Out-of-State Professionals	The average rate paid by commercial carriers in the State in CY 2013	\$220.8 M	\$94.4 M	\$126.4 M	42.7%

It should be noted that the Maximum Amount does not equal the amount that Medicare pays to providers. In most cases, the Medicare program also pays providers less than the allowable costs reported on their Medicare cost report. Therefore, the amount that Medicare pays to providers is an amount less than the Maximum Payment.

The amounts shown in the DVHA Payment column are inclusive of any rate increases made to providers since the time period for utilization in the study.