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Vermont Medicaid Payment Alignment Report

Act 85 of 2017

Submitted to
The Joint Fiscal Committee

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This report is submitted to fulfill the requirements of Section E.306.2 of Act 85 of 2017, titled *Medicaid Payment Alignment*.[1] The report describes certain payments and payment changes, both implemented and contemplated, within the Medicaid program. Section A sets forth the statutory charge. Section B describes the current state of Disproportionate Share Hospital (DSH) payments. Section C summarizes changes to certain primary care payments. Section D lists other primary care investments.

Section A: Statutory Charge

The study arises from language included in the State budget for State Fiscal Year (SFY) 2018.

Sec. E.306.2 MEDICAID PAYMENT ALIGNMENT
(a) It is the intent of the General Assembly that alignment of the various Medicaid provider payments, as funded in this act, support access to primary care, including access to independent primary care practices and mental health services statewide.
(b) In order to accomplish this, the Department of Vermont Health Access is authorized to make adjustments and transfers within the related appropriated amounts of fiscal year 2018 general funds for these line items in the aggregate as follows:

(1) Adjust the total DSH amount to a level no lower than $27,488,781.

(2) Set a specific limit for annual DSH payments to an in state academic postgraduate teaching facility within the DSH formula.

(3) Review and adjust current facility based payments, and specifically evaluate any Medicaid payments that are above the payment from Medicare for the same service in order to further enhance primary care payments in fiscal year 2018.
(c) The Department of Vermont Health Access shall report to the Joint Fiscal Committee in September and November 2017 on any adjustments and transfers made under this authority.

The next three parts of the report provide an update on payment issues listed in § E.306.2(b)(1) – (3).

Section B: Disproportionate Share Hospital (DSH) Payments

There are two primary purposes of DSH Payments: (1) to offset uncompensated costs borne either through the costs to serve uninsured patients or the costs not paid by DVHA or CMS for Medicaid beneficiaries and (2) maintain access for low income individuals.[2] DVHA will make DSH payments to hospitals in the amount of $27,488,781 for State Fiscal year 2018, the minimum amount set forth in Act

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[1] See http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT085/ACT085%20As%20Enacted.pdf.
[2] DVHA offered the House Health Care Committee a brief primer on DSH. *See* http://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House%20Health%20Care/Bills/H.518/FY2018%20Governor's%20Proposed%20State%20Budget/DVHA%20Budget/W~Michael%20Costa~Federal%20Medicaid%20Disproportionate%20Share%20Hospital%20(DSH)%20Allotment,%20Payments,%20and%20Proposal~2-22-2017.pdf. The State's annual DSH report offers more detailed information. *See* http://dvha.vermont.gov/for-providers/dsh-methodology-for-ffy-2017-final-10-05-16.pdf.

85. The current projected amount on a per hospital basis is listed in below in Table 1, along with historical payment data.

Table 1: DSH Payments, Federal Fiscal Years (FFY)2012 – 2018[3]

	DSH FFY 2012 Payments	DSH FFY 2013 Payments	DSH FFY 2014 Payments	DSH FFY 2015 Payments	DSH FFY 2016 Payments	DSH FFY 2017 Payments	DSH FFY 2018 Payments
Brattleboro Memorial Hospital	$ 1,176,989	$ 1,236,502	$ 881,885	$ 1,100,858	$ 895,517	$ 983,812	$ 517,313
Central Vermont Medical Center	$ 1,893,868	$ 2,057,789	$ 2,123,923	$ 3,113,501	$ 3,247,134	$ 1,606,925	$ 1,628,175
Copley Hospital	$ 677,478	$ 667,459	$ 819,721	$ 696,562	$ 502,588	$ 988,678	$ 758,102
Gifford Medical Center	$ 875,394	$ 807,107	$ 806,560	$ 842,693	$ 982,684	$ 858,641	$ 645,999
Grace Cottage Hospital	$ 153,081	$ 216,999	$ -	$ -	$ -	$ -	$ -
Mt. Ascutney Hospital	$ 302,698	$ 283,346	$ 533,586	$ 376,571	$ 187,766	$ 541,427	$ 683,877
North Country Hospital	$ 2,092,289	$ 1,848,818	$ 2,738,458	$ 2,432,098	$ 1,825,088	$ 1,463,567	$ 403,818
Northeastern Vermont Hospital	$ 1,033,166	$ 1,293,715	$ 1,759,289	$ 1,695,772	$ 1,472,395	$ 1,742,622	$ 1,075,299
Northwestern Medical Center	$ 2,109,676	$ 2,128,462	$ 1,543,718	$ 1,274,456	$ 1,455,325	$ 1,897,969	$ 1,278,056
Porter Medical Center	$ 753,493	$ 827,357	$ 600,425	$ 962,327	$ 505,159	$ 443,503	$ 813,664
Retreat Health Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rutland Regional Medical Center	$ 3,821,595	$ 4,251,425	$ 5,395,100	$ 4,701,489	$ 4,200,184	$ 5,693,662	$ 3,995,289
Southwestern Vermont Hospital	$ 2,437,759	$ 2,073,221	$ 2,563,962	$ 2,884,892	$ 1,927,505	$ 727,153	$ 1,043,610
Springfield Hospital	$ 1,396,906	$ 1,641,055	$ 1,433,114	$ 2,435,484	$ 1,523,045	$ 1,776,430	$ 881,186
University of Vermont Medical Ctr	$ 18,724,391	$ 18,115,526	$ 16,249,041	$ 14,932,076	$ 18,724,391	$ 18,724,391	$ 13,724,391
Totals	**$ 37,448,781**	**$ 37,448,781**	**$ 37,448,781**	**$ 37,448,781**	**$ 37,448,781**	**$ 37,448,781**	**$ 27,448,780**

The historical data reveals volatility in the annual payment made to individual hospitals. The volatility is due to the current DSH formula, which relies on many variables and compares a hospital's uncompensated costs to the experience of other hospitals. DVHA believes that the present DSH formula is inconsistent with the overall policy goals of making health care financing more predictable and sustainable. Accordingly, DVHA is willing to work with providers to re-evaluate the DSH formula for future years. DVHA believes that the issue of setting a proper DSH methodology is separate from setting the level of funding. The ACA requires future DSH reductions, but this issue is the subject of ongoing federal uncertainty.

[3] Hospitals are required to operate on a federal fiscal year starting in October while the State Fiscal Year starts in July. While not required, DSH payments are typically made in three equal installments in October, November, and December so that they fall in the same state and federal fiscal year.

Section C: Changes to Primary Care Payments

Increasing primary care investments is a key health care reform goal.[4] Investments in primary care can take several forms. Avenues for investment include the following:

- Payment rates for services,
- Additional or increases to payments from DVHA, The Blueprint for Health, and accountable care organizations, and;
- Investments for services primary care offices use, such as information technology or analytics.

The State of Vermont's investment in primary care should be viewed not just as rates but the sum of these expenses. Totaling all investments in primary care can be difficult due to challenges defining primary care; however, DVHA will be investigating this issue further and may have an update in the November report.

One strategy to promote this goal is to create equity between Medicare and Medicaid for primary care rates. Vermont took advantage of time limited federal funding to achieve this parity until the federal program expired on December 31, 2014. This was broadly referred to as the "primary care bump." Vermont policymakers have made incremental progress towards restoring the bump over the past several fiscal years, including allocating an additional $4 million in investment in SFY2017.

DVHA has now achieved this goal by aligning payment for certain primary care codes with Medicare through its recent update to its physician fee schedule and primary care incentive payments, which became effective August 1st.[5] Specifically, DVHA increased the rate paid to eligible primary care providers for certain services to equal the Medicare calendar year 2017 payment rates.[6] This increase is achieved by using a special conversion factor (CF), which was formerly called an Enhanced Primary Care Payment, or EPCP.

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[4] The Blueprint for Health has demonstrated Vermont's long-term commitment and practice of primary care investment and innovation. Additionally, the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement with the federal government is focused on primary care. *See* http://gmcboard.vermont.gov/payment-reform/APM.

[5] Vermont's Global Commitment Register (GCR) provides information on Vermont Medicaid policy changes. GCR 17-061 contains information on these primary care payments. See http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

[6] The Vermont Medical Society's comments to this proposed change listed creating equity with Medicare payments as a "major public policy milestone."

It is useful to understand how Medicare and Medicaid typically pay physicians. DHVA pays for professional services using the resource-based relative value scale, known as Resource-based Relative Value System (RBRVS). This system uses resource-based relative value units (RVUs) developed by Medicare as the basis for determining rates. DVHA updates these relativities periodically. There are three types of RVUs: physician work, practice expense, and malpractice. A provider's place of service determines whether a non-facility (all three RVUs) or a facility (just physician work) are paid. The relativities are then turned into a Medicaid rate by applying a Medicaid-specific Conversion Factor (CF). There is an enhanced CF for eligible primary care providers and services.[7] The enhanced payment is on certain codes associated with primary care. A list of services and codes eligible for the enhanced payment is provided on the next page in Table 2:

[7] Each of these RVUs are also multiplied by its corresponding Geographic Practice Cost Index (GPCI), which can account or geographical differences between providers. While this is important in some areas, Vermont uses the same GPCI statewide and it does not create any differentiation in payment for providers.

Table 2: Update to List of Primary Care Conversion Factor Eligible Service

HCPCS/CPT with NO CHANGE				PROPOSED HCPCS/CPT TO EXCLUDE			
HCPCS/ CPT Code	HCPCS Description	Prior to August 1, 2017 Updates, Included as EPCP CF?	Pre-August 1, 2017 Updates, Included as Primary Care CF?	HCPCS/ CPT Code	HCPCS Description	Prior to August 1, 2017 Updates, Included as EPCP CF?	Pre-August 1, 2017 Updates, Included as Primary Care CF?
90460	immunization admin	YES	YES	99217	Observation care discharge	YES	NO
90461	immunization admin	YES	YES	99218	Initial observation care	YES	NO
90471	Immunization admin	YES	YES	99219	Initial observation care	YES	NO
90472	Immunization admin each add	YES	YES	99220	Initial observation care	YES	NO
90473	Immune admin oral/nasal	YES	YES	99221	Initial hospital care	YES	NO
90474	Immune admin oral/nasal addl	YES	YES	99222	Initial hospital care	YES	NO
99201	Office/outpatient visit new	YES	YES	99223	Initial hospital care	YES	NO
99202	Office/outpatient visit new	YES	YES	99231	Subsequent hospital care	YES	NO
99203	Office/outpatient visit new	YES	YES	99232	Subsequent hospital care	YES	NO
99204	Office/outpatient visit new	YES	YES	99233	Subsequent hospital care	YES	NO
99205	Office/outpatient visit new	YES	YES	99234	Observ/hosp same date	YES	NO
99211	Office/outpatient visit est	YES	YES	99235	Observ/hosp same date	YES	NO
99212	Office/outpatient visit est	YES	YES	99236	Observ/hosp same date	YES	NO
99213	Office/outpatient visit est	YES	YES	99238	Hospital discharge day	YES	NO
99214	Office/outpatient visit est	YES	YES	99239	Hospital discharge day	YES	NO
99215	Office/outpatient visit est	YES	YES	99281	Emergency dept visit	YES	NO
99318	Annual nursing fac assessmnt	YES	YES	99282	Emergency dept visit	YES	NO
99324	Domicil/r-home visit new pat	YES	YES	99283	Emergency dept visit	YES	NO
99325	Domicil/r-home visit new pat	YES	YES	99284	Emergency dept visit	YES	NO
99326	Domicil/r-home visit new pat	YES	YES	99285	Emergency dept visit	YES	NO
99327	Domicil/r-home visit new pat	YES	YES	99291	Critical care first hour	YES	NO
99328	Domicil/r-home visit new pat	YES	YES	99292	Critical care addl 30 min	YES	NO
99334	Domicil/r-home visit est pat	YES	YES	99304	Nursing facility care init	YES	NO
99335	Domicil/r-home visit est pat	YES	YES	99305	Nursing facility care init	YES	NO
99336	Domicil/r-home visit est pat	YES	YES	99306	Nursing facility care init	YES	NO
99337	Domicil/r-home visit est pat	YES	YES	99307	Nursing fac care subseq	YES	NO
99341	Home visit new patient	YES	YES	99308	Nursing fac care subseq	YES	NO
99342	Home visit new patient	YES	YES	99309	Nursing fac care subseq	YES	NO
99343	Home visit new patient	YES	YES	99310	Nursing fac care subseq	YES	NO
99344	Home visit new patient	YES	YES	99315	Nursing fac discharge day	YES	NO
99345	Home visit new patient	YES	YES	99316	Nursing fac discharge day	YES	NO
99347	Home visit est patient	YES	YES	99356	Prolonged service inpatient	YES	NO
99348	Home visit est patient	YES	YES	99357	Prolonged service inpatient	YES	NO
99349	Home visit est patient	YES	YES				
99350	Home visit est patient	YES	YES				
99354	Prolonged service office	YES	YES				
99355	Prolonged service office	YES	YES				
99381	Init pm e/m new pat infant	YES	YES				
99382	Init pm e/m new pat 1-4 yrs	YES	YES				
99383	Prev visit new age 5-11	YES	YES				
99384	Prev visit new age 12-17	YES	YES				
99385	Prev visit new age 18-39	YES	YES				
99386	Prev visit new age 40-64	YES	YES				
99387	Init pm e/m new pat 65+ yrs	YES	YES				
99391	Per pm reeval est pat infant	YES	YES				
99392	Prev visit est age 1-4	YES	YES				
99393	Prev visit est age 5-11	YES	YES				
99394	Prev visit est age 12-17	YES	YES				
99395	Prev visit est age 18-39	YES	YES				
99396	Prev visit est age 40-64	YES	YES				
99397	Per pm reeval est pat 65+ yr	YES	YES				
99401	Preventive counseling indiv	YES	YES				
99402	Preventive counseling indiv	YES	YES				
99403	Preventive counseling indiv	YES	YES				
99404	Preventive counseling indiv	YES	YES				
99406	smoking and tobacco use	YES	YES				
99407	smoking and tobacco use	YES	YES				
99408	alcohol and/or sub abuse screen	YES	YES				
99409	alcohol and/or sub abuse screen	YES	YES				
99450	basic life and disability exam	YES	YES				
99460	Init nb em per day hosp	YES	YES				
99461	Init nb em per day non-fac	YES	YES				
99462	Sbsq nb em per day hosp	YES	YES				
99463	Same day nb discharge	YES	YES				
99464	Attendance at delivery	YES	YES				
99465	Nb resuscitation	YES	YES				
99466	Ped crit care transport	YES	YES				
99467	Ped crit care transport addl	YES	YES				
99468	Neonate crit care initial	YES	YES				
99469	Neonate crit care subsq	YES	YES				
99471	Ped critical care initial	YES	YES				
99472	Ped critical care subsq	YES	YES				
99475	Ped crit care age 2-5 init	YES	YES				
99476	Ped crit care age 2-5 subsq	YES	YES				
99477	Init day hosp neonate care	YES	YES				
99478	Ic lbw inf < 1500 gm subsq	YES	YES				
99479	Ic lbw inf 1500-2500 g subsq	YES	YES				
99480	Ic inf pbw 2501-5000 g subsq	YES	YES				

**E&M Codes from 99201 through 99499 or vaccine administration codes from 90460 through 90474; as of 7/1/2017 excludes 99217-99316.

**Reimbursement is for Physician fee's only and does not include any Facility fee's.

It is important to note that in achieving equity with Medicare in primary care that DVHA now mirrors Medicare policies that differentiate payment amounts between physician services and those services rendered by a nurse practitioner and physician assistant. DVHA has not always made this distinction in

previous years. Specifically, DVHA did not make this distinction between physicians and non-physicians when the EPCP was 100% federally funded and unintentionally failed to create this distinction in previous years.

DVHA funded these changes with several policy changes and an additional appropriation by the legislature. First, DVHA made several technical corrections to its enhanced primary code payments. Technical changes included:

- Exclusion of codes previously eligible for an enhanced payment that were not truly for primary care. (See Table 2). For example, several emergency room codes were being paid at the enhanced rate.
- Changes that shifted eligibility for the payment from one based on code utilization to one based on attestation as a primary care provider. This change excluded some clinicians that are not likely to be primary care focused and services that do not occur in a primary care setting. For example, several emergency room codes were previously included in the enhanced payment code set.
- A distinction between enhanced primary care payments made in a facility and non-facility setting. Previously, the program paid facilities (like hospitals) the higher non-facility rate. Now, DVHA is paying either a facility-based EPCP or non-facility-based EPCP depending upon the provider.
- Alignment with Medicare policies regarding the payment differential between physician and non-physician clinicians, as described in the above paragraphs.

The total net increase in spending on eligible primary care providers is estimated to be approximately $1.6 million; however, the adjustments described above reallocated some of the current enhanced payment and other payments to this investment.

Overall, DVHA believes that the program now better supports primary care by mirroring the underlying reimbursement principle with Medicare where it is prudent to do so. DVHA will continue to monitor the program to assess performance.

Section D: Other Primary Care Investments

DVHA continues to make other investments that support primary care. These investments include Blueprint for Health payments, accountable care organization (ACO) payments, and Primary Care Case Management payments.

The Blueprint for Health

The Blueprint continues to invest in primary care work and innovation. These investments consist of expenses to support practices and programs as well as direct payments to practices.

Investment expenditures include learning collaboratives, surveys, analytics, health information technology (HIT) development, and a variety of one-time and per member per month (PMPM) payments. Direct blueprint payments are made for the following programs:

- Patient-centered Medical Home (PCMH) PMPM (All Insurers)
- Community Health Team (CHT) Core Monthly Payments (All Insurers)
- CHT Medication Assisted Treatment (MAT) for Spokes PMPM
- Services and Supports at Home (SASH) Payments for Medicare Quarterly Payments
- Women's Health Initiative (WHI) One Time Payments for Medicaid (At Program Initiation)
- WHI PMPM for Medicaid
- CHT WHI Payments for Medicaid PMPM

Total Blueprint investments are expected to be approximately $39.2 million in SFY 18, of which the State of Vermont pays $25.2 million.

Accountable Care Organization (ACO)

The Vermont Next Generation ACO Program (VMNG) provides a $6.50 PMPM administrative fee to the ACO, and the ACO pays $3.25 of each PMPM to the primary care provider that is responsible for those attributed lives. Those payments have totaled an investment of approximately $719,000 in primary care as of August 31st.[8]

Primary Care Case Management (PCCM)

DVHA continues to make Primary Care Case Management (PCCM) payments to providers in the amount of $2.50 PMPM for their patients enrolled in Medicaid, totaling approximately $3.3 million annually. PCCM payments are distinguishable from Blueprint and ACO payments. First, the PCCM payment is not tied to a delineated and measurable program like the Blueprint and ACO. Second, it is not tethered to a prospectively known individual for a known period of time, unlike the ACO PMPM that follows a specific member for the year and is paid from the ACO. Instead, the PCCM methodology is based on ongoing health care utilization and can change monthly. Also, it is paid as part of DVHA's ordinary remittances to a provider, meaning that the provider experiences the PCCM payment as an add on to their regular payments from DVHA. Accordingly, there is no evidence to support that this payment is contributing to the provision of case management.

[8] See the September 2017 ACO report submitted by DVHA to the Legislature pursuant to Act 25 of 2017. Estimated publication date of September 15, 2017: http://legislature.vermont.gov/reports-and-research/find/2018.

Health Centers

DVHA has been engaged in a multi-year project to evaluate the way it pays health centers, both Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The result of this project will be re-setting health center rates starting calendar year 2018. DVHA is currently in the process of consulting with health centers and will update the committee on this issue in the November report.

Next Steps

DVHA continues to evaluate its payment rates and methodologies to ensure alignment with overall policy goals. DVHA will report again to the Joint Fiscal Committee on this issue in November, as required by Act 85.