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Mike Smith, *Secretary*
Martha Maksym, *Deputy Secretary*

October 28, 2019

To the Health Care Reform Oversight Committee:

Thank you for your question regarding whether and how the Medicaid funding increase recommendations in Chair Mullin's August 23, 2019 letter and OneCare Vermont's FY 2020 budget request for an additional $13.1 million in "state support" for "Health Care Reform Investments" fit within Vermont's Global Commitment to Health budget neutrality cap.

As described in Governor Scott's response to Chair Mullin's letter, dated September 10, 2019 and attached, the Department of Vermont Health Access (DVHA) has historically provided funding increases to multiple types of Medicaid enrolled providers and has done so within the limits of the Global Commitment to Health Budget Neutrality cap. Nevertheless, the Budget Neutrality cap does eventually limit the degree to which Medicaid could provide funding increases to hospitals through program rates, as proposed by Chair Mullin. The Agency of Human Services (Agency) has also funded Delivery System Reform, Medicaid Program, and Health Information Technology (HITECH) investments to support implementation of Vermont's All-Payer Accountable Care Organization (ACO) model.

On November 1, 2019 we will have projections about the Agency's position relative to the Budget Neutrality cap for CY19, CY20 and CY21. Based on prior assessments, we do not anticipate that the Budget Neutrality cap forecloses the possibility of Medicaid funds dedicated to health care system transformation. However, a separate limit called the Global Commitment to Health Investment Annual Limit does impact the OneCare Vermont request. This limit pertains to all investments supported by the Global Commitment to Health, including "Delivery System Related Investments" (DSRs). The DSR category of investment was created by the 2017 waiver extension and is intended to support the implementation of Vermont's All-Payer ACO Model, recognizing that one-time, start-up funds may be required to transform the health care payment and delivery system.

The table below from Vermont's 2017 Global Commitment to Health Waiver shows the specific annual limits on all categories of investments, including DSR. These amounts cannot be rolled over from Demonstration Year to Demonstration Year (DY).

	DY 1 of the extension	DY 2 of the extension	DY 3 of the extension	DY 4 of the extension	DY 5 of the extension	Total
	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	
Annual Investment Limit	$142.5M	$148.5M	$138.5M	$136.5M	$136.5M	$702.5M

OneCare's proposal for *"$13.1 million of different kinds of potential Health Care Reform Investments facilitated by the State of Vermont"*[1] is inclusive of:

- up to $7.8M in DSR investments, and
- an estimated $5.3M in funding that OneCare would receive through the prospective payments for the total cost of care, which would be directed to network providers as ACO-contributed investments to support implementation of the ACO care model (these would not be additional funds outside the Medicaid PMPM payments).

OneCare's budget submission also includes up to $3.5M in Informatics Infrastructure Support. Activities in this area have historically been funded using a combination of Health Information Technology (HITECH) funds and DSR investment funds.

In order to support any activities using either the DSR or HITECH funding mechanisms, CMS approval is required. The federal review process is presently underway for proposed CY20 activities. Additionally, Vermont's success obtaining an Institutions for Mental Disease Serious Mental Illness (IMD SMI) waiver impacts the Agency's ability to make DSR investments. Today, Vermont pays for IMDs as an investment subject to the aggregate annual limit. Without an SMI waiver to move this spending out of the investment category, there is only $950K to accommodate DSRs in CY20. Although the state is in active negotiations for an IMD SMI waiver, the timeline for approval and estimates of financial impact are still approximate. If Vermont does not receive timely approval of the IMD SMI waiver the Agency can only create capacity for OneCare's DSR request by eliminating or shifting other investments to Medicaid program expenditures.

Finally, State matching funds need to be identified in order to draw federal resources and proceed with DSRs.

Sincerely,

Michael K. Smith, Secretary, Agency of Human Services

[1] OneCare Vermont ACO 2020 Fiscal Year Budget Submission P. 28

PHILIP B. SCOTT
Governor

State of Vermont
OFFICE OF THE GOVERNOR

September 10, 2019

Kevin Mullin, Chair
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Dear Chair Mullin:

Thank you for your letter detailing your concerns with the recent rate increases approved by the Green Mountain Care Board (the Board) for insurance providers in Vermont's Qualified Health Plan (QHP) marketplace.

First, I want to remind the Board that my team is a committed partner in this effort. The fact is, I share your concern about these rate increases. And, as you observe, these cost increases underscore the importance of the innovative reforms we are pursuing in, what needs to be, a fully collaborative partnership.

Reducing the percent of household income spent on health care is a key performance indicator of this administration's State Strategic Plan. If a policy, reform or regulation will help achieve this goal, I will consider it. Likewise, if a proposal arbitrarily adds to the percent of household income being spent on health care, I will likely oppose it.

For example, as you may know, my team is working on creative proposals to address the small group and individual market in Vermont. We are actively exploring a state reinsurance program or other 1332 waiver design to maximize federal subsidies and support for the Exchange marketplace, understanding this group has difficult characteristics and demographic challenges. More broadly, we are also trying to move as quickly as possible to determine whether we can import drugs from Canada to have a meaningful and immediate impact on health care costs.

While we believe there are potential solutions to better finance the small group and individual market, we know that the root of the problem is that the cost of health care has been too high for years and is still growing too fast. While we are partnering with you in Vermont's All-Payer Accountable Care Organization Model Agreement to address the cost of health care, I am concerned with your general acceptance of the high cost of care, reflected in the recommendations you put forward.

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I do have concerns with certain points you made in your letter to me. For example, you incorrectly claimed that, because Medicaid spending is not increasing at the rate it did under previous governors, you concluded that there is a widening disparity in reimbursement between Medicaid, Medicare, and commercial insurers.

Thanks to the extraordinary work of the team at the Department of Vermont Health Access (DVHA), Vermont's Medicaid program has never been run more efficiently. Coupled with an improving economy, Medicaid enrollment has decreased and realized more value out of every dollar taxpayers invest in this important program.

Naturally, as you surely recall from your time in the Legislature, when there are fewer people enrolled in a program, appropriations for that program do not grow as quickly, or at all. More specifically, since 2016, Medicaid enrollment has declined by 21% – there are 43,476 fewer members. As well, over a similar period, Vermont's uninsured rate has slightly declined from 3.7% in 2014 to 3.2% in 2018.

Vermont Medicaid is now a national leader for reimbursement rates for Primary Care providers. Furthermore, the following describes Medicaid's recent approach to reimbursement increases for health care providers:

- The Department of Vermont Health Access (DVHA) has prioritized keeping outpatient rates for Critical Access Hospitals greater than or equal to 110% of Medicare and attempts to accommodate increases for other peer groups to the extent the budget allows. In July of 2019, Outpatient Prospective Payment System updates represented a 2% overall increase. [1]
- Since 2017, DVHA has prioritized maintaining primary care reimbursement rates at 100% of Medicare's rates; in the most recent fee schedule update, DVHA increased reimbursement for all other services from 80% to 82% of Medicare's rates. The July 2019 Resource-Based Relative Value Scale (BRVS) updates represented a 3.4% overall increase. [2]
- Beginning in January 2018, Medicaid adopted a new methodology for reimbursing Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). In the 2018 rebase, approximately $2.4 million was added to FQHC and RHC reimbursement. [3] The new methodology also established annual increases based on the most current Medicare Economic Index (MEI) to account for inflation: in 2019, rates were increased by 1.4%[4]; similarly, rates are expected to increase by 1.5% in 2020.
- In addition to the increases described above, Medicaid has also instituted increases for home health services[5], physician administered drugs[6], and emergency transportation[7] in the last year. Some of these increases have been a result of specific legislative appropriations; others have been a result of DVHA's efforts to align as closely with Medicare's rates of reimbursement as the DVHA budget will allow.

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I appreciate that you acknowledged the state's "limited revenue, tight budgets, and limits on investment funds," when it comes to Medicaid funding in health care reform. I would say these constraints apply to *all* parts of the budget – and we all have an obligation to look at the work and priorities of our state government in its totality.

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[1] https://dvha.vermont.gov/global-commitment-to-health/final-gcr-19-031-opps.pdf
[2] https://dvha.vermont.gov/global-commitment-to-health/final-gcr-19-034-rbrvs-fee-schedule-update.pdf
[3] https://dvha.vermont.gov/global-commitment-to-health/1final-gcr-17-096-fqhc-rhc.pdf
[4] https://dvha.vermont.gov/global-commitment-to-health/final-gcr-18-111-fqhc-rhc.pdf
[5] https://dvha.vermont.gov/global-commitment-to-health/final-gcr-19-030-state-plan-hh-increase.pdf
[6] https://dvha.vermont.gov/global-commitment-to-health/1final-gcr-19-028-pad-fee-schedule-update.pdf
[7] https://dvha.vermont.gov/global-commitment-to-health/final-gcr-19-032-transportation-rates.pdf

Yet, despite these challenges, working together, we actually increased rates to Medicaid providers by more than $40 million over the past five years, while enrollment declined:

Fiscal Year	Summary of Investment	Amount:
2015	• 1.6 percent rate increase across Vermont's designated agencies and special service agencies.	$7,237,938
2016	• Rate increases for patient-centered medical homes, community health teams, PCPs, Home and Community-Based Service providers, non-designated agencies mental health and substance use disorder providers • Rate increases for alcohol and drug abuse program providers. • Rate increases for designated agencies	$4,567,712
2017	• 2 percent rate increase for Vermont's designated agencies	$5,837,710
2018	• 2 percent rate increase to home and community-based providers • Rate increase to primary care physicians • Rate increase to designated agencies as part of a $14/hour initiative	$10,628,761
2019	• 2 percent rate increase for home health and home and community-based providers • Rate increase for designated agencies, directed to frontline staff	$5,088,845
2020	• Rate increase for assistive community care service providers • 2 percent rate increase to home and community-based providers • Rate increase for designated agencies	$9,141,578

While these investments are not direct Medicaid increases to hospitals, they buffer Vermont's downstream, community-based health providers to mitigate upstream costs in more expensive settings.

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I was also surprised to read the assertion that the "cost shift threatens Vermont's transition from fee-for-service to value-based payments…and a barrier to the targets outlined in the All-Payer ACO model," as it is inconsistent with views your Board has expressed in our previous discussions internally, and with our federal partners.

As you well know, the Vermont Medicaid Next Generation program "fixed prospective payments" have been cited as a benefit to provider participation in the model and the program scale has grown from 29,000 members in 2017 to 79,000 members in 2019 – more growth than the other payer participants have seen, combined. Vermont Medicaid has also taken advantage of the All-Payer Accountable Care Organization Model framework to increase Medicaid rates to providers, as documented by you and the Board in a memo to the Center for Medicare and Medicaid Innovation dated November 30, 2018.

As a reminder, your memo explains, "Among other provisions in section 10 (Payer Differential), the Model Agreement establishes that Medicaid reimbursement rate increases that address an existing payer differential or that are intended to ensure greater access should be treated differently than ordinary spending." The memo goes on to detail the Medicaid rate increases encouraged by the Model Agreement and that should be excluded from its calculation of spending growth.

> "In addition to the Medicaid rate increases that have taken effect so far in 2018, DVHA increased Medicaid professional services rates effective August 1, 2017 and these increases are expected to materially impact All Payer Total Cost of Care in 2018 and beyond…They were expressly approved to close the gap between Medicaid and Medicare reimbursement levels for professional services and to support access to primary care. In addition to the 2018 rate increases, the GMCB requests that the growth associated with these increases also be subtracted from the Medicaid portion of All-Payer TCOC."

Your own analysis makes clear that Medicaid rate increases in the All-Payer Model are in fact narrowing the payer differential and addressing the cost shift. Again, Medicaid is having more success than other payers in seeing its providers participating with OneCare Vermont in a new payment model and this should be our focus. The payment model both has the potential to reduce the rate of growth in health care costs and narrow the payer differential.

While your letter makes clear your frustration with the sharp rise in commercial insurance premium rates you approved, its attempt to shift responsibility for this increase to Vermont's Medicaid program is, in my opinion, wrong. That said, we have noted your desire to increase Medicaid rates for hospitals, and as I understand it, you think we can better address the Medicaid cost shift and facilitate health care reform by (further) increasing Medicaid rates for hospital services. We will take your recommendation into consideration.

Finally, as you know, I do not have unilateral authority over this issue. Accordingly, I am copying the appropriate members of the General Assembly on this response, as they too are important partners in these decisions.

Sincerely,

Philip B. Scott
Governor

PBS/kp
cc: Senate President Timothy Ashe
House Speaker Mitzi Johnson
Senator Jane Kitchel
Representative Kitty Toll
Senator Ginny Lyons
Representative Bill Lippert