MEDICAID BUDGET CONCERNS

NCSL Summit:
Sunday - August 6, 2017

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• VT pop. 626k (≤18 = 20% / ≥65 = 19%)
  – 38% covered by Self-Insured plans
  – 13% covered by Exchange QHP plans
  – 22% covered by Medicare
  – 24% Medicaid/CHIP as primary coverage plus
    • 8% Dual or supplemental Medicaid coverage
    • 56% of VT kids are Medicaid/SCHIP covered

• Medicaid+= $1.79b (state $ = $709m or 28%)
  – 46% Medical (in/out, dr, Rx) -- 16% on MH services
  – 12% DDS Services -- 11% Long-term Care
  – 6% DSH/Clawback/Other -- 6% Administration
  – 4% Substance Abuse
Total Health Care Spending in Vermont = $5.7 Billion

- 14 hospitals in Vermont
  - All of not-for-profit hospitals
  - UVMMC only tertiary in state
- Dartmouth-Hitchcock Medical Center (in NH)
  - Approx. 41% of patient discharges are VTers

Useful Fact #1
2 Carriers cover approximately 90% of the all private lives in Vermont - BCBSVT is 80% of that 90%

Useful Fact #3
Hospital Care accounts for 38% of all VT health care spending.
The GMCB was created in 2011 to:
- Regulate hospital budgets,
- Regulate health insurance rates (individual and small group market)
- Regulate certificate of need (CON) for major capital expenditures
- Review ACO budgets (new)
- Test new and innovative ways to pay for and delivery health care as part of its role in building a new system
  - Example: All-Payer Model

Five member board, appointed by the Gov. confirm by Sen.
Medicaid Budget Challenges
The Usual Suspects

• FMAP Fluctuations
• Reimbursement Rate Tensions
  – Impacts on other parts of the system
  – Recent actions
    • MH rate increase
    • Ambulance provider tax
    • Primary Care
    • DSH reduction
• Phase out of some waiver investments over time
• Annual consensus caseload and budget baseline & year end report - This is a good thing!
<table>
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<th>Year</th>
<th>Federal Share</th>
<th>State Share</th>
<th>Difference</th>
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<td>54.46%</td>
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<td>2018</td>
<td>53.47%</td>
<td>46.53%</td>
<td>-0.99%</td>
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= Years where FMAP decreased from previous year
ACA = Affordable Care Act
All-Payer Model (APM)

PURPOSE
• Aims to change the way health care payments are made from fee-for-service to a value-based, pre-paid service model across all payers (Medicare, Medicaid, Commercial)
• 5 year agreement Jan. 2017- Dec. 2022 (Note: 2017 = Year 0)

GOALS
• Improve the patient experience of care
• Improve the health of populations
• Reduce per capita health care cost growth from 2018-2022

- Limit health care cost growth to no more than 3.5% in aggregate across all payers
- Limit Medicare cost growth to 0.1% to 0.2% below the projected national per beneficiary growth.

Medicaid Leads w/ 1st ACO Contract
Risk arrangement
Budget Pressure or Relief?...
Traditional System Payment Mechanics

Payers
- Medicare (Fed)
- Medicaid (State/Fed)
- Commercial Insurers
- Self Insured Entities

Providers
- Doctors
- Hospitals
- FQHCS

Other Providers
- Pharmacies
- Nursing Homes
- Community partners: DAs, VNA, HH and others
- Out of State

GMCB Regulation
Hospital budgets
Insurance rates

Fee for service, Grants & Other Payments

Contracts

Payments

Patient lives attributed to the ACO based on payer contracts & Primary Care Dr. membership – Est at 36% of lives in 2018 reaching 70% in 2022

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GMCB Regulation
Hospital budgets
Insurance rates

ACO Capitated Rates

FFS payments
Questions for the Group

Anecdotes rule and time is always short -

It’s a tricky business of assuming savings in one area based on shifting those resources to another area

- Are we breaking something that works?
- Are we getting to someplace better?
- Are there perverse or unintended consequences?

How do you evaluate if the investments you make are making a difference?

- Does the analysis bring change?
- How? When?