

STATE OF VERMONT
GENERAL ASSEMBLY

HEALTH ACCESS OVERSIGHT COMMITTEE

Attached please find the report and recommendations of the subcommittee appointed to carry out the Medicaid Deficit and Reimbursement Study, authorized under Sec. 112 of No. 215 of the 2005 Adj. Sess. (2006), An Act Relating to Making Appropriations for the Support of Government.

Sec. 112 directed the Health Access Oversight Committee to study options for and develop a plan to eliminate the Medicaid deficit. The committee appointed a subcommittee of four members to review information and make recommendations to the full committee.

As described in the attached report, the recommendations of the subcommittee are as follows:

1. Develop New Ways of Looking at Medicaid Spending
2. Develop Better Data Systems and Reporting Mechanisms
3. Focus on Cost-Control Strategies that “Bend the Curve”
4. Expedite a Statewide Plan for Chronic Care Delivery and Payment Changes
5. Promote Strategies to Reduce the Prevalence of Chronic Disease
6. Monitor Financial Pressures within the Medicaid Long Term Care System
7. Increase Administrative Coordination and Integration in Medicaid
8. Maximize Medicaid’s Reliance On Predictable Funding Sources – Minimize The Use Of One-Time Funding
9. Dedicate all new revenue under the “Master Settlement Agreement” to Medicaid

Sincerely,

Jane Kitchel, co-chair

Mark Larson, co-chair

Jeanette White

Ann Pugh

Subcommittee, Medicaid Deficit Study

Attachment

Medicaid Deficit Study

What is Medicaid?

Medicaid is a complex health care financing system that provides assistance to about one in four Vermonters. While Medicaid is most familiar as a health insurance program for low-income individuals and families, it also supports a wide range of services that are not included in commercial health insurance. Currently, Medicaid supports:

- About one-half of all long term care (nursing homes, home health services) in Vermont
- The state's systems for the treatment of people with mental illnesses, developmental disabilities, or substance abuse issues
- A wide range of services for children, such as school-based therapies and support services

Medicaid is governed by both state and federal law. The federal government establishes who must be covered (mandatory populations) and who may be covered (optional populations). Each state decides which optional populations it will cover. The same concept of mandatory and optional also applies to services. For example, coverage of hospital care is mandatory, while coverage of prescription drugs is optional. Although some populations and services are optional, choices about who and what to cover may have unexpected financial consequences.

Who is on Medicaid?

Medicaid provides assistance to a wide variety of Vermonters, from children with serious illnesses to seniors who need some help paying their pharmacy bills. Broadly speaking, Medicaid covers any child below 300% of poverty (about \$60,000 for a family of four) and most adults below 150% of poverty (about \$14,700 for an individual). People can also qualify as a result of having a serious illness. The three descriptions below are examples of seriously ill people covered by Medicaid.¹

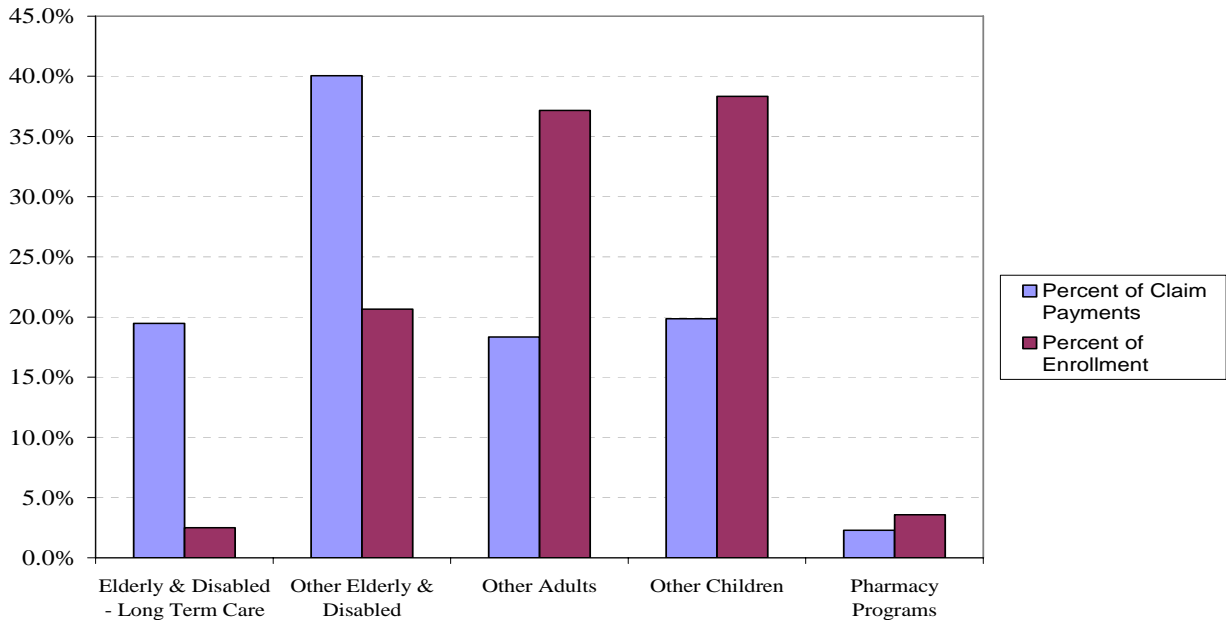
Michelle is a 10-year-old girl who has cerebral palsy. She lives at home, but without the services provided by the Medicaid program, she would need to be in a nursing home. She is on an individualized education program. Medicaid pays for personal care services, her 12 prescriptions, medical equipment that she needs, and care from physicians, dentists, and hospitals. Last year, Medicaid paid about \$196,000 for her care.

Bruce is a 34-year-old man with both developmental and physical disabilities. Medicaid pays for his six prescription medications, durable medical equipment, and numerous physician visits. Last year, Medicaid paid \$180,000 on his behalf.

Edna is a 70-year-old woman, suffering from heart disease and dementia. Last year, she also had pneumonia, bronchitis, and dehydration. Last year, she spent time in a hospital and a nursing home, and also received care at home. Although Edna is covered by Medicare, the federal program for people over 65, that program does not cover many of the services that Edna needed. Medicaid paid about \$130,000 on her behalf.

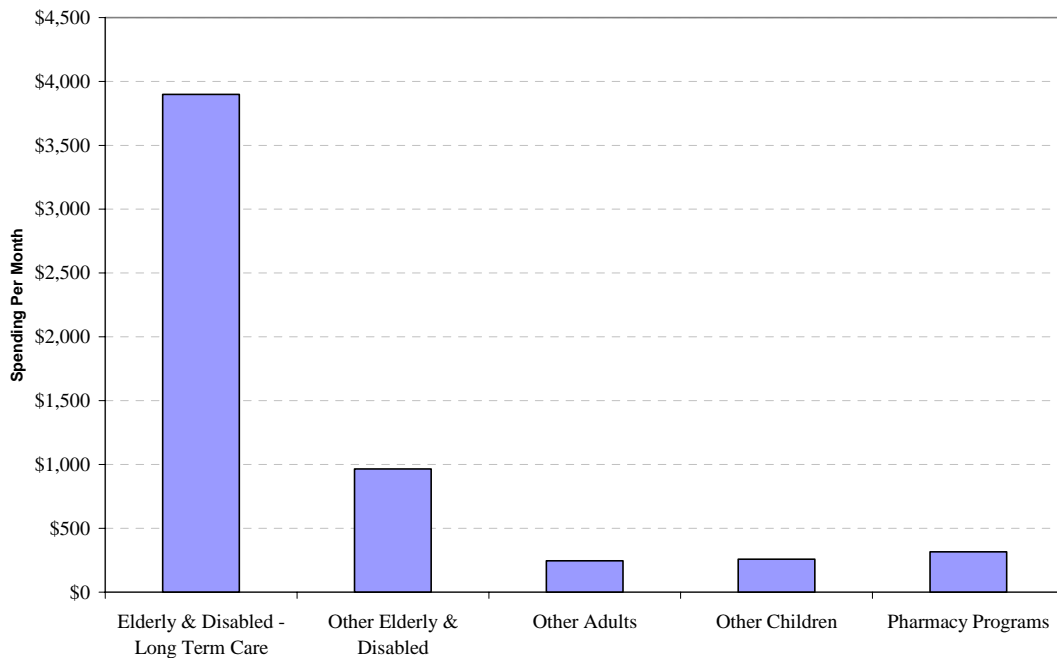
¹ These are composite examples – they do not describe specific individuals.

Proportion of Spending and Enrollment, Vermont Medicaid, 2006



Frail elderly individuals and people with disabilities comprise less than one-quarter of beneficiaries, but account for nearly 60% of Medicaid spending. Low-income children and adults make up three-fourths of Medicaid beneficiaries, yet they account for little more than one-third of spending for Medicaid services.

Per Person Per Month Spending, Vermont Medicaid, 2006



The differences in spending per person per month by beneficiary type reflect the intensive use of acute and long term care services in Medicaid coverage for frail elders or individuals with disabilities.

Why Does Medicaid Have Financial Issues?

Medicaid, as all health care financing programs, is confronted with the problem of an imbalance between revenues and spending. There is no source of revenues that can match the growth rate of health care spending.

For several years, there has been discussion of a Medicaid deficit. **A simple way to think about the deficit is that it is the amount of additional state funds that the program needs each year beyond the rate of growth in overall state revenues.**

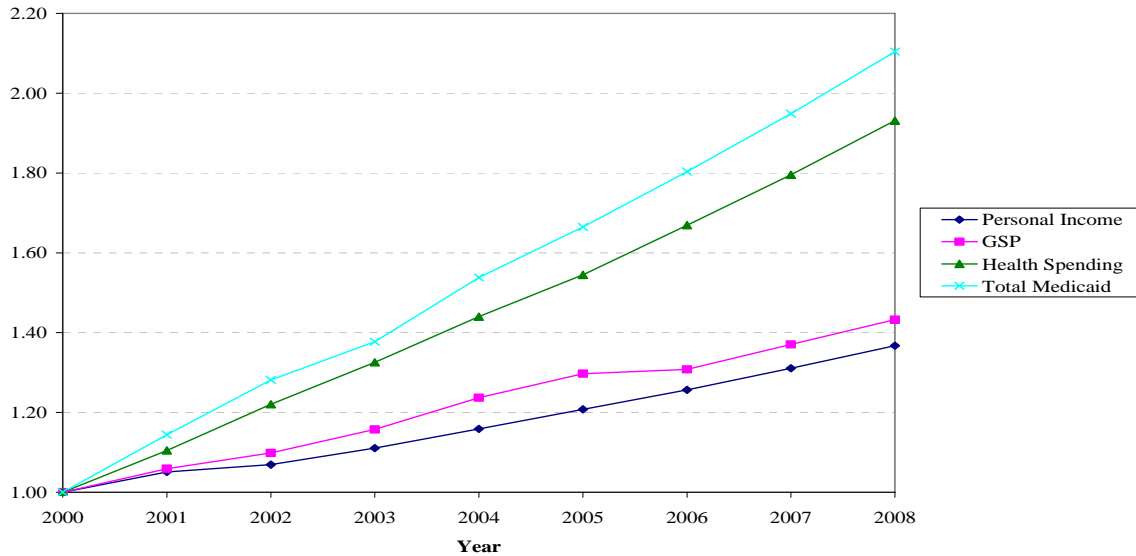
The central challenge in closing the Medicaid deficit is to match a program that has historically grown at 8% per year over the past two decades with a revenue growth rate of around 4% per year. Notwithstanding the slowdown in growth this year, there is little evidence to suggest that the growth of health care costs is likely to slow significantly in the future.

Medicaid is subject to the same drivers of health care costs that are pushing up commercial health insurance premiums for families and employers and Medicare premiums for seniors. In that sense, the state faces the same challenge as a family or employer trying to pay the annual increase in its health insurance bill. Those cost drivers include technological advances, demographics (aging of the population), consumer demand, and medical uncertainty (lack of consistent and evidence-based care protocols). However, Medicaid is unique in that it provides coverage for many of the most seriously ill people in the population, particularly those with multiple chronic illnesses. **To the extent that the cost of care for the most seriously ill grows faster than costs for all health care, Medicaid will be disproportionately affected.**

This is the heart of the ongoing Medicaid financial pressure. There are a number of possible measures of Vermont's ability to pay for health care, whether through Medicaid or private insurance. These measures, such as gross state product or personal income, typically grow at about 4% per year. Total health care spending historically has grown at about 8% per year. This is roughly the same rate of growth as the Medicaid program if eligibility expansions are excluded.

The chart below shows relative growth in these indicators, during the time period from 2000 to 2008. Relative growth means that each indicator's value was set to 1 in the first year of the chart (2000). The values in future years are proportionate to the 2000 value. For example, if gross state product (GSP) was \$10 billion in 2000 and \$12 billion in 2004, relative GSP would be 1.2 in 2004.

Relative Growth, Economy and Health Spending, Vermont



Between 2000 and 2008, the state's economy will have grown about 40 percent. Total health care spending in Vermont will have slightly less than doubled, while Medicaid spending will have slightly more than doubled. The slightly faster growth experienced by the Medicaid program is due in part to its responsibility to cover the sickest and most vulnerable Vermonters.

For the past several years, the Medicaid program has been kept in balance by using a variety of tools, including one-time funds, temporary federal funding enhancements, and most recently, the Global Commitment for Health waiver. There is discussion this year about the use of new, and temporary, tobacco settlement funds to help close the predicted shortfall in FY 2008.

While these approaches have worked in the short run, **it is clear that traditional approaches to Medicaid cost containment, such as reduction in benefits or changes in eligibility, will not provide a long-term solution to the tension between revenue and spending.** Other approaches will also need to be considered. These may include investment in chronic disease management, increased beneficiary involvement in medical decision-making, when possible, and evaluation of specific services for value and cost-effectiveness.

Recommendations

1. Develop New Ways of Looking at Medicaid Spending

Financial reporting for Vermont's Medicaid program should be redesigned to provide a new way of looking at Medicaid spending, particularly in the areas outside traditional health insurance. It is important to understand the different functions of Medicaid and that fact that it is, in effect, several health care financing programs in one. The appendix provides an example of a possible new report format that divides spending into five broad categories:

- Health Insurance – services typically provided under a commercial plan
- Medicare Wrap – payments to assist beneficiaries with Medicare's cost sharing
- Long Term Care – nursing home and home-based services for those with chronic illnesses that require substantial and ongoing care
- Mental Health / Developmental Services / Substance Abuse
- All Other – services that do not fall into the above categories, primarily school-based and other special services for children.

These categories reflect the different working parts of Medicaid as a safety net program and “payer of last resort,” which are far broader in scope than traditional health insurance coverage.

2. Develop Better Data Systems and Financial Reporting Mechanisms

Legislative committees need better data on expenditure growth trends in all program components funded under Medicaid.

- First, financial reporting should combine all Medicaid and Medicaid-related spending and revenues in one place. This will enable a more integrated perspective than has been available in past years when OVHA's spending for Medicaid services was separate from Medicaid spending paid for by other departments, including the Department of Health, Department of Disabilities, Aging, and Independent Living, the Department for Children and Families, and by local schools.
- Second, data should be presented in a way that will highlight leading cost pressures in the different program components of Medicaid and their relative impact on the overall Medicaid deficit. Clearer understanding of cost pressures will better inform legislators in deliberating long-term fiscal challenges and making difficult choices among remedies, whether they involve tightened spending or increased revenues.
- Finally, financial reporting should clarify the relative impact of the growth in various components of Medicaid on overall spending growth as a way of understanding each component's growing claim on funding and contribution to the funding shortfall.

3. Focus on Cost-Control Strategies that “Bend the Curve”

The most effective options to close the Medicaid funding gap are those that create higher value for each dollar spent and “bend the curve” in longer-term cost growth. Examples include quality improvement, chronic care management, and payment changes. The Blueprint for Health and Act 191 health reform endorsed the creation of a statewide system of care for individuals with chronic conditions as a strategy for improving quality and lowering costs. Studies show that up to 80% of Medicaid spending is on approximately 20% of enrollees, primarily those with severe chronic illness and disabilities

and the frailties associated with aging. Improving the way care is delivered to these beneficiaries will target limited resources more effectively, improve health outcomes and health status, and reduce costly hospitalizations and emergency room visits. This will reduce the rate of increase in spending per person by producing higher quality and efficiency in care, bending the growth curve in the overall costs of care.

Options that entail cutting enrollment, benefits, or provider rates do not address the fundamental problem, which is a spending growth trend that is several percentage points higher than the trend for revenue growth. For example, cutting enrollment will provide one-time budget relief through an immediate step-down in base spending. Yet, if the forces driving health care costs are not addressed, Medicaid spending will continue to trend upward at the same rate as before, once again widening the gap between spending and revenues. Furthermore, the responsibility for providing care to the individuals who are cut from the program will merely be shifted, increasing the burden of uncompensated care. Cutting enrollment, benefits, or provider rates does not address underlying causes and simply rolls back past gains in improving Medicaid access and quality or extending coverage to the uninsured.

4. Expedite a Statewide Plan for Chronic Care Delivery and Payment Changes

The Blueprint for Health must expedite a statewide plan for delivery and payment changes that will enable Vermont's payer systems to coalesce around a common model of chronic care delivery and payment. Vermont's Medicaid program will play a front-line role in pioneering chronic care management and payment initiatives, but the Blueprint has a fundamental responsibility to "get out in front" to lead and support those initiatives.

***Chronic Care Management.* Assessing the progress made in implementing chronic care management programs for Medicaid beneficiaries, and holding program managers accountable for results, is a central imperative over the next few years.** Vermont's movement into chronic care management for Medicaid beneficiaries has involved two related initiatives developed in consultation with the legislature—the Care Coordination initiative (begun in early 2006) and the Chronic Care Management Program (slated to begin July 1, 2007).

- How effective are Vermont's care management programs in identifying and reaching the high-risk, high cost beneficiaries with chronic illness who account for the bulk of Medicaid's expenditures?
- Are the care management initiatives overlooking any groups of beneficiaries (e.g., high-risk pregnant women and children with serious asthma)?
- How effective are these initiatives in influencing desired changes in patient and provider behavior?
- Is Medicaid working in an effective and coordinated manner with provider practices, and in tandem with the care management strategies used by other payers?
- Are the approaches used in the care management initiatives providing a satisfactory return on investment, and how is that being measured?

***Payment Changes.* A critical challenge for Medicaid (and other Vermont payers) is to develop payment system changes needed to support the essential elements of high quality chronic care called for in the Blueprint for Health and the Act 191 health**

reform legislation. These elements include care coordination, effective use of health care information by health care professionals and patients, flexibility in covered services, and patient self-management education and skill development. Fundamentally, there are two sets of options for reforming payment systems:

- Basic changes in the system (e.g., case rates, bundled rates, capitation, combining funding streams for different populations); or
- Add-on or incentive payments for quality care or penalties for performance that falls short of specific quality criteria (e.g., pay for performance).

While payment changes are expected to be a major area of health system reform in the next five years, they are highly complex, and currently there is little consensus among stakeholders in Vermont on what changes, or combination of changes, are needed.

***Coordinated Implementation of State Health Initiatives.* Medicaid’s efforts to restructure delivery and payment must be closely coordinated with other elements of state health reform.** Successful innovation by Medicaid should, through the Blueprint, spill over to improve health care delivery in the state as a whole, benefiting state employees and retirees, beneficiaries of Catamount Health plans, and commercially insured populations. However, for this to happen, **all state programs—Medicaid, Catamount Health, and the State Employees’ Health Benefits Plan—must be on parallel tracks in pursuing chronic care management approaches and payment changes.**

Accordingly, the process of mapping out delivery and payment changes under the Blueprint must be expedited. At the earliest opportunity, the Blueprint should lay out key objectives for delivery and payment system change and outline the options and specific milestones for achieving them. The public and private stakeholders that participate in the Blueprint need to be closely involved in the creation of the report so that it reflects their input and current realities of health care delivery. Through this process, the key options and decision points facing state policymakers can be brought forward without delay, along with the advantages and disadvantages and differing perspectives of stakeholders. The end result will be a framework that will consolidate the implementation efforts of all three state-sponsored programs—Medicaid, Catamount Health, and the State Employees’ Health Plan—and also provide guidelines for system change for the major commercial payers participating in the Blueprint for Health.

5. Promote Strategies to Reduce the Prevalence of Chronic Disease

Public health resources should be effectively organized and allocated to reduce the prevalence of chronic disease. Although embraced by the Blueprint and Act 191 health reform, reducing chronic disease prevalence has not received the high level of attention that other components of the Blueprint have received. Better quality and value in health care are important to reduce Medicaid costs. However, the big picture of health includes factors both inside and outside the health care system that affect our health. It is well established that lifetime medical spending is most affected by individual behavior – such as tobacco and substance dependence, lack of exercise, and an unhealthy diet – and social and environmental factors. To lower future demand for medical care, it is essential to address methods to prevent chronic disease occurrence and otherwise reduce prevalence.

- Are public health resources being allocated in the most effective way?
- Are public health programs being coordinated across sectors for the greatest impact,

rising above the “silos” that have often caused public health initiatives to work in isolation?

- Is policy development and decision-making based on the best evidence now available concerning health-enhancing interventions?

6. Monitor Financial Pressures Within the Medicaid Long Term Care System

Implementation of Vermont’s new long term care system for Medicaid involves fiscal challenges that will require a careful balancing of priorities in allocating available funding. Choices for Care, Vermont’s innovative waiver program for Medicaid long term care services, recently completed its first year of implementation. Its goals are to increase access to home- and community-based services, reduce reliance on nursing home services, serve more people, and manage overall costs for Medicaid long term care spending. During the first year, the number of people receiving access to Medicaid long term care services has increased significantly. While expanding services to more people is desirable, it is important to ensure that the current rate of expansion will not risk exacerbating financial pressures that down the road could overcommit Vermont’s Medicaid program. In addition, a critical question is whether sufficient funds will be available to support the reimbursement increases needed to ensure the financial sustainability of Vermont’s long-term care system, which includes nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers. Finally, the legislature will need to review the forthcoming report of the Long Term Care Sustainability Task Force, which is expected to provide guidance on creating more systematic reimbursement for home- and community-based providers.

7. Increase Administrative Coordination and Integration in Medicaid

Further structural changes may be needed to enhance administrative coordination and integration among the different components of Medicaid. Even after the recent reorganization of the Agency of Human Services (AHS), there remain major obstacles and challenges to working effectively across departments as a result of the institutional “silos” that fragment the assorted Medicaid delivery systems providing physical health, mental health, and long term care services. The Global Commitment waiver, by putting nearly all of Medicaid under a five-year spending cap, was said to “create incentives for greater inter-departmental collaboration and consistency across programs,” with resulting efficiencies and fiscal benefits. Representatives from the different departments that administer Medicaid programs have begun to meet regularly in four cross-departmental teams to seek greater efficiency and integration in fiscal, policy, operational, and quality improvement matters.

- How effective will these teams be in creating efficiency and coordination in care delivery as well as administrative processes and payment practices?
- What structural changes are needed to consolidate further the state’s health care financing programs and increase overall program effectiveness?

8. Maximize Medicaid’s Reliance on Predictable Funding Sources – Minimize the Use of One-Time Funding

For the last several years, budgetary gaps between revenue and spending in the Medicaid program have been filled using one-time funds. Continued use of one-time funds simply

delays the need to address Medicaid's financial issues in a sustainable way. Additionally, the availability of one-time funds is unpredictable, adding to Medicaid's financial uncertainties.

9. Dedicate All New Revenue Under the "Master Settlement Agreement" to Medicaid

Starting in FY 2008, the amount that Vermont receives under the Master Settlement Agreement between the states and tobacco manufacturers will increase by an estimated \$10 million, referred to as strategic payments. These funds should be committed to support Medicaid.

Appendix – A New Way of Looking at Medicaid

VERMONT HEALTH FINANCING PROGRAMS - Spending by Type of Service

	2002	2003	2004	2005	2006	2006 % of Total
Health Insurance						
Pharmacy (exc. rebates)	\$117,980,293	\$128,561,126	\$156,894,961	\$192,734,466	\$176,479,711	19.7%
Hospital	\$72,389,754	\$80,016,071	\$99,807,259	\$112,486,774	\$114,523,654	12.8%
Physician	\$47,033,851	\$50,951,364	\$55,207,725	\$64,613,763	\$65,551,049	7.3%
Other Professional	\$11,471,641	\$12,556,694	\$14,332,722	\$18,077,566	\$19,703,133	2.2%
DME / Supplies	\$5,133,288	\$5,875,682	\$6,374,241	\$6,985,238	\$7,850,837	0.9%
Indep. Lab & Xray	\$1,412,524	\$2,516,224	\$2,357,929	\$2,992,826	\$2,281,523	0.3%
All Other	\$7,067,226	\$7,742,834	\$3,466,930	\$3,748,280	\$3,339,625	0.4%
Total	\$262,488,577	\$288,219,996	\$338,441,767	\$401,638,913	\$389,729,532	43.6%
Medicare Wrap						
Hospital	\$8,336,690	\$8,072,058	\$9,032,965	\$7,946,819	\$12,415,931	1.4%
Physician	\$4,393,739	\$4,430,704	\$5,169,096	\$5,842,868	\$6,344,213	0.7%
DME / Supplies	\$526,388	\$711,688	\$1,065,129	\$1,082,956	\$1,342,290	0.2%
Other Professional	\$376,438	\$431,782	\$569,395	\$742,898	\$845,717	0.1%
All Other	\$2,535,731	\$3,350,203	\$3,190,261	\$3,958,946	\$4,293,517	0.5%
Total	\$16,168,986	\$16,996,435	\$19,026,846	\$19,574,487	\$25,241,668	2.8%
Long Term Care						
Nursing Home	\$80,622,291	\$83,349,569	\$91,543,115	\$98,462,697	\$101,376,898	11.3%
HCBS	\$21,675,277	\$25,670,005	\$28,328,786	\$34,449,225	\$37,154,894	4.2%
Personal / Res. Care	\$7,417,912	\$10,078,068	\$13,381,809	\$17,408,553	\$20,748,058	2.3%
Home Health	\$7,962,902	\$7,968,206	\$7,648,818	\$7,591,265	\$7,839,676	0.9%
All Other	\$1,396,815	\$1,646,337	\$1,738,155	\$1,899,321	\$1,835,498	0.2%
Total	\$119,075,198	\$128,712,186	\$142,640,683	\$159,811,062	\$168,955,024	18.9%
MH / DS / Substance						
Developmental Services	\$76,893,834	\$80,083,276	\$85,487,668	\$95,264,931	\$101,830,799	11.4%
Mental Health	\$89,971,451	\$80,547,977	\$80,830,143	\$86,238,177	\$89,843,505	10.1%
Substance Abuse	\$3,855,758	\$4,858,619	\$6,014,385	\$8,351,832	\$10,658,861	1.2%
All Other	\$233,106	\$242,580	\$926,172	\$3,550,781	\$4,328,073	0.5%
Total	\$170,954,148	\$165,732,452	\$173,258,369	\$193,405,721	\$206,661,237	23.1%
All Other						
Dept. Of Education	\$38,606,298	\$34,427,918	\$31,297,628	\$38,544,269	\$43,616,498	4.9%
SRS / PATH / DCF	\$19,558,340	\$21,847,133	\$22,479,990	\$26,534,652	\$25,916,110	2.9%
Dental	\$14,033,921	\$12,790,497	\$13,721,327	\$15,293,198	\$14,932,736	1.7%
All Other	\$12,952,621	\$16,825,546	\$18,699,756	\$18,135,909	\$18,731,809	2.1%
Total	\$85,151,180	\$85,891,094	\$86,198,701	\$98,508,027	\$103,197,152	11.5%
TOTAL	\$653,838,089	\$685,552,163	\$759,566,366	\$872,938,211	\$893,784,614	

**2006 Report of the Medicaid Deficit Subcommittee to the Health Access
Oversight Committee**

Senator Jane Kitchel, Co-Chair

Representative Mark Larson, Co-Chair

Senator Jeanette White

Representative Ann Pugh

January 15, 2007