Report to the Vermont Legislature

Sec. E.126b(d)(1) of Act 74 of 2021

Submitted to: Joint Task Force on Affordable, Accessible Health Care
House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

Submitted by: Joshua Slen, CEO, Health System Transformation, LLC

Prepared by: Joshua Slen, CEO, Health System Transformation, LLC
Julie Trottier, Health System Transformation, LLC
Beth Waldman, Health System Transformation, LLC
Tim Hill, Health System Transformation, LLC

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Dedication

This report is dedicated to the memory of Richard Slusky, who contributed to this project and countless other efforts to improve our healthcare system over the course of his career.

He will be missed by his many colleagues

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Improving Affordability and Accessibility by Reducing Health Care Costs for Consumers and Businesses in Vermont

Executive Summary

Task Force Charge

In 2021, the Vermont Legislature passed Act. No. 74, Sec. E.126b, creating a Task Force on Affordable, Accessible Health Care to explore opportunities to make health care more affordable and accessible for Vermont residents and employers. The Task Force is made up of three members from the House and three from the Senate. The full section authorizing the Task Force is found on page ii of the Appendix.

Task Force Membership

Sen. Virginia "Ginny" Lyons, Co-Chair
Rep. William J. Lippert Jr., Co-Chair
Sen. Kesha Ram Hinsdale
Sen. Richard Westman
Rep. Lori Houghton
Rep. Anne B. Donahue

Overview

This is the final report of the Task Force on Affordable, Accessible Health Care. This report provides the final documentation of four Task Force options developed throughout the Fall and early Winter of 2021.

The report includes the recommended policy options along with information on who the options would impact and how they would be impacted. The report delves into existing programs, what other states are doing and federal policies to ground the options in what is possible for Vermont to do now. The report builds off what has been accomplished to-date. Vermont's significant achievements in building a highly functioning health care system place the state in the enviable position of being able to consider expanding successful statewide care management, allows the leveraging of existing regulatory structures, provides an opportunity to extend long term care supports in the community to thousands more Vermonters, proposes a state-wide identification and stratification and return on investment approach, begins the conversation on a public option designed to reduce premiums in the small group market, and incorporates a benchmarking process to help insure that investments made by Vermont to improve the efficiency and effectiveness of the health care system accrue to all Vermonters.

If implemented strategically, the Options detailed throughout this report would impact every Vermonter. The policies outline approaches to increase access to long term services and supports, care management, lower cost health insurance, and to sustain the efficient and effective delivery of health care services necessary to keep cost growth to a minimum acceptable level for years to come.

The following list outlines the process by which the Task Force on Accessible Affordable Healthcare (Task Force) came to develop four final policy options for consideration, with the assistance of Health System Transformation, LLC (HST), the consulting firm engaged by the Vermont Legislative Joint Fiscal Office (LJFO) for this effort. The activity took place over a period of approximately four months, September 2021 – December 2021.

1. Public meetings at the Vermont Statehouse with the full Task Force
2. Regular updates with the Task Force Co-chairs and individual Task Force members
3. Regular meetings with Legislative Joint Fiscal Office (LJFO) staff
4. Informational interviews with Vermont healthcare leaders in various organizations
5. Review of correspondence sent to the Task Force from advocacy organizations
6. Research of other state activities related to the Task Force charge
7. Research of federal activity related to the Task Force charge
8. Analysis of Vermont healthcare data as found in the Vermont Healthcare Uniform Reporting and Evaluation System (VHCURES) all payer claims database.
9. Subject Matter Expert perspectives related to the Task Force charge
10. Presentation of four Options documents
11. Drafting of the four policy options
12. Drafting of a white paper on Affordability
13. Drafting of a white paper on the Medicare Savings Program (MSP)
14. Collection, analysis, and compilation of all of the above
15. Development of a Final Report
16. Development of a Final PowerPoint for use during the legislative session

From the initial presentation of more than twenty potential strategies, HST narrowed the focus to seven Policy Options through the process of research, analysis and stakeholder engagement. Three of those seven of policies are the subject of current ongoing activity elsewhere in the Vermont Legislature and/or Administration: Postpartum Expansion, Remote Access to Care, and Pharmacy Benefit Manager Regulation. Members of the Task Force support legislation in these areas through their respective committees of jurisdiction, and will continue to advocate for these strategies.

In addition, members of the Task Force have undertaken separate and parallel efforts toward supporting the healthcare workforce and addressing Health Equity, including the establishment of the Health Equity Commission (see page xiv of the Appendix for a list of reports relevant to work of the Task Force).

The four Policy Options presented in this report are detailed below.

- Cost Growth Benchmark and Affordability Standards
- Extend Moderate-Needs Supports
- Public Option
- Expand Blueprint for Health

Policy Options Summary

Policy Option	Vermonters Served	Estimated Number	Key Advantage	Time Frame[1]	Alignment with Other Options
Cost Growth Benchmark and Affordability Standards	All employers and individuals that have any health care expenses	600,000 (All Vermonters)	Reduction of premium rate increases across all payers	6-24+ months	Provides for statewide analysis of system costs and savings. Allows for stakeholder input on options. Establishes a target for growth and the process for moving savings from discrete initiatives into the rate setting process. Also allows for an Affordability Standard to complement the Cost Growth Benchmark.
Extend Moderate-Needs Supports	Vermonters who need support with Activities of Daily Living (ADLs), and their family caregivers	500 to 18,000	Access to assistance with activities of daily living for more Vermonters.	12-24+ months	Supporting individuals in the community delays or eliminates the need for more intensive levels of support reducing individual and system costs. Supports the cost growth benchmark goal of moderating the growth rate.
Public Option	Small businesses and their employees	Up to 35,000	Premium savings to small businesses and employees	12-24 months	Can incorporate care management and savings from Cost Growth Target performance improvement plans supporting lower ongoing premiums. Lower rates improve access to insurance and to care.
Expand Blueprint for Health	All Vermonters that need care management	~10% of Vermonters (65,000) may benefit from care management services (suggested by CMS CPC+ guidance)	Reduced duplication and gaps in care management programs; increase number of people served in successful community-based program can improve outcomes.	6-24+ months	ROI experienced via the Blueprint can be included as savings in Cost Growth Option and used to reduce the Public Option premiums.

[1] See page xxii of the Appendix for HST's PowerPoint presentation to the Task Force on 10/28/2021 for estimated timeframes for ***Enactment/Implementation*** efforts, and timeframes for ***Impact*** measurement.

Estimated Costs and Savings

Policy Option	Estimated Cost to Implement	Estimated Annual Ongoing Costs	Potential Savings
Cost Growth Benchmark and Affordability Standards	First three years of staffing and vendor costs $4.0 -$6.0 M	$1.5 - $2.0M; majority is for identification and stratification and return on investment (ROI) vendor.	1% lower cost growth = $65M / year
Extend Moderate-Needs Support	Waiver submission, analytics - $200,000	$1.7M - $33M	Skilled Nursing Home annual cost $117,348[2]. Cost avoided per 100 people per year = $11.7M / year
Public Option	Targeted actuarial analysis and waiver submission $300,000	$225,000 - $550,000 / year	$1,300 / year X 35,000 = $45.5M / year[3]
Expand Blueprint for Health	Initial ROI analysis $150,000, can be incorporated into the Cost Growth Benchmark vendor	The per person cost is not known at the time of this writing. 2020 Blueprint for Health costs are included on page xxiii of the Appendix.	The literature is mixed on the range of financial outcomes for care management. A state-level ROI analysis is recommended.

[2] https://vermontbiz.com/news/2020/december/08/most-long-term-care-costs-down-still-high-vermont
[3] As great as $45.5 million in yearly consumer savings, assuming premium growth limitations similar to Nevada (15 percent over four years) and Colorado (15 percent over three years).

Summary of Recommendations

Consider the Policy Options presented in this report as a suite of strategies that, implemented strategically, can promote the goals of affordable and accessible health care. Implementation of these Options should also be evaluated in relation to the initiatives already underway or under consideration by Vermont agencies and legislative committees.

Policy Option	Summary Justification for Recommendation
Cost Growth Benchmark and Affordability Standards	By putting in place a process to identify new healthcare technologies and services that have a demonstrated return on investment (ROI), adoption can be accelerated and savings can be captured for ratepayers.
Extend Moderate-Needs Supports	Extending supports is a broad middle class asset protection play because, once we reach 65, nearly 70% of us will need HCBS ADL supports at some point in our lives
Public Option	Implementing a rate structure between Medicaid and Commercial overall does not require all rates to be below today's commercial rates. If the desired policy goal is to immediately and directly address underinsured Vermonters today a plan that has lower overall consumer costs and the same coverage is the only way to guarantee this.
Expand Blueprint for Health	ROI can influence ERISA payers who do not contribute to Blueprint Community Health Teams today, and can make the case during insurance rate reviews for expansion to support all Vermonters who need care-management supports in their communities.

Cost Growth Benchmark and Affordability Standards

Description

This policy option includes expanding Vermont's current cost growth benchmark to extend beyond the population covered through the state's All Payer Waiver while also providing clear authority to the Green Mountain Care Board (GMCB) to use additional tools to drive payers and providers to meet the cost growth benchmark.

What is a Cost Growth Benchmark?

A cost-growth benchmark program is a cost-containment strategy that sets a limit on how much a state's health care spending can grow each year. The strategy sets accountability for spending growth at the state, provider and insurer level. The intended outcome is for healthcare cost growth to be slowed to more closely align with wage and income growth so that healthcare can remain affordable for individuals, businesses and states. It is important to do this while not negatively impacting access or health inequities.

What has Vermont done to date?

A component of Vermont's All-Payer Accountable Care Organization (ACO) Model Agreement with the federal government (signed October 2016) set a goal for the All-Payer Total Cost of Care per Beneficiary growth rate at 3.5% (and not more than 4.3%) for the 5-year period between 2018-2022.[4] However, this does not constitute a state-wide effort that affects all covered residents because it is limited to insurers that report data through VHCURES (including Medicare, Medicaid, all commercially insured, Medicare Advantage and self-insured reporting to VHCURES). The target includes spending for Medicare, Medicaid and individual products offered by Blue Cross Blue Shield of Vermont (BCBSVT). In addition, setting a public target for spending growth alone is not sufficient in slowing the rate of growth; a benchmark needs to be complemented by strategies designed to move the needle.

To support the state's goals of meeting a cost growth target, a state can also work with its stakeholders to put in place initiatives and incentives to limit cost growth. Among others, one option that may be included to support reaching the cost growth benchmark is to look at emerging technologies and best practices with potential for a return on investment (ROI) and consider the implementation of those initiatives over a rolling three-year period, with identification of opportunities in year one, implementation in year two, and incorporation of savings into rates in year three.

Who will it affect and how?

Cost growth benchmarks are aimed at reducing the overall cost of healthcare by limiting growth. Because the cost growth benchmark is aimed at limiting overall growth in the health care system, it impacts different stakeholders in different ways. In addition, impacts will vary based on the actions Vermont takes in pursuit of the benchmark, as well as the accountability measures a state utilizes to enforce the benchmark.

For example, reducing cost growth will limit the amount of cost increases an employer, Medicaid or Medicare pay for insurance coverage. Depending on how an employer sets cost-sharing with its employees as part of its overall insurance benefit design, limiting the amount of cost increases could also reduce the growth in employees' portion of the health insurance cost by limiting growth in cost-sharing, through constraining premium or co-payment growth, or both. Today, the cost growth has

[4] https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM_Summary_20211001.pdf

limited impact on consumers, because it does not apply to all Vermonters. Expanding the cost growth benchmark's reach could allow for consumers to have reduced growth in their cost sharing.

Setting a cost growth benchmark provides a mechanism to allow providers and payers to align in their negotiations towards the benchmark, tempering cost growth. Today, that impact is lessened because not all coverage is included. For providers, cost growth benchmarks may impact the services provided or patients seen based on what initiatives are put into place to reduce cost growth. This could, for example, increase spend in primary and preventive care while reducing hospital care and spending. For insurers, a cost growth benchmark could impact administrative funding and profits. Given that most health insurers that operate in Vermont are non-profit, the reduction in cost growth could impact the ability for these non-profits to re-invest in the health care system or the communities they serve. There is a theoretical possibility that implementing a cost-growth benchmark could have unintended consequences (ex. restrictions on patients receiving medically necessary services), though there is not yet evidence to validate this concern.

While GMCB has broad authority relative to containing costs in Vermont, the statutory authority supporting it is permissive rather than requiring GMCB to take certain actions. To date, GMCB has not had the resources or capacity to put into place requirements without being directed to do so. Revising the cost growth benchmark to extend beyond the population covered through the state's All Payer Waiver while also requiring GMCB to publish cost growth at the insurer and provider level and to implement performance improvement plans will help solidify Vermont's efforts to contain costs. At the same time, requiring GMCB to work with providers and insurers to develop initiatives in areas that are shown to be cost drivers in the state and consider those initiatives when setting the cost growth benchmark will further help the state to successfully reduce cost growth. Modifications to GMCB statute could also include strengthening its authority relative to health provider rate reviews.

Expected Outcomes/ Policy Considerations

While the State already has a partial cost growth benchmark in place, this section describes steps the state could take to re-consider its current approach. Steps could include:

1. Consider options and determine a cost growth target methodology. Key questions about what health care spending is being measured include:
    a. How to define Total Health Care Expenditures
        i. What spending is being measured?
            1. Medical expenses paid to providers by private and public payers, including Medicare and Medicaid (both claims and non-claims-based payments)
            2. Patient cost-sharing amounts
            3. Administrative expenses and operating margins/profit
        ii. What population's spending is being measured?
            1. Does Vermont want to include its entire population within the cost growth target or keep it as is (Medicare, Medicaid and individual market BCBSVT products)?
            2. Should residents be included when seeing out of state providers?
            3. Should out of state residents be included when seeing VT providers?
    b. What data will be used to measure total health care expenditures?
    c. What criteria will be used for selecting an indicator for the cost growth target?
        i. Will the target be tied to an economic indicator? Options include:

1. Personal income growth
2. Potential gross state product
3. Wage growth.

2. Setting the value of the target occurs after finalizing a methodology. As noted above, Vermont has previously set a cost growth benchmark as part of its all-payer waiver. As the state works to renew this waiver, it will negotiate a new cost growth benchmark with CMS. In considering the value, key items for consideration include:
    a. Use of historical vs forecasted values
    b. Adjustments to the target, including consideration of mitigation strategies to reduce growth
    c. Possible target values
    d. How often will the target be adjusted? Is it annually or a specific period of time? Will discussions about methodology be re-opened when considering the target?

3. Performance Assessment. Key questions include:
    a. How performance against the cost growth target will be measured at the state, insurance market, insurer and provider levels;
    b. Patient attribution to provider entities and minimum payer and provider size for reporting performance against the target;
    c. Mechanisms for risk adjusting performance against the target; and
    d. Methodology for calculating annual percentage change in Total Health Care Expenditures.

4. Authority and Governance. In Vermont, the Green Mountain Care Board already has authority to monitor the existing cost growth benchmark. Questions here will focus on:
    a. Collecting data to assess performance;
    b. Calculating and analyzing data on performance;
    c. Publishing performance and other data analysis consistent with the data use strategy which considers available data through the state's All Payer Claims Database and other sources to provide insight into the cost drivers and cost growth drivers influencing target performance;
    d. Procedures and timing for modifying the cost growth target; and
    e. Which health care entities should be required to report, and measures to ensure compliance with reporting requirements.

5. Initiatives to Support Efforts to Reduce Cost Growth. This will be a key focus of work in Vermont – considering which strategies or actions should be taken by the state, payers, purchasers, and providers to reduce health care cost growth and help all entities meet the cost growth target.
    a. Publishing Reports on Performance: Considerations include:
        i. Frequency of public reporting
        ii. Format of reporting
        iii. Elements to be included in reporting
        iv. What levels to report at (statewide, market level, insurer level, provider level)
        v. Should state hold public hearings specifically on performance against benchmark?
    b. Setting Quality Targets: Vermont may want to consider setting quality targets to ensure that implementing a cost growth benchmark does not reduce utilization of necessary

and high-value services, and promote continued quality improvement on population health measures.

c. Provider and/or Insurer Collaborative: Vermont could bring together providers and/or insurers to collaborate on strategies to reduce cost growth in areas that have been identified as cost drivers in the state. Topics for collaboration could include, for example:
    i. Emerging technologies
    ii. Clinical Best Practices
    iii. Reducing waste, including low value services
d. Performance Improvement Plans: These plans can be put in place to ensure that providers and/or insurers take the cost growth benchmark seriously by requiring those who continue to drive cost growth to put activities in place to reduce their own trends.
e. Concurrent efforts: GMCB has begun an effort to pursue affordability standards. This effort may be aimed at targeting cost growth in particular areas of the health system (e.g., focus on increasing spending on preventive care) and initiatives to improve the delivery system and advance payment reform. At the same time, the state could consider putting in place household affordability standards which take into consideration all out of pocket spending, including health care premiums and cost-sharing (co-payments and deductibles). These efforts can both align with the state's efforts to set a cost growth benchmark.

6. Implementation Strategy. Once a new cost growth approach and benchmark is finalized, there will be several potential implementation steps, including:
    a. Legislation to modify or enhance authority provided to GMCB to implement a cost growth benchmark
    b. Modifications to existing technical specifications
    c. Requesting data submissions from insurers and analyzing performance against benchmarks
    d. Publishing performance
    e. Annual review and implementation of initiatives to reduce spending growth in the state

Legislative Options

The GMCB, through 18 V.S.A. § 9375(b)(1) is charged to oversee the development and implementation of health care payment and delivery system reforms, including the authority to implement by rule methodologies for achieving payment reform and containing costs which may include the creation of health care professional cost-containment targets. It may be helpful to utilize a different section of the statute to provide this authority so that it is separate from other activities that the GMCB could implement relative to alternative payment methodologies (APMs). In separating it out, the language could also be strengthened to require the GMCB to set a comprehensive statewide benchmark as part of its regular review process, which would allow for a public vote after a public comment period. This allows for transparency and public input without having a full rulemaking process that can slow progress. If the Legislature so choses, the cost growth benchmark itself could be set in statute, as is the case in Massachusetts, and then adjusted by the GMCB within certain parameters. If the Legislature does not set the cost growth benchmark, the GMCB would benefit from legislative direction on how to set the benchmark. In addition, the GMCB would need clear authority through legislation to utilize corrective action plans payers.

Key to the success of the cost growth benchmark – and a big differentiator from how the cost growth target has been implemented in Vermont to date – is requiring through legislation that GMCB will work annually with health plans, providers and other stakeholders to develop initiatives that can help reduce spending growth in the state. These initiatives may include piloting emerging technologies and analyzing their benefits, and then over time making assumptions about their adoption as part of setting of the cost growth.

Finally, the GMCB uses its existing legislative authority to evaluate hospital budgets annually and conduct rate reviews. The amount of these budgets is directly linked with overall cost growth in the state and holding hospitals and other providers to targets and specified rates will be an important piece of monitoring and meeting the cost growth benchmark. GMCB could benefit from having clear statutory language which allows it to condition budgets and explicitly put corrective action plans into place to require hospitals to meet these targets. Likewise, the GMCB's authority in 18 V.S.A. § 9375(b)(6) and 8 V.S.A. § 4062 is limited to "approving, modifying, or disapproving" proposed rates. The Board also has such incidental, implied powers as may be needed to achieve this task. See In re ACTD LLC, 2020 VT 89, Sec. 19 (2020)[5].

The Board also has authority under 8 V.S.A. §§ 4513, 4584 and 5104 1) to issue supplemental orders to non-profit hospital and medical service corporations (BCBSVT) and health maintenance organizations (MVP) in connection with health insurance rate decisions and 2) to attach reasonable conditions and limitations to such orders if 3) the Board finds, on the "basis of competent and substantial evidence," that they are necessary to ensure benefits and services are provided at "minimum cost under efficient and economical management." In order to ensure that the rate review process can be used to ensure that insurers are complying with the cost growth benchmark, GMCB would benefit from plain language within the statute that makes clear that the rate review process can be used to enforce the benchmark against insurers.

To ensure that the statutory language applies to a broader set of providers and payers than is typically true, the GMCB will require broader authority relative to the cost growth target. These changes will provide the state with some greater authority These sections are the sections which could be changed to establish the state and GMCB with the authority to require policy actions from an insurer to support cost containment and health reform goals.

In addition, defining "affordability" in the rate review statute to mean that medical trend meets the benchmark established would clarify that the state must consider and provide for the potential to vary from the benchmark in rate review if there are access or contracting issues.

What have other states done?

While Vermont has implemented a partial cost growth benchmark, other states have gone further – implementing statewide benchmarks with public reporting across state, market, insurer and large provider levels, as well as potential for penalties or corrective action plans if the benchmark is not met.

Massachusetts: Massachusetts was the first state to establish a cost growth benchmark in 2012 via Chapter 224. The benchmark was set equal to the Potential Gross State Product (PGSP) of 3.6% for 2013-2017 and then PGSP minus 0.5% (3.1%) for 2018-2022.[6] The Center for Health Information and

[5] https://www.vermontjudiciary.org/sites/default/files/documents/op19-245.pdf
[6] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

Analysis was charged with analyzing and **reporting on payer and provider costs and cost trends** and to specifically compare growth rates relative to the benchmark.[7] The MA Health Policy Commission was also created and charged with monitoring performance of payers and providers relative to the benchmark to identify and implement strategies that would improve the ability of the state to meet its benchmark goals.[8] With regards to enforcement of the benchmark, the Health Policy Commission can **request performance improvement plans** from those that exceed the benchmark, as well as **convene public hearings** where those that exceed the benchmark are asked to testify.[9]

Delaware: Executive Order 25 in 2018 created a cost growth benchmark in Delaware. The growth rate was set at 3.8% for 2019, 3.5% for 2020, 3.25% for 2021, and 3.0% for 2022 and 2023 based on Delaware's per capita Potential Gross State Product (PGSP). Performance against the benchmark and related analyses are **publicly reported** by the Delaware Health Care Commission. There are not currently accountability measures outlined for those that exceed the benchmark.[10]

Rhode Island: Executive Order 19-03 in 2019 created a benchmark program in Rhode Island. The benchmark was set at Rhode Island's per capita Gross State Product (GSP) of 3.2% for 2019-2022, with a plan to reassess the target for 2023 and beyond. Performance against the benchmark and related analyses are **publicly reported** by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office for Health and Human Services. There are not currently accountability measures outlined for those that exceed the benchmark.[11]

In addition to setting a cost growth benchmark, Rhode Island has also set affordability standards that insurers must demonstrate compliance with during their annual rate reviews. The Affordability Standards are intended to advance affordability of commercial coverage. The standards are described below in the Affordability section of this paper.

Oregon: Oregon created a benchmark program in 2019 via SB 889 that was implemented beginning January 1, 2021. The benchmark was set at 3.4% for 2021-2025 and 3.0% from 2026-2030 based on a review of various economic indicators as well as growth targets selected by other states.[12] The Oregon Health Authority reports publicly on performance and conducts analyses to understand drivers of cost growth and subsequently develop strategies to improve performance.[13] With regards to enforcement of the benchmark, **performance improvement plans are required** from any payer or provider that exceeds the benchmark, and those that that surpass the benchmark 3 out of 5 years **may be fined in proportion to their excessive spending**.[14]

Connecticut: Connecticut created a benchmark via Executive Order No. 5 in 2020. Connecticut's benchmark was set at 2.9% using a 20/80 weighting of Potential Gross State Product (PGSP) and median income, though the rate was adjusted to 3.4% and then 3.2% for the first two years of

[7] https://www.chiamass.gov/mission-and-history/
[8] https://www.mass.gov/about-the-health-policy-commission-hpc
[9] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[10] https://dhss.delaware.gov/dhss/files/benchmarksummary013119.pdf
[11] http://www.ohic.ri.gov/documents/cost%20trends%20project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf
[12] https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Presentation%20Slides_updated.pdf
[13] https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Governor-Appontment-Letter-10-18-2019.pdf
[14] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

implementation.[15] The state's Office of Health Strategy is currently establishing a baseline by analyzing pre-benchmark cost growth, and will **publicly report** on performance relative to the benchmark in the future.[16] Connecticut currently does not have established consequences for entities exceeding the benchmark.

Washington: With the passing of HB 2457 in 2020, Washington created the Health Care Cost Transparency Board. On September 14, 2021, the Board voted to set their benchmark at 3.2% for 2022-2023, 3.0% for 2024-2025, and 2.8% for 2026, based on a 30/70 blend of Washington's Potential Gross State Product(PGSP) and historical median wage.[17] To help achieve the benchmark's goals, the Board will also work towards identifying cost drivers and providing recommendations for reducing health care spending to the Legislature on an annual basis.[18]

New Jersey: Executive Order 217 was signed on January 28, 2021, to create an Interagency Working Group to determine their benchmark value and strategy for implementation.[19] New Jersey intends to use 2022 as a transition year for their benchmark program before using a benchmark value of 3.5% for 2023, 3.2% for 2024, 3.0% for 2025, 2.8% for 2026, and 2.5% for 2027. New Jersey based its benchmark value on a 25/75 blend of Potential Gross State Product (PGSP) and projected median income.

Nevada: Nevada is in the process of drafting an executive order to establish their cost-growth benchmark, with a goal of it taking effect at the start of 2022.

What has the federal government done?

The only federal government involvement in cost-growth benchmarks has been CMS agreements with Vermont and Maryland that set targets for cost-growth for all payers (Maryland's rate was set at 3.58%). Similarly, to Vermont, however, Maryland's agreement with CMS sets a growth rate target as a goal for a separate program (namely an All-Payer Model) rather than the benchmark being its own central focus with strategies specifically designed for that purpose.[20]

To what extent have Cost Growth Benchmarks translated to improved affordability?

While several states have recently begun implementing cost growth benchmarks, only Massachusetts has had a benchmark in place long enough to measure how the approach has impacted affordability. Prior to the establishment of its benchmark, Massachusetts had one of the highest annual growth rates in health care spending in the United States; since the implementation of the benchmark, Massachusetts' annual growth in per capita commercial health care spending has fallen below the national average year after year. This accounts for an approximately $9.3 billion dollar difference in spending from 2013 to 2019 than if Massachusetts performed at the national average.

However, this has not necessarily translated directly into savings for consumers. In fact, out-of-pocket spending growth has increased since the benchmark was implemented and continues to outpace growth

[15] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[16] https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/CT-OHS-Implementation-Manual_final-v-1_5.pdf
[17] https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf
[18] https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board
[19] http://www.cshp.rutgers.edu/content/nj-benchmark-program
[20] https://hscrc.maryland.gov/Documents/Modernization/Total%20Cost%20of%20Care%20Model%20-%20Background%20and%20Summary_7_26_17.pdf

in income. That being said, this should not be interpreted as a failure of state policy, as this trend is more of a product of the increased prevalence of high deductible plans, among other factors. The true takeaway here should be that strategies intended to slow growth in overall health care spending may not alone be able to meaningfully impact health care affordability at the individual and household levels.

What are Affordability Standards, and how might they relate to Cost Growth Benchmarks?

Rhode Island's Office of the Health Insurance Commissioner (OHIC) established a set of Affordability Standards in 2009 that insurers must demonstrate compliance with during their annual rate reviews. The Affordability Standards are intended to advance affordability of commercial coverage.
The standards created in Rhode Island can be summarized as follows:

- Expansion and improvement of primary care infrastructure
- Insurers were required to increase the proportion of total medical payments that went towards primary care by one percentage point each year between 2010 and 2014- that figure must now be at least 10.7%
- Increased adoption of the patient-centered medical home (PCMH) model
- Insurers were required to provide financial support for an all-payer PCMH pilot project and now must ensure that 80% of their contracts with primary care practices are with OHIC designated PCMHs.
- Support for the use of electronic health records and the state health information exchange
- Insurers were required to provide financial support to enable increased adoption of electronic health records by providers and, starting in 2012, to support Rhode Island's health information exchange, CurrentCare.
- Implementation of comprehensive payment reform

While this standard covered topics such as alternative payment models, quality incentives, care coordination, transparency, and administrative simplification, the limits that it set on annual rates of increase is perhaps the most impactful component of these affordability standards. Insurers' prices for both inpatient and outpatient services were not to increase annually at a rate greater than the percentage increase in the U.S. Consumer Price Index (CPI) plus one percent. More recently, insurers have also been required to limit their annual increases in budgets for Population-Based Contracts to the CPI plus one and a half percent.

A 2019 study focused on assessing the impact of Rhode Island's Affordability Standards found that quarterly fee-for-service spending declined by an average of $76 per enrollee over the period of 2010 to 2016. This finding was not associated with any drops in utilization, nor were quality measures adversely affected. Other states such as Colorado and Delaware have recently started to explore developing their own affordability standards to follow in Rhode Island's footsteps.

Rhode Island's Cost Growth Benchmark and Affordability Standards are not explicitly tied together. However, both efforts are led by the same state agency (OHIC) and are designed to work in step with each other towards the same ultimate purpose of controlling health care spending.

What other approaches exist in consideration of Household Affordability?

To make meaningful progress on the affordability of healthcare at the consumer level, it helps to first define and measure what the state of household affordability currently looks like. CMS defines affordable coverage as "a job-based health plan covering only the employee that costs 9.61% or less of

the employee's household income." The Massachusetts Health Connector produces an affordability schedule that defines the maximum percentage of income that individuals, couples, and families should spend on their premiums based on their federal adjusted gross income. The percentage starts at 0% for the lowest income bracket and caps out at 8% for the highest bracket. This schedule is used to determine whether an individual should or should not be penalized for lacking insurance per the state's individual mandate, but it is also used to provide state financial support to those earning below 300% of the Federal Poverty Line to help make their insurance more affordable. Vermont does something similar today with its Vermont Premium Assistance Program which provides increased subsidies (above federal subsidies) for Vermonters within incomes between 133 – 300% of the federal poverty level. Also in Massachusetts, the Center for Health Information and Analysis' Massachusetts Health Insurance Survey assessed affordability through four specific issues: having family medical debt, reporting problems paying family medical bills, spending a high share of family income on out-of-pocket health care expenses, and foregoing health care needs due to costs.

Current definitions of affordability that are in use have been criticized for focusing principally on premiums, without consideration of out-of-pocket spending and variability due to location. In its 2021 Health Care Cost Trends Report, the Massachusetts Health Policy Commission laid out a policy recommendation to account for this concern by focusing on setting measurable goals to reduce out-of-pocket spending. In Connecticut, the state created a tool called the Connecticut Healthcare Affordability Index to determine affordability for 19 different household types based on the impact of healthcare costs (including premiums and out-of-pocket expenses) on each household's ability to meet basic needs.

While Vermont may not have established definitions of affordability through the State, Vermont Legal Aid issued a report in 2018 which assessed the affordability of healthcare for Vermont residents through three different measures, one of which gauges whether Vermont families are able to still meet their basic needs after purchasing health insurance.

Colorado is another state that is working on defining affordability by accounting for total out-of-pocket costs as well as impact on financing one's basic needs. In addition, Colorado has undertaken a separate effort with affordability in mind. In 2020, Colorado established the Health Insurance Affordability Enterprise with the authorization to assess a health insurance affordability fee on insurers and a special assessment on hospitals to subsidize the purchase of health insurance by certain low-income individuals, increase the affordability of health insurance on the individual market, and fund the Colorado reinsurance program.

Health Equity Impact

By managing the growth in overall costs, this option will promote access and improve equity by making healthcare more affordable for Vermont households. To the extent that growth in out-of-pocket costs are targeted to a lower overall rate than the benchmark the impact on individuals may be impacted positively over time.

Alignment with other proposed Options

As part of Vermont's overarching Cost Growth Target and Affordability Index, the ROI on performance improvement plans tracked by a shared statewide vendor can also include Blueprint for Health expansion activities as well as savings experienced long term via the expansion of Vermont's Moderate-Needs HCBS. Additionally, those identified savings can be used to set rates for a public option offered by the state on Vermont's health insurance exchange.

Extend Moderate-Needs Supports

With rising risk there are fewer individuals but increased need

Description

This policy option includes:

- Advanced analytic tools
- Limited package of home- and community-based services (HCBS), including support for family caregivers

The use of **advanced analytic tools,** which would enable program administrators to more effectively target the provision of Moderate-Needs Supports services to individuals who are predicted to need more intensive long-term services and supports (LTSS) in the future. This feature is closely aligned with both the Cost Growth Benchmark and Affordability Standards Option and Blueprint for Health Expansion Option, in that it harnesses the power of emerging technologies to identify the Vermonters who are most in need of services.

A limited package of home- and community-based services to address nutrition, dehydration, falls prevention, social isolation, medication management, and other needs typically not covered by standard insurance plans. These additional services will improve quality of life, promote health and wellbeing, and stave off the need for more intensive long-term services and supports.

Support for family caregivers, who help keep their loved ones healthy and at home. Nationally, two out of three (66%) older people with disabilities who receive LTSS at home get all their care exclusively from a family caregiver, mostly wives and daughters. Another quarter (26%) receives some combination of family care and paid help; only 9% receive paid help alone[21]. With higher income, households can provide more unpaid family caregiver time, therefore additional support is especially needed for low- and moderate-income households. Support for these caregivers is particularly important given the current healthcare workforce shortage. HST recommends adding caregiver support to this **Extend Moderate-Needs Supports** option.

[21] https://www.caregiver.org/resource/selected-long-term-care-statistics/

Vermont would need to consider alternatives and develop the best approach for the state. Many states are beginning to offer services and payments to family caregivers, as summarized in the table below and described in the 'What have other states done?' section.

State	Program Name	Caregiver Support	Maximum Annual benefit
Oregon	Family Caregiver Assistance Program	Personal care services Adult day services Respite services Emergency response systems Special medical equipment and supplies Supports for consumer direction Assistive technology Home modifications Home delivered meals Transportation Counseling / Support Groups Family Caregiver Hotline Education and training for unpaid caregivers.	$6000
Washington	Tailored Supports for Older Adults	Adult Day Care Caregiver Training and Education Counseling / Support Groups Home Modifications Housekeeping / Errands / Yard Work Information Regarding Caregiving Meal Delivery Personal Emergency Response Systems Respite Care Specialized Medical Equipment / Supplies Therapies (massage and acupuncture) Transportation	$7500
Arizona	Family Caregiver Grant Program	Information and referral Training Support groups Respite Home modifications	$1000
Hawaii	Kupuna Caregivers	Cash to pay for things like Adult Day Care Personal Care Meal Preparation Transportation	$25000

The September 2021 Administration for Community Living[22], outlined the following recommended five priority areas:

- Increased awareness of family caregiving.
- Increased emphasis on integrating the caregiver into processes and systems from which they have been traditionally excluded.
- Increased access to services and supports to assist family caregivers.
- Increased financial and workplace protections for caregivers.
- Better and more consistent research and data collection.

Who will this affect and how?

Vermonters with any or no health insurance, who are identified as needing home- and community-based services (HCBS) by their health care providers via provider referrals and by data-driven risk stratification tools, and who are found clinically and financially eligible for the program. (Please see HST's Moderate-Needs Group [MNG] cohort analysis and extrapolation to the broader Vermont population on page 25 following this Policy Option.)

Population Group	Estimated Number of Vermonters	Estimated Annual Cost[23]
Vermonters who meet Moderate-Needs Group (MNG) clinical criteria with incomes below 300% SSI FBR and are currently on the MNG wait list	500 -- 700[24]	$1.7 -- $2.4 million[25]
Medicare Members who meet MNG clinical criteria with incomes above the MNG cut off ($2,523 per month per individual)[26]	11,587 -- 14,715[27]	$20 -- $25 million[28]
Commercially insured who meet MNG clinical criteria with incomes above the MNG cut off ($2,523 per month per individual)[29]	2,589 -- 3,371[30]	$4.5 -- $5.9 million[31]

[22] https://acl.gov/news-and-events/announcements/news-release-raise-family-caregiving-advisory-council-report-congress
[23] Please see page 25 or HST's MNG cohort analysis and extrapolation to the broader Vermont population
[24] DAIL is currently working to update the wait list
[25] The MNG average benefit for individuals receiving services between 7-1-2020 and 6-30-2021 was $3,476.21. Multiplying by 500 and 700 provides the total cost range.
[26] https://www.ssa.gov/OACT/COLA/SSI.html
[27] HST started with a cohort of Vermonters identified in VHCURES as receiving the MNG benefit and ran multiple simulations accounting for demographic medical utilization information. The result is an estimate of the maximum number of individuals that would potentially access a new limited MNG benefit.
[28] Using a benefit figure of 50% of the MNG average, $1,738.10, and multiplying it by the 11,587 and 14,715 figures provides the cost range. HST believes this range is the high end of the estimate and the actual eligible population in any given single year is likely to be far lower. Further research and analysis is warranted.
[29] https://www.ssa.gov/OACT/COLA/SSI.html
[30] See footnote 5
[31] See footnote 8

The lifetime probability of becoming disabled in at least two Activities of Daily Living (ADLs), or of being cognitively impaired is 68% for people age 65 and older[32]. Individuals who have significant needs to support their ADLs often need supports not covered by traditional insurance and these uncovered costs can be expensive and debilitating to family finances. A federal government study estimated that out of pocket HCBS costs from age 65 to death are approximately $140,000 (in 2015 dollars)[33].

Access to a limited benefit of HCBS for those people who need them but are not yet financially and clinically eligible for full Medicaid LTSS may provide the necessary supports to stave off the need for more intensive services later.

Expansion of the Moderate-Needs Group is intended to reduce the total number of and extend the timeline for individuals who could ultimately become "Medically Needy" for Medicaid which, for individuals with income too high to qualify for Medicaid, requires them to "spend down", reducing their assets, in order to become eligible for long term services and supports[34].

What has Vermont done?

As part of the Choices for Care program administered by the Department of Disabilities, Aging and Independent Living (DAIL), Vermont offers a limited HCBS benefit to adults with "Moderate Needs" whose income is at or below 300% of the SSI payment standard after deducting recurring monthly medical expenses and who are without available resources that are easily converted to cash. Clinical eligibility requires a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. This program is limited by available funding and serves about 1,000 Vermonters at any one time.[35]

Current MNG services include:

1. Case Management – up to 12 hours per calendar year via the local AAA or Home Health Agency.
2. Homemaker – up to 6 hours per week via the local Certified Home Health Agency
3. Adult Day – up to 50 hours per week.
4. Flexible Funds – Small amount of flexible spending funds through the chosen case management agency.

> Eligibility for Choices for Care Highest and High needs groups, which pays for full HCBS or Nursing Facility care as well full Medicaid coverage, requires applicants to meet the clinical criteria for nursing home level of care and financial criteria with specific income and asset limitations.

What have other states done?

HCBS services for individuals not financially eligible for Medicaid or that don't quite meet nursing home level of care:

- **Oregon** submitted a request to CMS on November 1, 2021 for an 1115 Demonstration Waiver that creates a federally matched program; Oregon Project Independence (OPI) and a new Family Caregiver Support Program for older adults and adults with physical disabilities who are not

[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8040099/
[33] https://aspe.hhs.gov/reports/long-term-services-supports-older-americans-risks-financing-research-brief-0
[34] https://aspe.hhs.gov/reports/analysis-pathways-dual-eligible-status-final-report-0
[35] Moderate Needs Services | Adult Services Division (vermont.gov)

currently accessing Medicaid programs. These programs provide limited services and supports to individuals at risk of entering the Medicaid long-term services and supports system, with the intent to assist individuals to either avoid or delay entering the Medicaid system. Adults with incomes up to 400% of the Federal Poverty Level (FPL) who pass a resource test and meet certain clinical eligibility criteria would be eligible, with a projected enrollment of up to 4,500 individuals in OPI and up to 1,800 individuals and their caregivers in the FCAP. The member per month (PMPM) cost is projected to be $289 for OPI and $500 for FCAP, and the state is projecting a small savings to the Medicaid program at the end of a 5 year demonstration period[36].

- The Kupuna Care program (KC) is a **State of Hawaii**-funded program that provides community-based long-term care services. It is intended to provide in-home services to impaired elders, starting at age 60, who fall into the "gap group." These are elders who do not qualify for other government programs and do not have private assistance to help. This normally includes those with financial resources not high enough to afford the high cost of private-pay services, but not low enough to qualify for regular Medicaid or have levels of care not high enough to qualify for long term care Medicaid[37]. Approximately $9M was budgeted in 2020 and varying numbers of individuals were served, depending on the service, from approximately 700 for personal care services to 3,900 for case management and home delivered meals[38].

- In September 2021 **California** released its list of "In Lieu of Services" for their Medicaid program, Medi-Cal[39]. These include services available to Medi-Cal beneficiaries that are intended to address social determinants of health, which would otherwise not be available but are offered as a less expensive and potentially more effective 'upstream' alternative to an existing state plan service. Included are services that would align with the Vermont Moderate-Needs Expansion Option:
  - Respite Services
  - Day Habilitation Programs
  - Personal Care and Homemaker Services
  - Environmental Accessibility Adaptations (Home Modifications)
  - Medically Supportive Food/Meals/Medically Tailored Meals

- As part of their 1115 demonstration waiver, **North Carolina** is in the process of standing up 'Health Opportunities Pilots'[40] which will test the effectiveness of providing new services to Medicaid beneficiaries that address certain social determinants of health, including housing modifications, access to healthy foods, and interpersonal violence.

Additional Support for Caregivers:

- **Washington State's** Tailored Supports for Older Adults (TSOA) is a program authorized under their 1115 waiver that provides services to support unpaid caregivers and provides a small

[36] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-1115s-projectindependence-application-pa.pdf
[37] https://www.elderlyaffairs.com/site/454/services_faq.aspx
[38] https://health.hawaii.gov/opppd/files/2020/12/EOA_LEG-REPORT-2020-w_attachment-12.21.20.pdf
[39] https://www.dhcs.ca.gov/Documents/MCQMD/ILOS-Policy-Guide-September-2021.pdf
[40] https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

personal care benefit to people who don't have an unpaid family caregiver to help them. It creates a new eligibility category and benefit package for people age 55 or older who are at risk of needing long-term services and supports in the future who don't currently meet Medicaid financial eligibility criteria[41]. Quarter 2 of 2021 enrollment was 3,544 dyads and 6,631 individuals, at a cost of $5.5M.[42]

- **Arizona's** Family Caregiver Grant Program[43] supports friends and family caring for Arizonans with incomes up to $75,000 for a single person or $150,000 for a married couple with information and referral, training, support groups, respite, and home modifications. Grants are capped at $1,000 and the administration has requested $325K in their 2023 budget[44]

- **Hawaii's** Kupuna Caregivers program helps family caregivers who work at least 30 hours/week outside the home by providing up to $70/day benefit in services that make caring for aging family members who are 60 and over more affordable and accessible. It can help pay for things like adult day care costs, home health care workers, extra help preparing meals, and transportation[45]. In 2019 the state budgeted $1.5M and 114 individuals were served. A study conducted showed a reduction in caregiver burden after receiving program services, and the state has since developed a plan to maximize the number of caregivers served.[46]

Health Equity Impact

This option will reduce disparities and promote access by making important HCBS available to more Vermonters, regardless of insurer or income level, facilitated with the use of population health data analytics to tailor services to peoples' specific needs, reduce gaps in care, and avoid duplication of services. Further, providing needed support to family caregivers will enable more families to care for their loved ones in culturally familiar ways[47]. Support for family caregivers will also help alleviate workforce pressures by encouraging families to care for loved ones rather than to seek out external caregivers.

Alignment with other proposed Options

A statewide identification and stratification system can help identify Vermonters that are appropriate for limited HCBS and Caregiver Supports offered in this Moderate-Needs Expansion option, as well as services provided by the Blueprint for Health and other payer and provider care coordination and care management programs. Additionally, as part of Vermont's overarching Cost Growth Target and Affordability Index, the ROI experienced via the Moderate-Needs expansion can be 'booked' as savings, along with other proven cost saving technologies and interventions, and formally used by the Green Mountain Care Board to regulate commercial health insurance premiums as well as positively impact budgets for publicly-funded care.

[41] https://www.hca.wa.gov/health-care-services-supports/program-administration/tailored-supports-older-adults-tsoa-0
[42] https://www.hca.wa.gov/assets/program/quarterly-progress-report-dy5q2.pdf
[43] https://legiscan.com/AZ/text/SB1172/2019
[44] https://des.az.gov/about-des/budget-information
[45] http://www.careforourkupuna.com/#introducing
[46] https://health.hawaii.gov/opppd/files/2019/12/EOA-Annual-Legislative-Report-2019.pdf
[47] https://acl.gov/sites/default/files/RAISE-Initial%20Report%20To%20Congress%202021_Final.pdf

Federal Support

HST believes that a detailed financial model analysis would show the potential for future savings to both the state and federal government. With that in hand, Vermont could negotiate with CMS for federal support for this option. The vehicle for that could be an amendment to Vermont's current 1115 Global Commitment for Health waiver, a separate demonstration project, or some combination of the two. Other state examples above should be reviewed in detail as part of Vermont's modeling.

Further Research

People need varying levels of MNG services, depending on their preferences, clinical condition, and other informal supports available to them. A deep dive into Vermont specific data will provide needed insight into the level of need and projected costs. A detailed analysis of Medicaid claims data specific to Choices for Care MNG individuals and a further analysis of the Commercial and Medicare insured individuals as well as some analysis of ERISA lives would help to further define the level of need for the services suggested in this options document. There is also information available from the Washington State program which can also inform the detailed analysis of an expanded Vermont option.

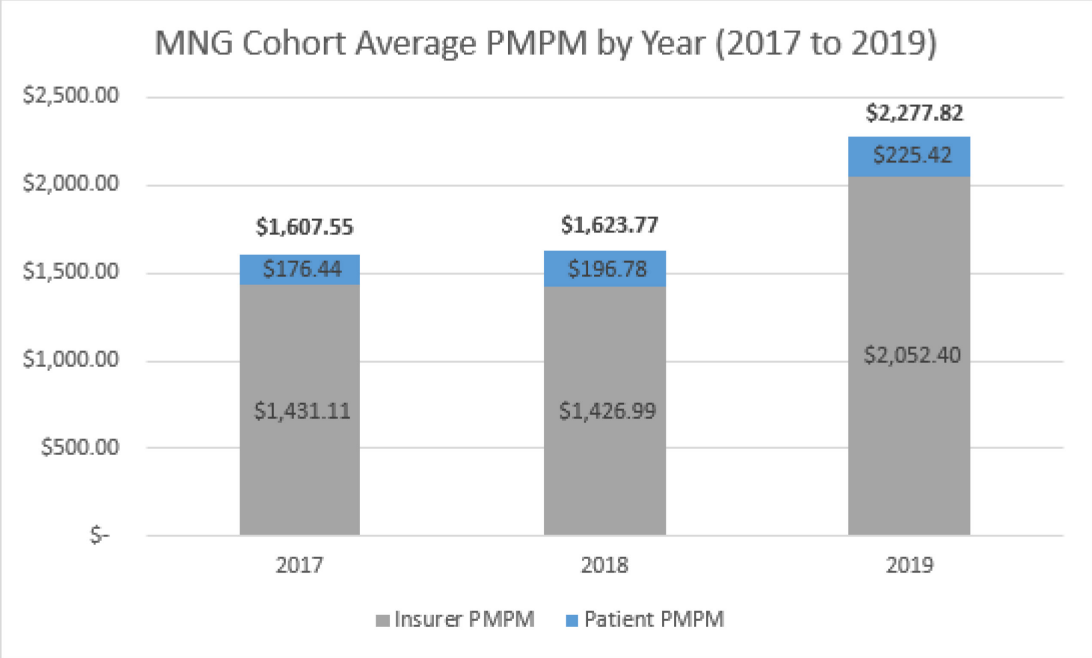
Moderate-Needs Group (MNG) Cohort Data Analysis[48]

Introduction to the Methodology for the MNG Cohort

- HST reviewed available data in the VHCURES dataset to identify individuals that were in the MNG during calendar year 2019 and then looked backwards to calendar years 2017, 2018, 2019.
- There are 328 individuals that have a WM (With Medicaid) code in their claims data in 2019. HST understands that those with a WM code in the Aid category field are a subset of the total Moderate-Needs Group (MNG) population.
- Of the 328 individuals with a WM code in 2019, 306 individuals have age, insurance, and location data available.

MNG Cohort Figures and Analysis

Figure 1.1 The Average PMPM by Year for the MNG Cohort from 2017 to 2019



[48]In conducting this analysis HST relied upon the "WM" AID category code in the VHCURES database to identify a subset of approximately one third of the individuals in MNG during the study time period. It is not known if or how this subset of the MNG population may differ from the MNG population in total.

Figure 1.2 The Average PMPM for the MNG Cohort from 2017 to 2019

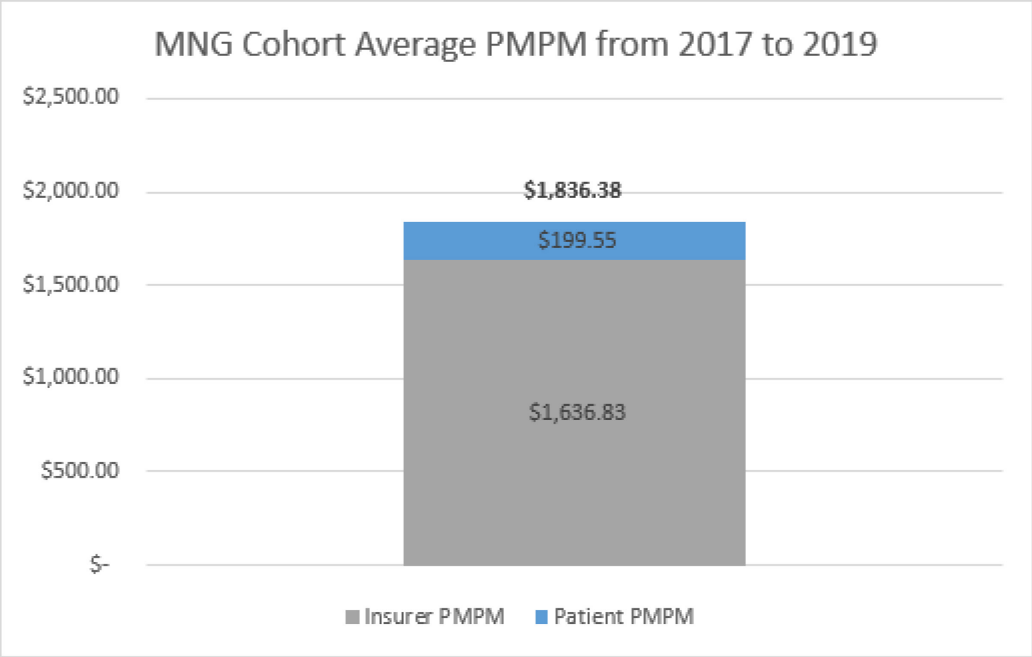
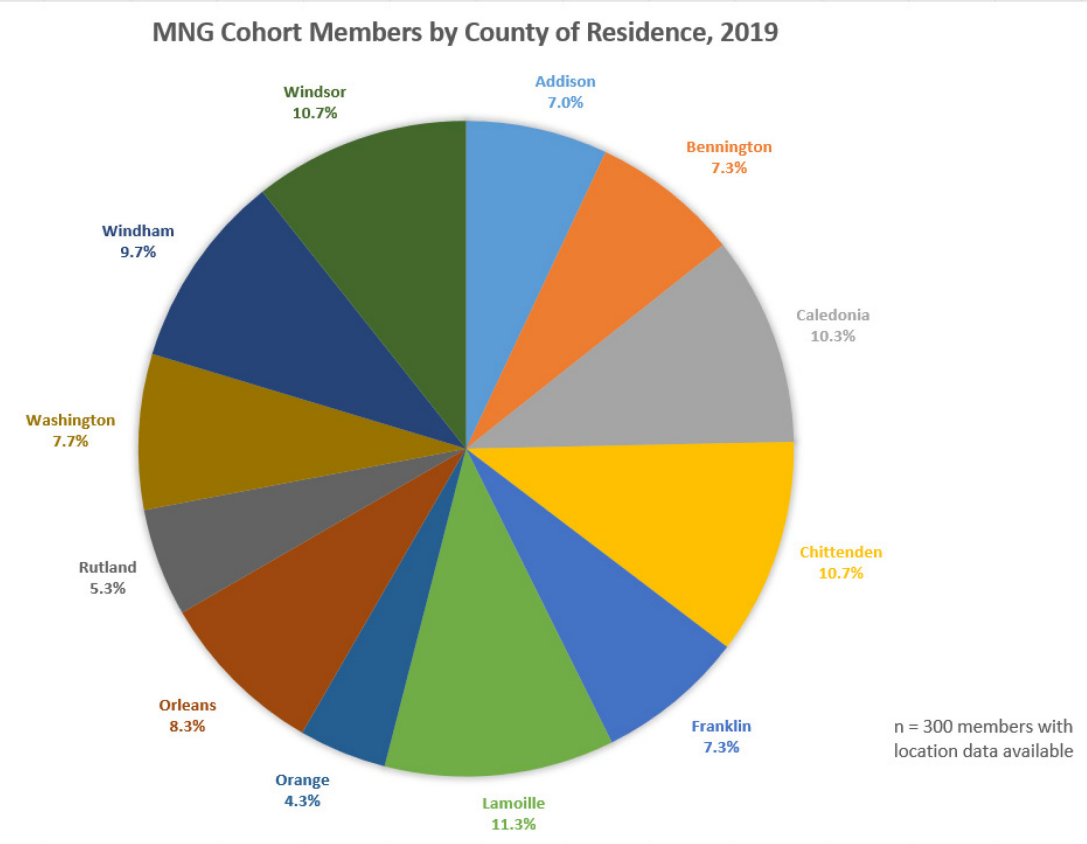
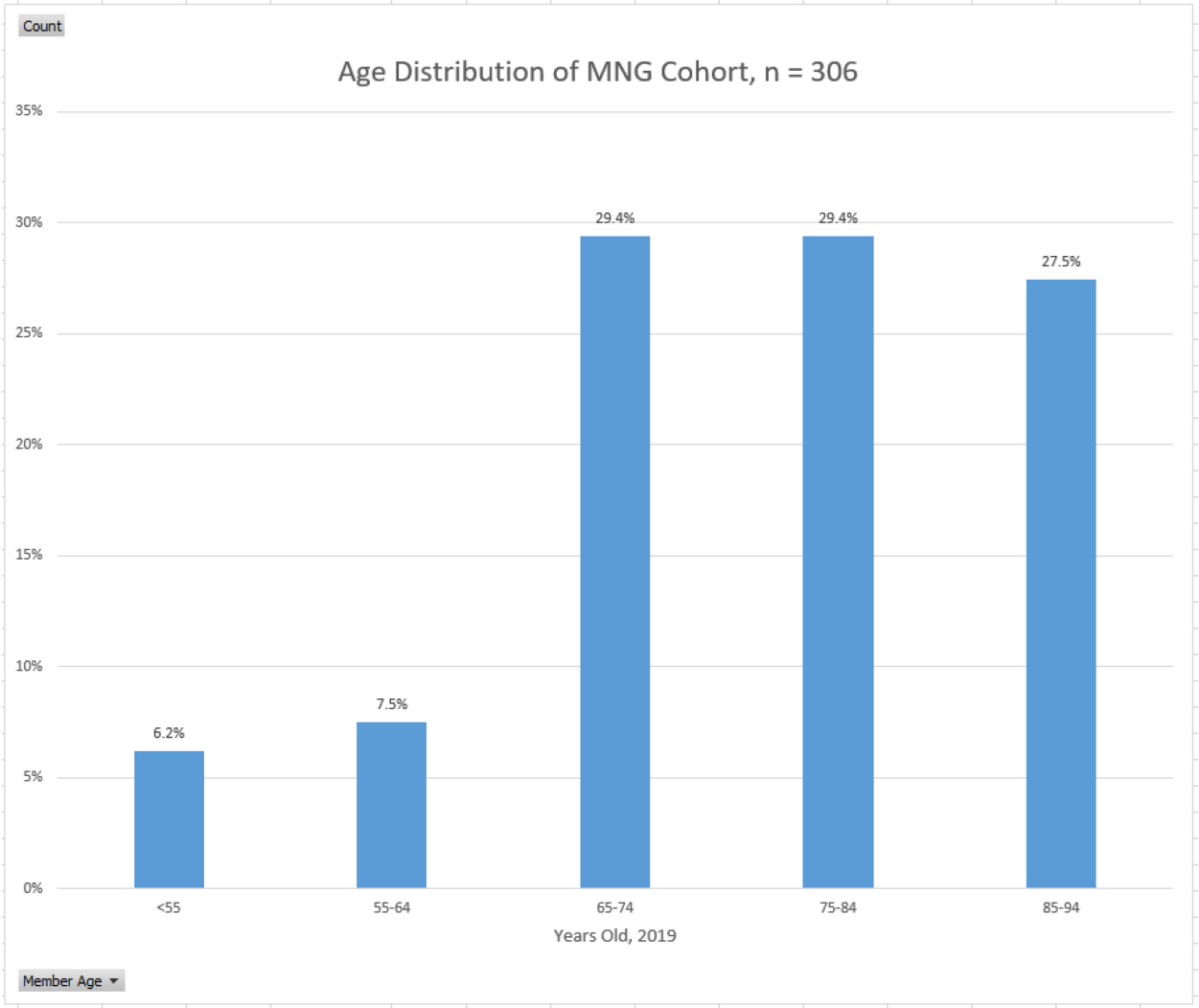


Figure 2. Breakdown of MNG Cohort Members by County



Cohort consists of 328 individuals with claim history; only 300 individuals have location data.
Note: Grand Isle and Essex counties are excluded due to small cell sizes.

Figure 3. Age distribution of MNG Cohort



Note: Age data exists for 306 individuals of the 328 individuals MNG Cohort.

Figure 4. Top Hospital Diagnoses for MNG Cohort

HST reviewed the top 37 hospital diagnoses from the MNG Cohort and selected the Ambulatory Care Sensitive Conditions (ACSC) and Mental Status Conditions that have a high likelihood of identifying potential individuals with clinical needs similar to those in the MNG cohort in the total VHCURES population (as of December 2019). The list of the top conditions is included below:

Row Labels	Distinct Count of id
ESSENTIAL PRIMARY HYPERTENSION	89
SHORTNESS OF BREATH	84
ENCOUNTER FOR IMMUNIZATION	81
UNSPECIFIED ESSENTIAL HYPERTENSION	80
OTHER LONG TERM CURRENT DRUG THERAPY	76
OTHER AND UNSPECIFIED HYPERLIPIDEMIA	75
COUGH	75
HYPERLIPIDEMIA UNSPECIFIED	73
OTHER MALAISE AND FATIGUE	71
WEAKNESS	70
CHEST PAIN UNSPECIFIED	70
NEED PROPHYLACTIC VACCINATION&INOCULATION FLU	67
PAIN IN SOFT TISSUES OF LIMB	65
DIZZINESS AND GIDDINESS	65
PERSONAL HISTORY OF OTHER SPECIFIED CONDITIONS	63
LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS	61
URINARY TRACT INFECTION SITE NOT SPECIFIED	60
OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD	59
PURE HYPERCHOLESTEROLEMIA	59
HEADACHE	58
DIAB W/O COMP TYPE II/UNS NOT STATED UNCNTRL	57
LOW BACK PAIN	57
TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	56
MAJOR DEPRESSIVE DISORDER SINGLE EPISODE UNS	56
ANEMIA UNSPECIFIED	55
PERSONAL HISTORY OF NICOTINE DEPENDENCE	54
PERSONAL HISTORY OF OTHER SPECIFIED DISEASES	54
LOCALIZED EDEMA	54
ASHD NATIVE CORONARY ARTERY W/O ANGINA PECTORIS	54
ESSENTIAL HYPERTENSION, BENIGN	54
UNSPECIFIED ANEMIA	51
LUMBAGO	51
UNSPECIFIED ABDOMINAL PAIN	50
OTHER FATIGUE	50
UNSPECIFIED BACKACHE	50
ALTERED MENTAL STATUS UNSPECIFIED	49
LONG TERM CURRENT USE OF ASPIRIN	49

Potential MNG Population Data and Analysis

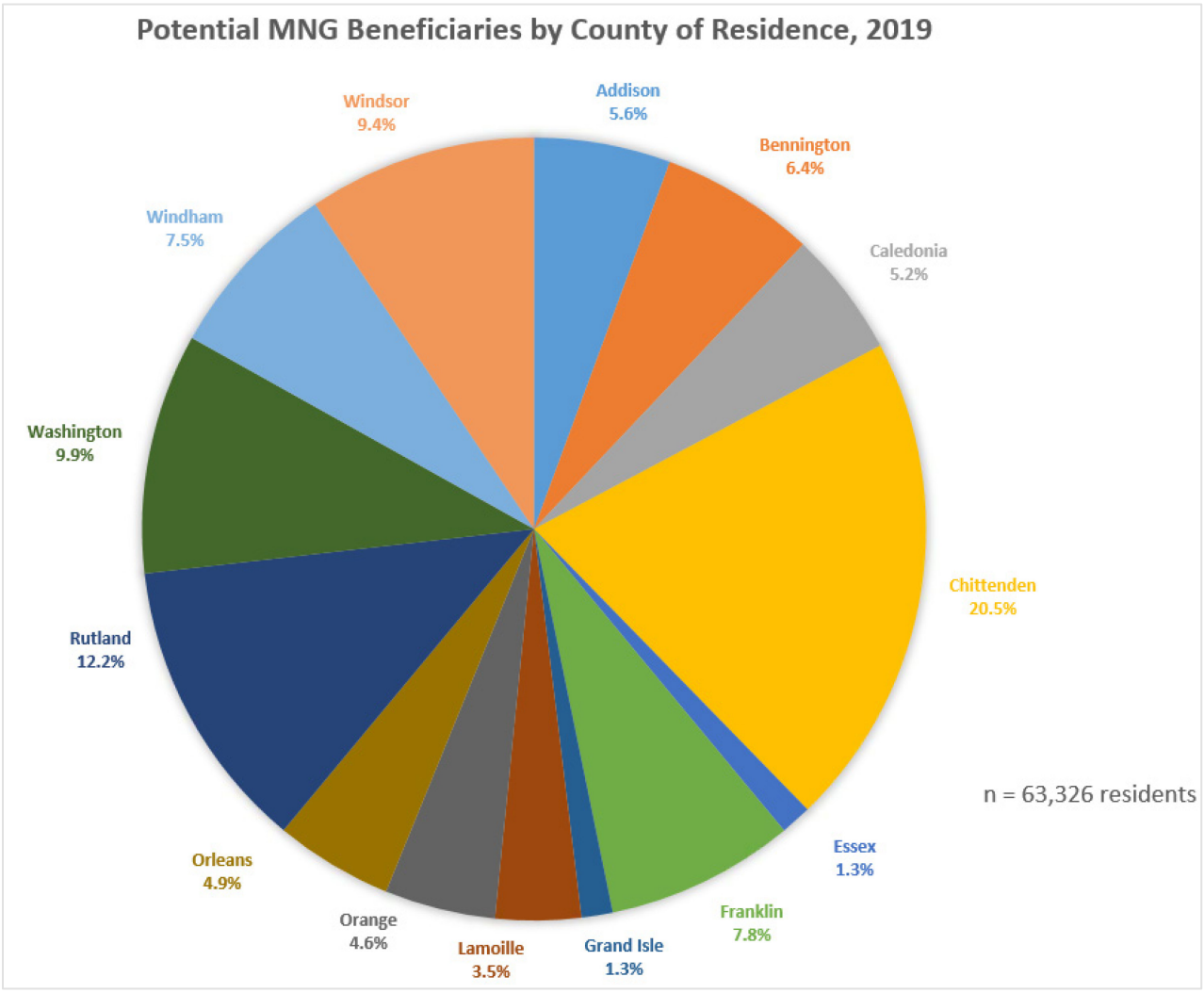
Introduction on the Methodology for the Potential MNG Population[49]

- Using the Top MNG Cohort ACSCs and Mental Status Conditions, HST determined that:
    - 63,422 individuals 45 and older had at least one of those conditions.
        - Of the 63,422 individuals 45 and older, 96 individuals do not have location, age, or insurance data, lowering the number to 63,326.
- HST further filtered down those numbers to identify those that were within the middle 80% range (between $3,330.35 and $67,667.36) and middle 90% range (between $2,002.04 & $90,035.28) of each member of the MNG Cohort's Annual Spend.
    - Of the 63,326 individuals 45 and older with insurance data:
        - Those with annual spends falling within the middle 80% range = 14,176
            - Those with Commercial insurance = 2,589
            - Those with Medicare = 11,587
        - Those with annual spends falling within the 90% range = 18,086
            - Those with Commercial insurance = 3,371
            - Those with Medicare = 14,715
- Individuals 45 and older represent 96.7% of the total MNG Cohort.

[49] This analysis does not include those individuals covered by ERISA plans.

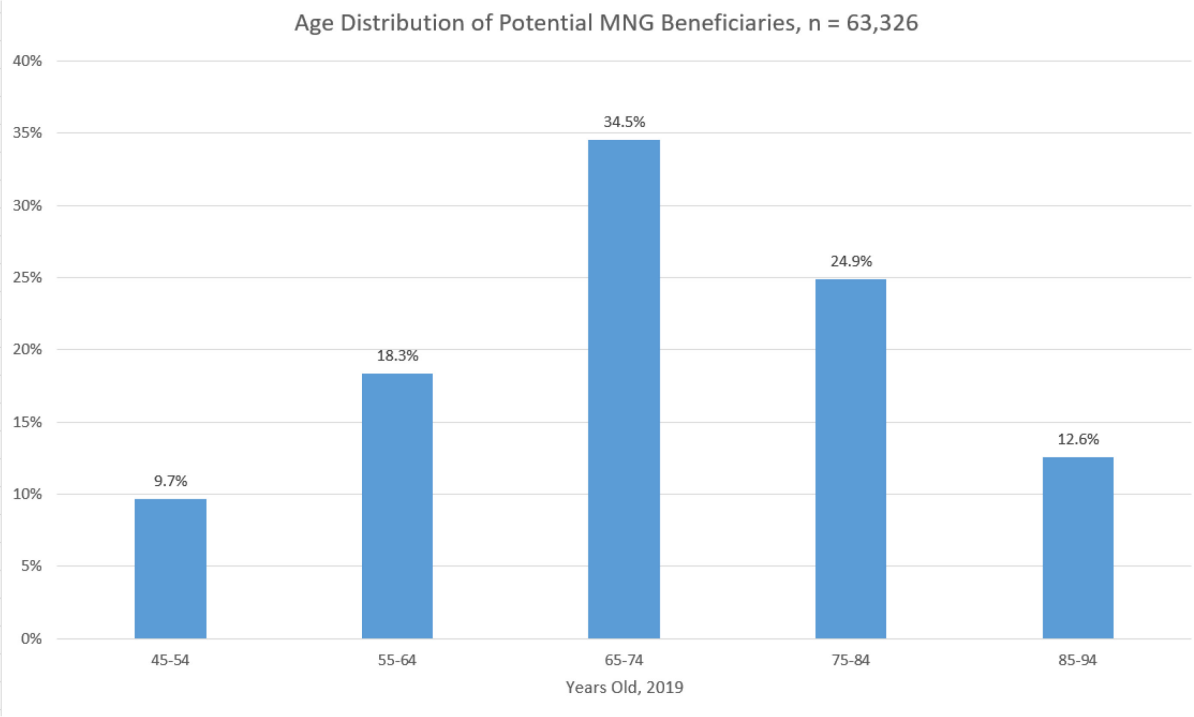
MNG Cohort Figures and Analysis

Figure 5.1 Breakdown of Potential MNG Beneficiary Members by County (45+ Breakdown)
The following is the county breakdown for 45 and up.



Of the 63,422 individuals 45 and older, 96 individuals do not have location data.

Figure 6.1. Age distribution of MNG Cohort (45+ Distribution)
The following is the age distribution for the 45+ Potential MNG group.



Of the 63,422 individuals 45 and older, 96 individuals do not have age data.

Public Option

Description

This option is an insurance coverage program that is designed to leverage the state's position as a purchaser/regulator to create coverage options for Vermonters. A public option is generally offered alongside commercial, individually purchased (e.g., through the marketplace) and other public insurance plans as a means to either broaden coverage options or enhance competition among carriers.

Approaches to a public option typically vary along a continuum of government intervention:

- At one end would be a program where government intervention and control would be maximized, e.g., creating a new government administered insurance offering.
- At the other end would be a program implemented in partnership with private plans, where private plans administered and delivered benefits subject to oversight and guidance by the state.
- In the middle would be a program by which existing state programs were offered or made generally available to a broader section of state's residents, e.g., a Medicaid or state employee benefits buy-in program.

Who will it affect, and how?

Consideration of a public option is typically made to advance one or several public policy goals:

- Reducing Costs. By reducing premiums or cost sharing either through regulation or some combination of regulation and market competition.
- Increasing Access. To the extent that existing commercial, marketplace or public programs are leaving certain populations uncovered.
- Addressing Market Weaknesses. To the extent that there are limited coverage options geographically or risk pools statewide or in particular counties are weak.

In achieving these policy goals, a public option would affect all stakeholders in the health care system, although the structure and approach to implementation will determine stakeholder reaction:

- **Consumers.** In general, consumers are likely to support public option initiatives, particularly if the benefit of reduced cost and increased access are felt broadly. At the same time, some advocates may leverage consideration of a public option to drive resolution of equity and access issues for otherwise marginalized populations or to press for greater government control of health care generally (e.g., as a substitute for a single payer).
    - The combined small group and individual market in Vermont has roughly 69,000 consumers (or about 11 percent of all Vermonters, per the Green Mountain Care Board [GMCB]). The market is split roughly evenly between small group and individual enrollees -- according to CMS data, in 2020 there were roughly 34,000 individual market plans purchased on the marketplace, of which about 24,000 were subsidized. When combined with the roughly 3.9 percent of Vermonters who are uninsured, the potential consumer impact of an affordable, accessible public option plan is potentially significant.

- From a consumer cost perspective, according to GMCB, since 2015 weighted average small and individual market premium increases have hovered right around 8 percent, ranging from a low of 3.5 percent in 2021 to a high of 11.5 percent in in 2020. Holding premium increases from 2021 (where the unsubsidized family silver plan premiums is $2,171, according to Vermont Health Connect), to even 95 percent of historic increases would save Vermonters hundreds of dollars per year. ***Moreover, if a public option could successfully reduce premiums year over year (as is required in Nevada and contemplated in other states), the savings for families could be as much as $1,300 per year.***

- **Insurers**. Where the public option lands on the "government intervention" continuum will generally determine insurer support. A strictly government run plan designed to compete with insurers in existing markets is likely to run into opposition. On the other hand, a partnership where insurers are given the opportunity to compete for new customers in a lightly regulated market will be more welcome.

- **Providers.** To the extent that the goal of a public option is increasing access – providing coverage to patients who might currently be driving provider uncompensated care and bad debt – providers are generally going to be supportive. On the other hand, using a public option to decrease costs, either via premium reductions or out of pocket limits, necessarily requires a source of funding. To the extent that provider payment limitations are considered as a source of funding, provider support may be limited.

Financing Considerations. If reducing costs is a consideration, some infusion of funding will be needed to drive reductions to consumers, for example:

- Provider reductions. Recouping state expenditures through provider rate limitations would generate an estimable level of savings, although at the risk of provider participation and potential access issues
- Competition. It is theoretically possible, although hard to estimate, that through benefit design and by stabilizing the risk pool (by increasing consumer participation) it is possible that increase competition alone could reduce costs.
- New appropriations/State only dollars.
- Federal dollars. It is possible to craft a public option initiative leveraging federal 1332 demonstration waiver authority that could allow the state to re-capture Advanced Premium Tax Credits (APTC) and cost sharing subsidy savings accruing to the federal government as the result of the program in the form of federal pass-through payments.

The Role of the State. Another key policy consideration is the state's appetite for government intervention, i.e., where on the continuum of options should a public option proposal land? As noted, there will be tension in stakeholder reaction, with consumer advocates likely to favor more aggressive state intervention in a public option while providers and insurers will view government intervention through a different lens.

The Role of the Federal Government. Under the Affordable Care Act (ACA), the U.S. Department of Health and Human Services (HHS) has the authority to approve demonstration waivers ("1332 Waivers") to experiment with market-place coverage if doing so provides equivalent coverage at the same or

lower cost. Notably, states could use this authority to recapture savings that would otherwise accrue to the federal government if the changes they are proposing reduce federal payments for APTC and cost sharing subsidies (i.e., "pass-through funding"). This pass-through funding creates an opportunity for states to advance a public option and use federal dollars to help pay for it, assuming the demonstration is structured appropriately.

To date, states have only requested 1332 demonstration waivers to finance reinsurance waivers: no state has made a request for pass-through funding to finance a public option. Further, the Biden administration has not articulated any priority or strategy related to 1332 authority (as they have for similar authority for Medicare and Medicaid demonstrations). On the other hand, it is likely that the Administration would look favorably on a public option given the President's campaign position on a federal public option.

What have other states done?

Washington State:

- Description: Enacted a public private partnership, "Cascade Care," (July, 2019) designed to increase access to affordable coverage in the individual market by requiring standardized public option plans. Largely financed with provider rate reductions. There is currently not a federally financed (i.e., 1332 waiver) component to the program.
- Status: Public option went live in 2021 with five carriers, but only in 19 of 39 counties, requiring enactment of provider participation requirements for future years.

Nevada:

- Description: Enacted a public/private public option (June 9, 2021) requiring issuers offering Medicaid managed care to make good faith bids for a standardized set of benefits. Financed by premium rate regulation with provider payment floors (and other protections) to ensure provider participation. Statute requires appropriate marketplace (1332) and Medicaid (1115) waiver proposals to secure additional federal funding.
- Status: Currently in stakeholder engagement to design plans to offer in the 2026 plan year.

Colorado:

- Description: Enacted a watered-down version of 2020 public option legislation (June, 2021). Instead of a proposed public private partnership offering qualified health plans (QHPs) on and off the exchange with the goal of making coverage affordable (from the 2020 bill), the final law requires issuers to offer standard benefits at all metal levels in counties where they currently offer coverage. Financed by regulated premium reductions and backstop provider rate limitations. Statute requires request for federal (1332 waiver) passthrough funding (but to finance other state initiatives).
- Status: In public process to design the standard benefit plan in anticipation of offering for the 2023 plan year.

Oregon:

- Description: Enacted a second public option study bill (2021) directing the Oregon Health Authority to create an implementation plan for a public health plan for individuals and families in the individual health insurance market and small employers.
- Status: The implementation plan, associated analyses, and recommendations for the structure and design of the public health plan are due to the Legislative Assembly by January 1, 2022.

New Mexico:

- Description: Medicaid buy-in with the goal of providing a low-cost health insurance choice for New Mexico residents. Financed with state dollars.
- Status: Legislation stalled since 2019.

Connecticut

- Description: Proposals to allow small businesses and individuals to enroll in state employees program (failed in 2019) and create a public option for small businesses and non-profits (2021).
- Status: Legislation under consideration.

Health Equity Impact

The United States Centers for Disease Control and Prevention (CDC) describes Health Equity as "…action to ensure all population groups living within an area have access to the resources that promote and protect health". This Public Option can positively impact health equity by setting cost sharing or network requirements to address economic, racial, or geographic disparities or access issues, or to add benefits on top of essential benefits to compliment other programs.

Alignment with other proposed Options

Savings identified in Cost Growth Target performance improvement plans, Moderate-Needs Group, and Blueprint Expansion Options can be used to reduce the Public Option premiums.

Policy Implementation and Considerations for Further Study

State experience across the country indicate that leveraging a public option (defined broadly) is viewed as a viable means to expand coverage options, increasing access and addressing affordability issues for consumers—even as data on outcomes related to early implementers are still uncertain. It is also the case that introducing a new coverage option is complex and multifaceted, with disparate and interconnected impacts on consumers, issuers, providers, employers, and the state.

States which have implemented some form of public option (Nevada, Colorado and Washington), as well as states that are still considering the appropriateness of a public option for their market, have rested their decision-making upon some level of detailed study and analysis to understand policy design and implementation considerations before moving forward (or as a guide to deciding whether or not to move forward).

Given the size of the market and the potential for affordability gains related to a public option, a prudent, forward looking next step would be to authorize/direct further study and analysis on this issue to refine and make more precise the viability of a public option to address affordability and access in Vermont.

There are a number of policy levers and implementation considerations to take into account in analyzing the viability of a public option. The analysis should illuminate pros and cons associated with implementation options based on actuarial and policy analysis, as well as examining what has or has not worked in other states (such state comparisons provide an advantage not available to early adopting states).

In this case, the study should also examine those levers with a particular focus on the uniqueness of the Vermont marketplace, including:

1. **What Type of Public Option?**
   As noted, a public option generally is considered along a continuum of state intervention – ranging from creating a new state sponsored insurance program, to a state plan "buy in", to a public private partnership.

   Based on the experience and stakeholder reaction in other states, notably Nevada and Washington, where public option legislation has been enacted, a public private partnership where the state sponsors a plan (either through bidding or regulation) on the marketplace would be most likely to meet dual goals of increasing access and affordability for Vermonters.

   There are two approaches to administering a public private partnership—via contracting with an existing issuer or administered by the state with the help of a Third Party Administrator (TPA).

   Using an issuer requires significantly fewer administrative state resources, since it only requires contracting and oversight and not full implementation and operational support. Using TPA to operationalize the program reduces the need for new agency resources, including hiring new expertise and investing in technology to review and pay claims – however, the state holds the risk of premiums covering all medical and administrative expenses.

   State Approaches to Type*s*: Both Nevada and Washington are leveraging commercial issuers as the delivery mechanism. In Nevada, issuers who wish to participate in Medicaid managed care must submit a good faith bid (and they have the option to open competition to other issuers). In Washington the Health Care Authority has procured five carriers that will offer the newly created Cascade Care public option plans in 19 counties.

   Opportunities for Vermont-Specific Analysis: Both Washington and Nevada opted for a public private partnership to advance the public option in their state. Given Vermont's market dynamics (discussed below), it might be worth considering further examination of a public program buy in, either via Medicaid or the public employee program, as a potential option for the state (given recent history and policy considerations in the state, the third type of public option -- a new state-run plan -- is likely not viable for Vermont).

2. **What is the Most Appropriate Plan Benefit Design?**
   In order to operate on the Marketplace, a state-sponsored public option must meet the requirements of a HP, including offering the ten essential health benefits, community rating and participating in risk mitigation programs (i.e., risk adjustment and reinsurance). In addition. A public option plan will need to compete among plans to draw consumers, and plan design – benefit levels and cost sharing protections – will be key to generating enrollment in a competitive marketplace. The public option could be offered in all the metal tiers of marketplace insurance plans (bronze, silver, gold, and platinum) or in only a subset. Moreover, multiple public plans could be offered within a metal tier or just a single plan (allowing varying combinations of cost sharing and deductibles and provide different benefits, such as coverage of dental and vision care).

   Plan design can also be a lever to drive other important policy considerations or savings for the state. For example:

   - Setting cost sharing or network requirements to address economic, racial, or geographic disparities or access issues.

- Adding benefits on top of essential benefits to compliment other programs, such as services tied to ADL supports and perhaps some other non-traditional supports focused on improving and maintaining function in populations at risk for needs in the LTSS area.
- Creating value or performance based contracting opportunities with providers, or networks of providers, to drive clinical improvement and cost savings via shared risk arrangements, for example.

State Approaches to Plan Benefit Design: Washington requires carriers to offer at least one gold and one silver standard plan and incents other key outcomes in benefit design as part of the procurement including: lower deductibles, access to more services before the deductible, and copays to provide transparency and predictability of costs for consumers. In addition, there are quality and value participation requirements specific to the Cascade Care public option plans.

Nevada requires carriers to meet QHP requirements at the silver and gold level and aims to prioritize insurer applicants with networks that: align the providers across the public option and state Medicaid program, include rural and safety-net providers, strengthen the primary care and behavioral health workforce (particularly in rural areas), accept value-based payment models, and decrease disparities in access and outcomes and provide culturally competent care.

Opportunities for Vermont-Specific Analysis: The study can examine whether the benefit designs in the public option can be used to drive desirable policy outcomes in the state. For example, using the plan to set cost sharing or network requirements to address economic, racial, or geographic disparities or access issues, or to add benefits on top of essential benefits to compliment other programs. Further, the all-payer model in Vermont provides an opportunity to examine how provider contracting, networking and payment arrangements can be used to drive savings and quality improvements.

3. How Will Premium Savings and Financing be Established?

A public option will need to compete on premium, not just to draw enrollees but also if federal passthrough savings are to be considered. The effect that establishing a public option would have on premium tax credits would depend on how the public option's premiums compared with those of private plans. Notably, a lower benchmark premium also lowers federal costs due to reduced federal tax credits.

As noted, the state could seek a Section 1332 waiver to recoup the difference in costs in the form of pass-through funding if the state-sponsored plan is the new benchmark or becomes the lowest-cost plan.

Generally, there will be two levers available to the state to drive premium savings: provider rate limitations or premium regulation.

Using provider rate limitations, the state would set a benchmark provider reimbursement rate to be used by the contracted carrier, or in direct state negotiations with providers. In order to reduce premiums, this reimbursement rate would need to be set below the current commercial rates but would have to be balanced against the need to attract providers and pay a reasonable amount for clinical services. The state may consider incenting provider participation in order to maintain lower-than-Marketplace rates, such as tying participation in the public option to participation in other state-procured health coverage programs (e.g., Medicaid).

Premium regulation would entail authorizing requirements for bidders to reach a premium reduction target and leave the mechanisms of the reduction to the carrier. Existing carriers may have more flexibility to negotiate rates for a state-sponsored product than for a traditional commercial offering with the backing of the state.

State Approaches to Premiums and Financing: Washington caps rates at 160 percent of Medicare with floors for primary care and rural hospitals. Of note, because in the first year of operation, plans were only offered in 19 of 39 counties, Washington is amending their program to add hospital tie-in requirements to ensure access and participation.

Nevada is taking a hybrid approach to ensure premium savings. First, the state ties participation in the Medicaid managed care plan to offering public option plans. Second, they set a payment floor to Medicare provider rates. Finally, to ensure premium savings for Nevadans, public option plans must submit rates that are at least 5 percent lower than the previous year's rates for a benchmark Marketplace plan; annual premium increases must be no higher than the Medicare Economic Index for that year. The state may revise these requirements if it ensures at least a 15 percent reduction in premiums over the first four years.

Opportunities for Vermont-Specific Analysis: In general, we know that a public option can theoretically help drive premium down for intended populations. An actuarial study will help determine specifically for Vermont, given its market and risk profile, if a public option premium can be meaningfully set to drive enrollment, and hopefully capture savings for consumers.

The study should also examine the role of premium savings on potential passthrough funding available to Vermont via a 1332 demonstration waiver, and how those savings might be applied to offsetting any state costs for the program.

The study should also be used to understand the impact of extended ARPA premium subsidies on the current marketplace and as well as the impact of their extension or expiration on the viability of a public option. Such analysis will be helpful in discussions with the Administration over continuation/expiration of the enhanced subsidies.

The premium analysis should also, to the extent practicable, illuminate impacts on small employers of premium reductions and enrollment changes.

To the extent that Vermont moves forward with cost growth or affordability targets, is there an opportunity to tie premium growth or reduction targets for a public option to a broader scheme of growth limitations?

4. **What Market/Resident Eligibility is Most Appropriate?**

The state will also need to consider resident eligibility and market segment for the public option: in particular, will the target population include both subsidized and unsubsidized populations who may benefit from a lower-premium product? Further, given that the small and individual group markets in the state share a risk pool, it makes sense to open the option to both segments.

Eligibility can also be a tool to drive access and affordability efforts at targeted populations. For example, leveraging a public option to assist small group market in meeting the cost and coverage demands for their employees. Setting up a plan on the exchange with lower premiums, or where

individuals could receive subsidies, might be more attractive option for employers. Alternatively, either as a stop gap or as part of a public option implementation plan, the state could set up navigator or other assister programs to help small employers understand the financial considerations associated with offering coverage versus allowing employees to seek subsidized coverage on the marketplace. Of course, the federal guardrails (particularly limitations on increases to federal spending of 1332 waivers) need to be considered when targeting previously covered small group members – waivers that increase federal spending (e.g., by increasing the # of state residents receiving subsidies when previously covered by employers) will not lead to passthrough funding.

State Approaches to Eligibilit*y*: Washington and Nevada make coverage open to those eligible to enroll on the exchange; Nevada is studying opening coverage to small employers and their employees.

Opportunities for Vermont-Specific Analysis: Unlike Washington and Nevada, the small group and individual markets in Vermont are combined, requiring unique technical actuarial and policy analysis to understand the premium and uptake parameters of a public option in Vermont.

Also unlike other states, insurance coverage and offerings in Vermont are fairly stable; the study should examine whether or not a public option would further promote uniformity across the state, or not.

The presence of only two issuers in the state makes analysis of a public option somewhat unique relative to what other states have undertaken. The analysis should specifically consider the impact of limited issuers and how the # of issuers might inhibit or promote the goals of a public option.

The study could also be useful in understanding the role of information and comparison tools for small employers seeking to understand the value of providing coverage or having employees seek coverage in the marketplace

5. **State Administration**

Enacting a public option will also require consideration of the locus of administrative accountability in the state. Under any scenario, the interplay of marketplace oversight, provider rate setting, access and beneficiary protections will require consultation across all relevant state agencies.

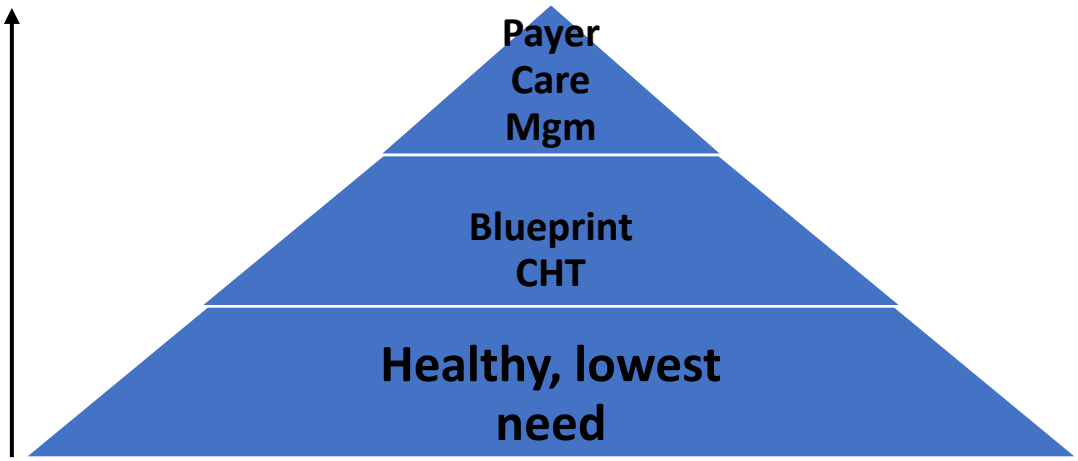
State Approaches to Administration: Cascade Care, in Washington, is administered by the state exchange in partnership with the Medicaid agency and the insurance commission. In Nevada, the plan is administered by the Human Services agency, in consultation with the marketplace and insurance commission.

6. **Study Timing and Execution**

Executing Agency: States have taken varying approaches to assigning further responsibility for additional analysis. In Nevada, the study was authorized by the state legislature to be conducted by a legislative committee. In Washington and Colorado, the state executive branch was directed to do the study by the legislature. With appropriate resources, the Department of Vermont Health Access, as a locus of both Medicaid and marketplace operations and policy would likely be an appropriate locus of responsibility, in coordination with the Green Mountain Health Board and the Department of Financial Regulation.

Timing: Ideally given the timing of plan design and implementation, any study would need to be complete in time for the state and issuers to operationalize any recommended changes. Anticipating a 12-18 month plan implementation window, a study would need to be complete sometime in the summer of 2022 in time for the 2024 plan year.

Expand Blueprint for Health



With rising risk there are fewer individuals but increased need

Description

This option proposes expanded and improved use of claims and other patient-level data, in addition to publicly available social determinants of health data, to enhance the referral of Vermonters to Blueprint Community Health Teams (CHTs) for care management[50] and to make the connection to ongoing return on investment (ROI) analysis. This will promote increased payer investment in the Blueprint to fund the expansion of cost-effective Blueprint services, as well as to incorporate those observed savings into reductions of health insurance premiums and possibly other household cost sharing. Both the identification and stratification of potential community members who could benefit from Blueprint services and the return on investment analysis of the population served will serve to move the successful Blueprint program forward.

Who will it affect?

Vermonters with any or no health insurance, who are referred by their Primary Care Medical Home (PCMH) or identified with advanced analytics as needing care management and then referred to appropriate Blueprint for Health CHTs across the state. ROI analysis will promote the uptake of Blueprint services, inform payer rate setting, and enable targeted quality improvement efforts.

Why this option?

The Blueprint for Health is a well-respected state-run program that supports care management services in communities, at the practice level, enabling local communities to develop their system as needed. The Blueprint for Health is viewed as a leading program in the effort to promote primary care transformation and address mental health, substance use, and unmet social needs. The Blueprint for Health accomplishes these goals by mobilizing community-based resources to work closely with primary care and women's specialty practices.

Vermont's payers (Medicaid, Medicare, and Commercial Payers) make direct payments to support Blueprint services. In 2020, these payments amounted to $9,381,138 to the Health Service Area

[50] Throughout this Policy Option description, HST utilizes "care management" broadly to refer to care management, case management, and care coordination activities.

Administrative Entities to fund CHT staff capacity, $9,821,223 in quality payments to the Patient-centered Medical Home practices for National Committee for Quality Assurance (NCQA) recognition, and $6,607,313 to support Medication Assisted Treatment in Vermont's Hub and Spoke model. Vermont Medicaid contributes additional resources to support other programs as well as administrative and some analytic capacity[51].

Further evolution and expansion of the Blueprint requires advanced analytics that will use emerging technologies to:

1. Identify Vermonters needing care management services and refer them to care within the Blueprint or, where appropriate, other care management resources in the state.
2. Measure and consistently report ROI so that payers and other stakeholders can understand the value of their Blueprint investment. This information can identify anticipated and actual savings, which can support future decisions on investing in care management and can also be included in the Green Mountain Care Board (GMCB) rate review processes[52].

Expected Outcomes

With high-quality data-driven decision making, the Blueprint can leverage its well-developed community-based infrastructure and positive reputation to effectively identify Vermont patients needing supports. In collaboration with other payer and provider care management activity (such as programs run by Vermont Medicaid -- Vermont Chronic Care Initiative and BCBSVT) and utilizing informed patient identification, the Blueprint can move toward a common reporting process to identify gaps in care and avoid duplication of services. Payers and regulators can depend on systematic ROI analysis to move toward the most cost-effective care and to inform rate setting.

To assure efficient and effective use of care management resources in Vermont, this option recognizes the need to inventory existing programs and to put in place a mechanism for referral to the Blueprint and other care management resources that considers the resources dedicated to specific individuals. This option does not propose statewide coordination of all these programs at the operational level. HST does envision working towards common ROI reporting across multiple programs and recommends that the state begin by updating the 2015 Vermont Health Care Innovation Project (VHCIP) Care Models and Care Management (CMCM) Work Group report that inventoried existing programs in the state[53]. This survey includes 42 care management providers across the state, grouped into the following categories: ACO, Health Plan, State Agency, Blueprint Community Health Team, Community Service Provider, and Health Care Provider. Ideally, a common format for reporting could help to streamline and align different populations that teams like Vermont Chronic Care Initiative (VCCI)[54], Blue Cross Blue Shield of Vermont integrated care management[55], and the Blueprint Community Health Teams (CHTs)[56] serve and will describe the services performed with shared definitions.

Health Equity Impact

The Blueprint for Health is uniquely positioned to promote health equity in the state. Funded by all healthcare payers, it was intentionally designed to serve all Vermonters, regardless of insurance status.

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[51] https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf
[52] https://ratereview.vermont.gov/
[53] https://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/3-09-15%20Care%20Management%20Inventory%20Survey%20Report.pdf
[54] https://dvha.vermont.gov/providers/vermont-chronic-care-initiative
[55] https://www.bluecrossvt.org/health-community/your-health-and-wellness/help-managing-your-health
[56] https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams

Patients who receive brief mental health counseling (or any service) with a Blueprint-funded behavioral health specialist are not subject to out-of-pocket cost sharing, reducing the financial burden for Vermont households as well as increasing access to care. Additionally, the use of publicly available, non-claims data to identify Vermonters needing services will help to address the bias inherent in claims data toward people who are utilizing the health care system, which misses people who are not already accessing care.

What have other states done?

Many states have programs that fund Blueprint-type services including risk screening and embedded care management and behavioral health services in primary care practices. Highlighted below are new programs and initiatives that capture the most current understanding of effective primary care delivery system innovation.

Maryland's Primary Care Program[57] (MDPCP) is a key element of Maryland's Total Cost of Care (TCOC) All-Payer Model. It is similar to the Blueprint in that it is a voluntary program open to all qualifying primary care providers that provides funding and support for the delivery of advanced primary care throughout the state. Separate entities (in Maryland they are Care Transformation Organizations and in Vermont they are Health Service Areas [58]) hire and manage an interdisciplinary care management team capable of furnishing an array of care coordination services to patients attributed to participating practices.

The MDPCP also uses data from several sources, including claims and publicly available data, for risk stratification and assignment to care. Patient outcomes are optimized by focusing those care coordination resources on the patients for whom these resources will generate the most benefit.[59] In 2020, which was year 2 of the MDPCP, over 2,700,000 patients were served[60]. With the bundle of support and guidance provided by Maryland Department of Health (MDH), beneficiaries attributed to MDPCP practices experienced significantly lower rates of COVID-19 infection, inpatient admissions, and deaths as a proportion of the total population. Robust and readily accessible support, data, and guidance from MDH to advanced primary care practices enabled better outcomes by overcoming one of the chief challenges during a pandemic: prompt, data-driven, and effective action at the population level.[61]

In August 2020, eight **Washington State** payers jointly developed and signed a memorandum of understanding (MOU) outlining a multi-payer initiative that strengthens primary care through an integrated whole-person approach that includes behavioral and preventive services, under the umbrella of the **Washington Primary Care Transformation Model** (PCTM)[62].

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[57] https://health.maryland.gov/mdpcp/Pages/home.aspx
[58] https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-transformation-network
[59] https://health.maryland.gov/mdpcp/Documents/MDPCP%20Pre-AH%20Risk%20Score%20Specifications%20and%20Codebook.pdf
[60] MDPCP_Year2_2020_Summary.pdf (maryland.gov)
[61] Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm - Milbank Memorial Fund
[62] https://www.hca.wa.gov/about-hca/value-based-purchasing/multi-payer-primary-care-transformation-model#resources

The Model, which is targeted for implementation in January 2023, includes the following components:

1. Primary care as integrated whole-person care, including behavioral and preventive services
2. Shared understanding of care coordination and providers in that continuum. Patients are assigned to care teams based on level of need, stressing the importance of managing chronic disease, behavioral health, oral health, social support needs, and the goals of the patient, family, and caregiver.
3. Aligned payment and incentives across payers to support model. Plans will align payment approaches, which will be tied to measurable value metrics and may include a combination of transformation of care fees, comprehensive payments, and performance-based incentive payments.
4. Financing. Payers agree to an incremental and defined percent (%) of spend on primary care as a proportion of total cost of care.
5. Improved provider capacity and access. Patients are empaneled or attributed to high-functioning care teams to coordinate and provide care, and patients receive meaningful annual engagement using a range of modalities.
6. Application of actionable analytics (clinical, financial, and social supports.) Payers and providers together use cost and utilization data that is interoperable with and across EHR systems to develop, implement, and document interventions to improve performance.
7. Aligned measurement of "value" from the model. Primary care is defined as integrated whole-person care, including evidence-based behavioral and preventive services.

A recent study published in the American Journal of Managed Care examined 14 health care interventions funded under the second round of Health Care Innovation Awards by CMS. It determined that ***the features most strongly associated with a reduction of total expenditures included behavioral health, telehealth, and health information technology****. Overall, the best performing programs saved an average of $73 per member per month.*

https://www.ajmc.com/view/features-of-health-care-interventions-associated-with-reduced-services-and-spending

The Centers for Medicare and Medicaid Innovation's Comprehensive Primary Care Plus (CPC+) is the largest and most ambitious primary care payment and delivery reform model ever tested in the United States and is currently operating in 2,610 primary care practices and 18 regions across the country. Through CPC+, CMS is testing whether multi-payer payment reform, actionable data feedback, robust learning supports, and health information technology (IT) vendor support enables primary care practices to transform how they deliver care and improve patient outcomes. CPC+ requires practices to transform across five care delivery functions: (1) access and continuity, (2) care management, (3) comprehensiveness and coordination, (4) patient and caregiver engagement, and (5) planned care and population health. The model is running for five years in each region[63].

Alignment with other proposed Options

A statewide identification and stratification system can help identify Vermonters that are appropriate for Blueprint services and other payer care management programs, as well as for the limited HCBS and Caregiver Supports offered in the Moderate-Needs Expansion option. Additionally, as part of Vermont's overarching Cost Growth Target and Affordability Index, the ROI experienced via the Blueprint can be 'booked' as savings, along with other proven cost saving technologies and interventions, and formally used by the Green Mountain Care Board to regulate commercial health insurance premiums as well as positively impact budgets for publicly-funded care.

[63] https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus

Further research

Vermont-specific data analysis will reveal the current Blueprint service reach and identify needs and opportunities for expansion. Specifically, data showing where care management is happening across the state and across payers. HST recommends conducting a thorough care management inventory, developing common program definitions, identifying the individuals served and creating common groupings of individuals served.

Appendix

Task Force Charge

Sec. E.126b TASK FORCE ON AFFORDABLE, ACCESSIBLE HEALTH CARE; REPORT

(a) Creation. There is created the Task Force on Affordable, Accessible Health Care to explore opportunities to make health care more affordable for Vermont residents and employers.

(b) Membership. The Task Force may be composed of the following six members:

(1) three current members of the House of Representatives, not all from the same political party, who shall be appointed by the Speaker of the House; and

(2) three current members of the Senate, not all from the same political party, who shall be appointed by the Committee on Committees.

(c) Powers and duties. The Task Force shall explore opportunities to make health care, including prescription drugs, more affordable for Vermont residents and employers, including identifying potential opportunities to leverage federal flexibility and financing and to expand existing public health care programs. In completing its work, the Task Force shall:

(1) keep in mind the principles for health care reform enacted in 2011 Acts and Resolves No. 48 and codified at 18 V.S.A. § 9371:

(2) identify the primary drivers of health insurance premium increases in Vermont;

(3) review the findings and recommendations from previous studies and analyses relating to the affordability of health care coverage in Vermont;

(4) determine actions the State can take without federal assistance to address the unmet health care needs of Vermont residents and employers;

(5) analyze the long-term trends in out-of-pocket costs in Vermont in individual and small group health insurance plans and in large group health insurance plans; and

(6) identify opportunities to decrease health care disparities, especially those highlighted by the COVID-19 pandemic and those attributable to a lack of access to affordable health care services.

(d) Assistance.

(1) To the extent that applicable funds are appropriated in Sec. B.1106 of this act, the Joint Fiscal Office shall contract with a consultant to provide the Task Force with technical and research assistance in carrying out the duties set forth in subsection (c) of this section. The consultant's primary focus shall be on monitoring and reviewing opportunities made available by the Biden Administration to expand access to affordable health care through existing public health care programs or through emerging opportunities to address the unmet health care needs of Vermont residents and employers. The consultant shall remain available to assist the committees of jurisdiction as needed throughout the 2022 legislative session.

(2) In addition, the Task Force shall have the administrative, technical, and legal assistance of the Office of Legislative Operations, the Office of Legislative Counsel, and the Joint Fiscal Office.

(f) Reports.

(1) On or before December 1, 2021, the Task Force and the consultant shall brief the leadership of the House Committee on Health Care and of the Senate Committee on Health and Welfare on their preliminary findings.

(2) On or before January 15, 2022, the Task Force and the consultant shall present to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance their findings and recommendations regarding the most cost-effective ways to expand access to affordable health care for Vermonters without health insurance and those facing high health care costs and the various options available to implement these recommendations.

(g) Meetings.

(1) The first meeting of the Task Force shall occur on or before August 15, 2021.

(2) The Task Force shall select House and Senate co-chairs from among its members at its first meeting. The Co-Chairs shall alternate acting as Chair at Task Force meetings.

(3) A majority of the Task Force membership shall constitute a quorum.

(4) The Task Force shall cease to exist on January 15, 2022.

(h) Compensation and reimbursement. For attendance at meetings during adjournment of the General Assembly, the members of the Task Force shall be entitled to per diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 23 for not more than five meetings. These payments shall be made from monies appropriated to the General Assembly.

Process

Prior to the Task Force meeting on September 29, 2021

HST met with JFO and the Task Force Co-Chairs to discuss the approach for the scheduled Task Force meeting, including the process for developing an initial list of Options. HST worked internally to produce an initial Options list, as well as drafting principles of affordable and accessible healthcare for Task Force consideration.

Task Force meeting on September 29, 2021

At the scheduled public meeting of the Task Force in September, the members began with a discussion of the proposed principles of affordable and accessible healthcare, which were amended based on that discussion, and are included on page x of this Appendix.

HST then presented a list of 21 Options, to which a 22nd was added during the discussion. The initial options were grouped in the following categories:

- Cost Containment and Value Based Purchasing
- Affordable Care Act (ACA) Section 1332 Waiver
- State subsidies and service expansion
- Pharmacy
- Transparency and Regulation

Task Force members directed HST to do further research and narrow down the list prior to the next full Task Force meeting.

Documents related to the September 29, 2021 meeting can be found on the Vermont legislature website: https://legislature.vermont.gov/committee/document/2022/368/Date/9-29-2021#documents-section

Prior to the Task Force meeting on October 28, 2021

HST Subject Matter Experts reviewed and ranked the Options to narrow the list to seven.
The variables considered included:

1. Household affordability impact: # people x level of change
2. Accessibility impact: # people x level of change
3. Timeframe and legislative or programmatic lift
4. Health equity impact
5. Level of federal involvement needed
6. State/federal savings or cost

HST also began to conduct informational interviews with Vermont healthcare stakeholder leaders during this period. The conversations typically centered around the proposed Options list, but were not limited to those topics. Individuals interviewed provided important insights that were used to inform the Options documents to come.

Multiple interim meetings were conducted with JFO and Task Force co-chairs and members to keep all parties informed and provide opportunities for course corrections

Task Force meeting on October 28, 2021

At the scheduled public meeting of the Task Force on October 28, HST Subject Matter Experts presented initial research conducted on the following seven Options:

1. Public Option
2. Medicaid Post-Partum Coverage
3. Remote Access to Health Care Services
4. Extend Moderate Needs Supports
5. Cost Growth Containment/ Affordability Boards/ Affordability Standards
6. Expand VT Blueprint for Health, e.g., improved analytics, reduce cost sharing, increase access to mental health and maternal health services
7. Legislation directed at Pharmacy Benefit Managers (PBMs)

Task Force members asked questions and engaged in a fruitful discussion to further clarify their priorities. The seven options were reduced to four, based primarily on the fact that action was currently being taken by the legislature and/or the administration on three of the Options: Medicaid Post-Partum Coverage, Remote Access to Health Care Services, and Pharmacy Benefit Managers (PBMs). Therefore, the Task Force consensus was that HST would focus on the remaining four.

Documents related to the October 28, 2021 meeting can be found on the Vermont legislature website: https://legislature.vermont.gov/committee/document/2022/368/Date/10-28-2021#documents-section

HST's PowerPoint presentation to the Task Force is included on page xxiv of this Appendix.

Prior the Task Force meeting on December 15, 2021

Note: The scheduled public meeting of the Task Force on November 22, 2021 was pre-empted due to a special session of the legislature held that day.

HST continued stakeholder informational interviews, meeting with some individuals several times. A full list of those stakeholder organizations can be found in on page xv of this Appendix.

This period of time was also devoted to a deep dive into the four prioritized options:

1. Cost Growth Benchmark and Affordability Standards
2. Extending Moderate Needs Supports
3. Public Option
4. Expansion of VT Blueprint for Health

Research was focused on understanding what other states have done in these areas, what the federal government has done or its stated intentions, and what Vermont has done. This was overlayed with stated Task Force priorities as well as insight gained from stakeholder interviews and correspondence from advocates. Copies of the correspondence received start on page xvi of this Appendix.

During this time HST also established a Data Use Agreement to access the VHCURES data set. That data mining and analysis work was primarily focused on the Extending Moderate-Needs Supports Option.

Multiple interim meetings were conducted with JFO and Task Force co-chairs and members to keep all parties informed and provide opportunities for course corrections.

Task Force public meeting on December 15, 2021

This meeting brought to fruition the activity conducted up to this point. HST Subject Matter Experts discussed in detail the four Options, allowing for robust discussion with the Task Force throughout. Additionally, a demonstration of advanced population health identification and stratification was presented by Clarify Health, as an example of what is possible if Vermont decides to invest in this technology to support the proposed Options, as well as other healthcare delivery system structures.

As a result of the Task Force discussion at this meeting, HST added an additional research topic: How the state can make use of the Medicare Savings Program to increase accessibility and affordability for Vermonters. This whitepaper can be found on page liii of this Appendix.

The Policy Option documents begin on page 9 of this report, including detailed analysis of the VHCURES data. Where appropriate, the documents provide legislative and administrative options/considerations, as well as details on how other states have approached the issue. Each Option also contains a Health Equity impact statement and a description of how it intersects with and complements the other three Options.

Documents related to the December 15, 2021 meeting can be found on the Vermont legislature website: https://legislature.vermont.gov/committee/document/2022/368/Date/12-15-2021#documents-section

HST's PowerPoint presentation to the Task Force is included on page xxxii of this Appendix.

September 29, 2021 Handout: About Health System Transformation, LLC

Health System Transformation, LLC (HST) as a business entity has been in existence for five years. The organizational roots, however, span across the decades that founder and President Joshua Slen has worked in direct state and state facing roles. The HST approach is to develop a bespoke team for each engagement made up of individuals with the necessary expertise to provide deep subject matter expertise, analytics, research, writing, project management, and a host of other supports to assure that your project is superbly staffed. Every member of the curated team that HST assembles hasworked in the healthcare space for decades. Collectively, HST brings together experts from all areas of state facing healthcare. Joshua and the individual HST team highlighted below are nationally known health policy experts responsible for designing and implementing state-wide health system improvements including transformational population health interventions and federally approved Medicaid Waivers. Over the past thirty years Joshua has worked in multiple states, including Vermont, directly for the State Legislature and Governors. He has lead state budget development, run the Medicaid program, negotiated federal waivers, supported state-wide quality improvement, built population management programs, worked for and with multiple Health Information Exchanges, and more. HST works today with multiple corporate and non-profit clients on complex health policy and strategy issues. HST continues to lead the health system improvement conversation nationally supporting multiple initiatives across multiple states and with the federal government.

Your HST team includes hand-picked individuals that provide the skills and expertise gained through decades of healthcare experience at the state and federal levels along with system level experiences in health information technology, quality improvement, and many other healthcare areas. Joshua and Julie have done dozens of projects pulling together bespoke teams to support state health system efforts over the past several years. Key individual team member background information is included below.

Julie Trottier, MSA

is a native Vermonter who brings 30 years of experience in public and private sector health and human service care delivery system development, care management, quality assurance and improvement, and healthcare administration. She has worked for three departments within the VT Agency of Human Services, including DAIL, DCF, and DVHA and has been a leader and team contributor to a number of healthcare initiatives including the Vermont Chronic Care Initiative, the Blueprint for Health, and severalnational federally sponsored practice transformation demonstrations. In her work both within Vermont and on consulting projects in other states and for the Centers for Medicare and Medicaid Services, Julie has facilitated connections between state and federal government agencies and community providers to develop value-based practices for health and human services funding and delivery, operational procedures, and improved care coordination for Medicare and Medicaid enrollees.

Tim Hill, MPA

is the Senior Vice President, Health, for IMPAQ International. He is a highly experienced health policy executive with a demonstrated ability to lead diverse teams developing and implementing health policy solutions in fast paced environments. He has strong policy, financial management and program implementation qualifications and a 25-year track record of successful interactions at the highest levelsof the executive branch, Congress, oversight agencies and the press. Mr. Hill is a recognized expert in the health policy community as a strong communicator who brings a risk-based, solutions-oriented mindset to problem solving and policy development. Immediately prior to joining IMPAQ, Mr. Hill was the senior career executive with policy and operational oversight of Medicaid and Children's Health Insurance

Program (CHiP) as the Deputy Director of the Center for Medicaid and CHIP Services (CMCS) within CMS. Mr. Hill also served as Deputy Director of the Center for Medicare, overseeing policy and operations of the Medicare Part D and Medicare Advantage programs. Mr. Hill has been an accountableleader in several other senior positions within CMS, including CMS Chief Financial Officer, CMS Program Integrity Director and Deputy Director of the Center for Consumer Information and Insurance Oversight.

Beth Waldman, JD, MPH

is a Senior Consultant at Bailit Health with national expertise in health care policy, program development and implementation, specializing in Medicaid and CHIP programs and coverage for the uninsured. During her fourteen plus years with Bailit Health, Beth has been actively involved in efforts across the country to improve access and delivery of health care to low-income individuals while working to make coverage more affordable and assist payers in efforts to expand value-based purchasing. Beth's work includes assisting states and other stakeholders in delivery system and payment reform design, including PCMH and ACO development; Medicaid managed care procurements;care management and health home program design; behavioral health reform, including integration, opiate prevention and treatment; design and implementation of Medicaid and other public program expansions; quality measurement; and long-term services and supports strategy and integration.

Immediately prior to joining Bailit, Beth served as the Massachusetts Medicaid Director and was responsible for the administration of all aspects of the Massachusetts Medicaid program, MassHealth, including DSH policy. Beth played a key role in the development and implementation of the Commonwealth's historic Health Reform Law. Beth negotiated the federal waiver, oversaw the implementation of several MassHealth population and service expansions, and served as a member of the Board of the Commonwealth Health Insurance Connector Authority. Prior to becoming Medicaid Director in September 2003, Beth spent nine years in various roles at the Division of Medical Assistance.In her various roles, Beth gained expertise in all aspects of the state's Medicaid program – including eligibility, provider rate payments, managed care contracting, and long-term care services.

https://www.linkedin.com/in/joshuaslen/
www.linkedin.com/in/julie-trottier-a714a922
https://www.linkedin.com/in/timothy-hill-786b487a/
https://www.linkedin.com/in/beth-waldman-b724a5b/

September 29, 2021 Handout: Proposed Principles of Affordable and Accessible Health Care

A focus on affordable health care:

- moderates the rate of cost growth.
- monitors all health care related spending per household, including premium contributions andall out-of-pocket spending (deductibles, cost-sharing obligations, and other health care expenses).
- can be defined as a maximum percent of income annually per household.
- means that households can obtain the necessary health care to maintain good health without sacrificing basic needs and without incurring unreasonable levels of debt.
- means that health insurance coverage must provide an adequate benefit package with a defined set of services. Gaps and cliffs in coverage should be reviewed and addressed regularly with regulation and law updates.
- does not simply shift costs from one group to another.
- does not overburden employers.

Accessible health care:

- is available to all Vermonters regardless of their zip code.
- is available irrespective of insurance carrier or lack thereof.
- is available to all Vermonters regardless of race, ethnicity, gender identity, sexual orientation, disability status, citizenship, or immigration status.
- means receiving timely services.
- includes necessary transportation to health care services.
- includes remote options.
- includes the ability for individuals to access a provider with the expertise they need.
- includes services that address mental health and substance use disorders.
- includes support and referrals to services that address health related social needs.

September 29, 2021 Handout: Initial Options for Discussion

Option	Brief Description
Cost Containment and Value Based Purchasing	
Cost Growth Containment/ Affordability Boards/ Affordability Standards	Utilizing data to understand and define what is affordable for families and individuals earning different incomes and living in different communities allows policymakers to create solutions to ensure health care is more affordable. Instituting affordability standards would help keep policymakers, providers, and insurers accountable for providing care and coverage that is accessible and equitable.
Cost Growth Benchmark	A cost-growth benchmark program is a cost-containment strategy that limits how much a state's health care spending can grow each year. Massachusetts established the first program in 2012. A growing number of states are now using the strategy to contain costs for patients, providers, and payers.
Episodes of Care across all payers	In contrast to traditional fee-for-service reimbursement where providers are paid separately for each service, an episode-of care payment covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event. Maternity is one area where an Episode approach can support savings. There are many other areas where episodes can drive efficiencies. Savings can be realized in three ways: 1) by negotiating a payment so the total cost will be less than fee-for-service; 2) by agreeing with providers that any savings that arise because total expenditures under episode-of-care payment are less than they would have been under fee-for-service will be shared between the payer and providers; and/or 3) from savings that arise because no additional payments will be made for the cost of treating complications of care, as would normally be the case under fee-for-service. Episode-of-care payments also are known as case rates, evidence-based case rates, condition-specific capitation and episode-based bundled payments.
Health insurance rate review	For over a decade, Rhode Island has used its health insurance rate review authority to constrain the growth of hospital prices to the rate of inflation plus one percent. Other states, including Colorado and Delaware, are moving to implement similar strategies giving the insurance commissioner the authority to enforce affordability standards as part of the health insurance rate review process.

ACA Section 1332 Waiver	
Public Option	Under a 1332 waiver, states have access to additional federal funding that could be critical in advancing coverage reforms. Section 1332 can be used to extend eligibility for premium tax credit (PTC) subsidies to public option enrollees even if they would not otherwise qualify — for example, if income is above 400 percent of the federal poverty level or the option is offered outside the state's marketplace. Section 1332 also could allow the state to recapture savings that would otherwise accrue to the federal government. This is known as "pass-through funding" —for example, the federal cost savings that accrue from subsidies because of lower public option premiums would be refunded to states. States can use pass-through funding to defray program costs, enhance benefits, and expand consumer subsidies, among other options.
Reinsurance	Most states (15 out of 16 with federal approval) have leveraged Section 1332 waivers to seek federal approval and pass-through funding for state-based reinsurance programs, which aim to lower health insurance premiums for plans sold in the individual insurance market. A reinsurance program is a reimbursement system that protects insurers from high medical claims for beneficiaries with complex and costly medical needs. It usually involves a third party acting as an insurer for the insurance company by paying part of a claim once it surpasses a certain amount, or by covering part or all of the claims for individuals with pre-determined, high-cost conditions.
Adjusted Plan Options (APO)	The APO waiver concept, if approved for a state, would enable a state to take advantage of the flexibility provided under section 1332 of the PPACA to increase consumer choice and affordability by allowing a state to provide state financial assistance for non-Qualified Health Plans (non-QHPs), allowing non-QHPs to be sold on the existing Exchange, expanding the availability of catastrophic plans beyond the current eligibility limitations, applying PTC to catastrophic plans and potentially certain non-QHPs sold on the Exchange, and/or other approaches. The APO waiver concept encourages states to target solutions to their unique problems or challenges in the individual and small group insurance markets, free from the constraints of certain federal requirements imposed by the PPACA.
State subsidies and service expansion	
Remote Access to Health Care Services	Legislation to require remote access to healthcare services, including telehealth, which may increase participation for those who are medically or socially vulnerable or who do not have ready access to providers. Remote access can also help preserve the patient-provider relationship at times when an in-person visit is not practical or feasible.
Premium and Cost Sharing Subsidies	Vermont could offer subsidies to populations ineligible for federal assistance as a way to provide assistance to populations otherwise left out of state-federal programs. This would be in addition to benefits provided through Vermont public programs today.

Health Equity: Expand VT Blueprint for Health Community Health Teams, including Mental Health and Maternal Health	Vermont could increase the number of mental health providers and care managers available to all participating Blueprint practices, including women's specialty practices to support pre and postpartum patients. These services would be available to all Vermonters, regardless of insurance status.
Enhanced services provided to 'pre-duals '	Home- and community-based services (HCBS) help seniors and people with disabilities and chronic illnesses live independently outside institutions by assisting with daily needs. HCBS include but are not limited to home health aide services, assistance with self-care tasks such as eating or bathing, supportive housing, and assistive technology. Providing a modified level of HCBS services to Vermonters not yet eligible for them under current rules may stave off the need for more intensive services in the future, thereby saving Medicaid dollars that would have been spent, in addition to improving current quality of life.
Draft a resolution to encourage the federal government to make temporary ACA premium subsidies permanent	The American Rescue Plan (ARP), recently signed into law by President Biden, increases and expands eligibility for Affordable Care Act (ACA) premium subsidies for people enrolled in marketplace health plans. These changes to marketplace premium subsidies are temporary, in effect only during calendar years 2021 and 2022.
Expand Medicaid to additional income levels for certain ages	Expand access to affordable health care through existing public health care programs or through the creation of new or expanded public option programs, including the potential for expanding Medicaid to cover individuals between 50 and 64 years of age and for expanding Vermont's Dr. Dynasaur program to cover individuals up to 26 years of age to align with the young adult coverage under the Affordable Care Act.
Pharmacy	
Pharmacy Cost Sharing limits / reductions	Vermont could reduce cost sharing for prescriptions and limit the total cost sharing for pharmacy across all payers.
Fines for Unsupported Price Increases	Some drugs with unsupported price increases disproportionately contribute the most to increased spending. States can require manufacturers to pay a penalty based on their sales volume for the identified drug within the state.
Legislation directed at Pharmacy Benefit Managers (PBM)	Legislation to require increased transparency of PBM operations, including shedding light on how they determine the pricing reimbursement of prescription drugs

Transparency and Regulation	
Legislation to prohibit hospital consolidation	Consolidated health systems leverage their market power in negotiations with insurers because the insurer cannot afford to exclude must-have providers from its network. Dominant health systems can use all-or-nothing negotiations to raise prices for all of their affiliated providers by threatening to prevent any of their providers from participating in the insurer's network unless the insurer accepts the prices and terms set by the health system. These types of distorted negotiations between providers and insurers directly contribute to higher costs for states, employers, and patients.
Legislation to prohibit anticompetitive contracting	Vermont can consider options to promote and protect competitive markets including vigorous antitrust enforcement policies, legislative action, and increased oversight of insurance contracts.
Community Benefits Reporting and Charity Care Requirements	The COVID-19 pandemic has impacted state budgets and illuminated racial and ethnic health disparities that recent health improvement efforts have not adequately addressed. It is more important than ever that nonprofit hospitals provide meaningful community benefit investments aimed at least in part on improving health equity in exchange for the large tax exemptions they receive. State leaders have an opportunity to use policy levers that go beyond the federal community benefit requirements to hold hospitals accountable for their commitment to improve community health.
Publish consumer-focused price data	As spending on health care services continues to grow—particularly for hospital, physician and clinical services—state and federal policymakers are leveraging health care price transparency as a potential strategy to curb rising health care costs. Price transparency takes many forms, but the overall intent is to increase consumer knowledge of health care prices. The theory is essentially "knowledge is power"—if a patient has sufficient understanding of the costs for a health service prior to receiving care, they can seek high quality services at the lowest cost. Moreover, lawmakers and other stakeholders can utilize price information to pursue effective cost containment strategies and policies.
Reducing use of low value services	Choosing Wisely (http://www.choosingwisely.org/) is a physician based effort that has been implemented across a number of states that aims to promote conversations between physicians and patients by helping patients choose care that is: 1) supported by evidence, 2) not duplicative of other tests or procedures already received, 3) free from harm, and 4) truly necessary.

Reports Relevant to the Work of the Task Force

Members sought to avoid duplication of the related work already accomplished and ongoing, including separate and parallel efforts toward supporting the healthcare workforce, and addressing Health Equity with the establishment of the Health Equity Commission.

To focus their work, the Task Force reviewed a list of reports[64] relevant to their charge:

Report topic	Report Author	Date due	Source of Report Requirement
Prior authorization – clinical prior authorization requirements in Medicaid	Department of Vermont HealthAccess	September 30, 2021	2020 Acts and Resolves No. 140
Findings and recommendations of Facilitation of Interstate Practice UsingTelehealth Working Group	Director of theOffice of Professional Regulation	December 15, 2021	2021 Acts and Resolves No. 21
Updated health care workforce strategic plan	Director of HealthCare Reform	December 1, 2021 (to GMCB by October 15, 2021)	2020 Acts andResolves No. 155, dates amended by 2021 Acts and Resolves No. 74
Health Equity Advisory Commission(first) annual report	Health EquityAdvisory Commission	January 15, 2022	2021 Acts and Resolves No. 33
Analysis of health equity data collectedacross State government (first) annual report	Department ofHealth	January 15, 2022	2021 Acts and Resolves No. 33
Prior authorization – ways to increaseuse of tools in EHRs to complete requests for imaging/pharmacy	Department ofFinancial Regulation	January 15, 2022	2020 Acts and Resolves No. 140
Prior authorization – opportunities for/obstacles to aligning/reducing requirements under All-Payer ACO model	Green MountainCare Board	January 15, 2022	2020 Acts and Resolves No. 140
Benchmark plan review, including impacts of adding coverage for certain services and of requiring at least two primary care visits annually without cost-sharing	Department ofFinancial Regulation	January 15, 2022	2021 Acts and Resolves No. 74
Continuing education for health careproviders to improve cultural competency, cultural humility, and antiracism in Vermont health care system	Health EquityAdvisory Commission	October 1, 2022	2021 Acts and Resolves No. 33
Prior authorization – “gold carding” pilotprogram	Health insurerswith >1,000 Vermont lives	January 15, 2023	2020 Acts and Resolves No. 140

[64] https://legislature.vermont.gov/committee/document/2022/368/Date/9-29-2021#documents-section

HST Stakeholder Meeting Schedule

Organization	Meeting Dates
Bi-State Primary Care Association	10/21/2021
Dartmouth-Hitchcock Medical Center	10/21/2021
Department of Vermont Health Access (DVHA)	11/15/2021 12/01/2021
Green Mountain Care Board (GMCB)	10/14/2021 10/26/2021 10/22/2021 11/03/2021 11/09/2021
Health First Vermont	11/08/2021
OneCare Vermont	10/14/2021 12/07/2021
Secretary, Agency of Human Services	10/25/2021
Slusky Consulting, LLC	10/21/2021
University of Vermont Medical Center	10/25/2021
Vermont Agency of Human Services, Office of Health Care Reform	10/20/2021 10/26/2021 11/18/2021
Vermont Association of Hospitals and Health Systems (VAHHS)	10/13/2021
Vermont Blue Cross Blue Shield (BCBS)	10/11/2021 10/26/2021
Vermont Department of Disabilities, Aging and Independent Living (DAIL)	10/27/2021 11/10/2021 12/01/2021
Vermont Health Care Advocate	10/14/2021
Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)	11/30/2021
Vermont Medical Society	10/13/2021

Stakeholder Correspondence: Vermont Office of the Health Care Advocate

VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE
264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05401
(800) 917-7787 (TOLL FREE HOTLINE)
(802) 863-7152 (FAX)

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

Opportunities to Address Affordability and Access in the 2022 Legislative Session

The Office of the Health Care Advocate brings the following proposals to the Legislative Task Force on Affordable, Accessible Health Care. There will certainly be additional proposals brought from various parties that we will support but we want to make sure that this list of proposals is considered.

Medicaid Post-Partum Coverage - Extend Vermont's post-partum coverage from the current 60 days to a full year. This is an available state option under current law for 5 years starting in April of 2022.

Medical Debt Reduction H.287 - Address the crushing impacts that medical debt has on Vermonters. Vermonters who have medical debt are less likely to get the right care at the right time if they are struggling to pay off the debt they already have or are avoiding care due to the fear of taking on more debt. We can achieve this by creating a statewide minimum standard for hospital free care policies to find a better balance between free care and medical debt.

Medicare Savings Program (MSP) - Update Vermont's eligibility for this important program to the Connecticut model – Expanded eligibility will improve access and affordability for low-income, senior and disabled Vermonters to improve affordability on Medicare premiums, out of pocket costs, and prescription drugs.

ARPA One Time funding

Dental Grants - Access to dental care has been seriously impacted by Covid. We hear from the provider community that the year of deferred care has resulted in more Vermonters needing significant dental care. We also hear from Vermonters about their needs and their challenges affording the care they need. We propose a one-time grants program to help Vermonters get back on track in their dental care.

Investing in Health Equity & Economic Development for New American and BIPOC Vermonters - Propose allocating ARPA monies to private or non-profit clinics and/or centers that provide (or plan to provide) health care services and employment opportunities for BIPOC and New American Vermonters, including those arriving from Afghanistan.

Michael Fisher – Chief Health Care Advocate
mfisher@vtlegalaid.org

Stakeholder Correspondence: Labor and Community Organizations

Vermont Workers' Center
179 S. Winooski Ave. Unit 202
Burlington, VT 05401

16 August 2021

Task Force on Affordable, Accessible Health Care
Sen. Virginia "Ginny" Lyons
Sen. Kesha Ram
Sen. Richard Westman
Rep. William Lippert, Jr.
Rep. Lori Houghton
Rep. Anne Donahue

Labor and Community Organizations Call on Health Care Task Force to Prioritize Human Rights

Dear Task Force Members,

We, the undersigned organizations representing Vermont residents from all walks of life, support the goals of the "Task Force on Affordable, Accessible Health Care" and would like to offer recommendations drawn from our values and our experience: to finance Act 48, commission an independent evaluation of the All-Payer model and hold public hearings.

Lack of access to affordable health care constitutes a serious human rights crisis in Vermont. Too many people are uninsured, while tens of thousands are forced to delay or skip medical care every year. Thankfully, clear and workable policy solutions are available to address this crisis. We encourage Task Force members to take up and champion these human rights solutions, advancing health care as a universal, equitable and democratically controlled public good for all Vermont residents.

A Universal System

In 2011 Vermont passed Act 48, which directed the state "to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents." The financing plan for Act 48 put forward by the Shumlin administration would have extended comprehensive health coverage to everyone in the

state, covered 94 percent of the average resident's health care costs, and simultaneously raised net incomes for nine out of ten Vermont families.[1]

Today, Vermont should implement the publicly financed health care system laid out in Act 48—a system which is not only possible, but economically advantageous for the vast majority of Vermont residents. To do so, existing payments need to be more equitably shared among residents and businesses so that the wealthy and big businesses pay their share and no one is asked to pay more than they can afford. Such a change cannot be made successfully in a piecemeal fashion, as all components of a health care system are interconnected.

Advancing Equity

Everyone in Vermont has a human right to health care, but not every individual or every community has identical health needs. Poor and working-class people—especially Black, Indigenous and other people of color, immigrants, women, LGBTQ people, elders, people with disabilities, and incarcerated people—have been egregiously underserved by our current health care system.

Public financing must steer health care resources to where they are most needed, addressing disparities through targeted investment in areas such as cultural competency for health care workers, home- and community-based health services, and health clinics in rural regions. State government must undertake proactive efforts to ensure those of us impacted by long patterns of political exclusion and marginalization are empowered to make decisions about our care, including working with the Office of Health Equity to center the needs, rights and leadership of communities who unjustly experience health inequities.

Democratic Control

The mandate of the Task Force is to make health care more affordable, but this cannot be done without addressing the power of hospital corporations and other companies to drive up prices and ration care.

Born to support the goals of Act 48, the state's All-Payer model has instead become a vehicle for corporate consolidation, giving a small number of executives and board members enormous power to set prices, squeeze health care workers, and decide how

[1] "Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System", p. 3. https://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf

Medicaid money and other health care dollars get spent—all with very little accountability.

Members of the Green Mountain Care Board (GMCB) charged with regulating the model have repeatedly promoted the interests of UVM Health Network and its affiliate, OneCare Vermont. Former GMCB Chairs Al Gobeille and Anya Rader Wallack and former Medicaid Director Cory Gustafson have all taken senior positions with UVM Health Network. This revolving door undermines public trust in government.

Despite these concerns, state officials are moving to expand the All-Payer model, risking further monopolization of health care by large hospital systems and erosion of community-based care. We call for a health care system that is democratic and accountable to the people who use it, beginning with public hearings that enable people to speak directly to public officials.

Recommendations

Fundamental changes are needed to ensure that health care financing and delivery systems serve the people of Vermont, realize their right to health and advance equity.

In pursuance of its goal to make health care more affordable, we ask the Task Force to:

1. Recommend the legislature fulfill its obligations under Act 48 to finance universal, publicly financed health care. Review and cite Shumlin administration and Vermont Workers' Center/Partners for Dignity & Rights findings that universal health care would increase net incomes for 93 percent of Vermont families[2] and could be equitably financed through wealth, income and payroll taxes.[3]
2. Call for an independent evaluation of the All-Payer model and a pause on the renegotiation process. Review and cite the findings of State Auditor Doug Hoffer on the All-Payer model's role in driving up health care costs for Vermont residents.[4]
3. Hold public hearings to enable the public to speak directly to the Task Force. Early versions of the Task Force legislation contained provisions for up to eight

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[2] "Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System", p. 54, Table 19. https://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf

[3] "Equitable Financing Plan for Vermont's Universal Healthcare System," https://www.workerscenter.org/financingplan.

[4] "The Growing Cost of Healthcare in Vermont: It's Time to Reel it In", https://auditor.vermont.gov/sites/auditor/files/documents/Health%20Care%20Expenditures%20final%208-15-20.pdf

public hearings held across the state. Regrettably, these were not included in the final legislation.

As legislators tasked with making health care more affordable, you can end the ongoing health care crisis in our communities. It is time to move towards a system that ensures access and affordability and prioritizes the health and participation of Vermont's residents over the financial interests of unaccountable hospitals and health care companies.

Respectfully,

AFT-Vermont
Brattleboro Solidarity
Education Justice Coalition of Vermont
Green Mountain Self Advocates
Migrant Justice
Out in the Open
People's Kitchen
Rights & Democracy
The Root Social Justice Center
Rural Vermont
United Food and Commercial Workers (UFCW) Local 1459
Vermont AFL-CIO
Vermont Center for Independent Living
Vermont Coalition for Disability Rights
Vermont Health Care for All
Vermont Interfaith Action
Vermont Workers' Center

Stakeholder Correspondence: Letter from Organizations

From: Oxfeld, Ellen D.
Sent: Wednesday, September 15, 2021 8:21 PM
To: vlyons@leg.state.vt.us; kram@leg.state.vt.us; rawestman@gmail.com; wlippert@leg.state.vt.us; LHoughton@leg.state.vt.us; adonahue@leg.state.vt.us
Cc: Speaker@leg.state.vt.us; Becca Balint <bbalint@leg.state.vt.us>
Subject: Letter from Organizations to Affordability Task Force

To: Task Force on Affordable, Accessible Health Care

From: Vermont Federation of Nurses and Health Professionals, Deb Snell, President
ACLU of Vermont, Falko Schilling, Advocacy Director
League of Women Voters of Vermont, Sue Racanelli, President
Rural Vermont (Graham Unangst-Rufenacht, Policy Director; Mollie Wills, Grassroots Organizing Director)
Rights and Democracy (Kiah Morris, VT Movement Politics Director)
Vermont State Labor Council, AFL-CIO (Liz Medina, Executive Director)
The Root Social Justice Center (Shela Linton, Executive Director)
Vermont Health Care for All (Deb Richter, President)

Date: September 15, 2021

As you follow your statutory charge "to explore opportunities to make health care more affordable for Vermont residents and employers" we, the undersigned, ask that you give full consideration to H.276, a bill that would implement universal, publicly financed health care over a period of ten years, starting with universal primary care.

In March this year a group of organizations and physicians wrote to the House Health Care Committee urging it to take up and vote out H.276. Unfortunately, House Health devoted no time to H.276 during the 2021 session. The Task Force can rectify that error by discussing H.276 this summer, taking public testimony on it, and recommending to the Speaker of the House that the House Health Care Committee be directed to advance H.276 as soon as January 2022.

We suspect that most if not all of you support the principle of health care as a human right. However, the time has come to go beyond the rhetoric of health equity and to begin implementing concrete measures that turn this perceived right into a reality for Vermonters. It is now recognized the world over that public financing is the only way to guarantee universal access at an affordable societal cost.

We have no faith that universal access can be obtained by any iteration of the federal Affordable Care Act, which is based on private insurance and premium subsidies for high deductible plans that discourage people from seeking the care they need.

We have no faith that the U.S. Congress will have the political will to pass an improved Medicare for All program anytime soon.

We have no faith in the ability of payment reform schemes such as the All Payer/ACO Model, nor of managed care in general, to make health care more affordable and accessible to Vermonters. If anything, these are distractions from the work that must be done.

Which leads us to conclude that H.276 is currently the only viable starting point for advancing the principles we share.

We are fully cognizant of the hesitancy you feel when asked to make fundamental changes in how health care is financed. It is an enormous industry with many vested interests, and shifting from employer-based insurance to tax-based financing brings up myriad issues. Governor Shumlin backed away in 2014, believing the time was not right. We understand that many of you who were involved during the Shumlin years may believe the time is still not right. We disagree.

Because of COVID-19, the need for concerted public health measures, administered by the government, has never been more evident.

The pandemic and resulting job losses have caused thousands of Vermonters to lose their health insurance.

Medical debt is soaring and is a leading cause of personal bankruptcy and homelessness.

High deductible insurance policies create incentives to avoid primary and preventive care—a perverse outcome, given that most countries around the world have found that a robust primary care network that is universally accessible is the bedrock of population health. In 2018, 47% of privately insured persons under age 65 in the U.S. were enrolled in high deductible plans, according to the National Center for Health Statistics. The percentage is likely higher now.

Vermont's primary care practitioners are leaving the profession at an alarming rate, citing emotional burnout, inability to properly care for the uninsured and underinsured, mountains of insurance paperwork, prior authorization requests, data reporting, and clinical practice interference by corporate management, all at the expense of time with patients.

For these and other reasons, we cannot afford to put off substantive health care reform—delay cannot be justified from a financial viewpoint, nor from the perspective of advancing health care equity; and delay solely on the basis of political expediency is morally unacceptable. According to Vermont's own Principles of Health Care Reform (18VSA §9371), "the State of Vermont must ensure universal access to and coverage for high quality, medically necessary health services for all Vermonters." What could be more plain?

H.276 gives you, our legislators, the opportunity to avoid the massive shift required to finance the entire realm of health services with taxes all at once. Instead it makes public financing take effect incrementally, starting with universal primary care, then moving to universal dental care, and on to other services over a ten-year period. This allows the financing to be adjusted to fit each incremental need. It also allows the public to get a taste of health care as a human right, and to become advocates for full implementation.

Unfortunately, Vermont is no longer a leader in health reform efforts. Other state legislatures have recently taken bold steps toward universal care at the state level. While some of these initiatives may not result in immediate implementation, at least an effort is being made and the public is being engaged. We fear that the Vermont legislature wishes to avoid a debate on universal health care, and instead waits for changes at the federal level. If this is the case, Vermonters will needlessly suffer. Some will die, waiting for affordable, accessible health care that never comes.

Please take a serious look at H.276 and make a positive recommendation on it to the full legislature.

Blueprint for Health 2020 Annual Budget

Vermont Blueprint for Health 2020 Annual Budget[65] by Program Elements and Funding Source

Blueprint Program Elements	Annualized Budget for 2020	Description	Money Flow	Payer Participation
Patient-Centered Medical Home (PCMH) Program				
PCMH Per Member Per Month (PMPM) Payments	$9,821,223	PMPM Quality Payments for NCQA Recognition	From Payers to Practices (Parent Organizations)	All Payers
QI Facilitators	$1,016,840	In practice QI coaching for NCQA, ACO priorities, and practice priorities	Grant to Local Hospital or Contract w/ QI facilitator	DVHA / Medicaid
Community Self-Management Program				
Regional Coordinators	$427,050	Part time staff to organize workshops	Grant to Local Hospital	DVHA / Medicaid
Master Trainers	$25,000	Train workshop leaders	Grant to Local Hospital	DVHA / Medicaid
Workshop Costs	$210,750	Leader stipends, materials, rooms	Grant to Local Hospital	DVHA / Medicaid
Management Contract	$199,000	Data aggregation, leader training	Contract with Local Hospital	DVHA / Medicaid
Community Health Teams (Core/Primary Care)	$9,381,138	Teams support PCMH practice and interface with community services	From Payers to Local Hospital	All Payers
Spoke Staff (Extended CHT)*	$6,607,313	RN & Counselor teams support MAT prescribers	From Payer to Local Hospital	DVHA / Medicaid
Women's Health Initiative				
PMPM Payment to Specialty Practices	$171,561	Attestation to program elements	From Payer to Practices	DVHA / Medicaid
PMPM Payment to PCMH Practices	$79,320			
One-Time Practice Payments	$31,926	Workflow changes for screening, same-day long-acting reversable contraception	From Payer to Practices	DVHA / Medicaid
Social Workers (Extended CHT)	$1,011,249	Staff for brief interventions and navigation to services	From Payer to Local Hospitals	DVHA / Medicaid
Program Management	$1,207,000	Change management & program administration	Grant to Local Hospital	DVHA / Medicaid
Data and Analytics Contracts				
All-Payer Analytics †	$340,600	Program evaluation & payment	Contract with Vendor	DVHA / Medicaid
Medicaid Analytics†	$300,000	Federal reporting and evaluation	Contract with Vendor	DVHA/Medicaid
Patient Experience of Care Survey	$136,000	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA / Medicaid

* Vermont Department of Health manages Hubs

† Represents a significant decrease in funding from 2019 and much was not expended in 2020 due to a disruption in analytic contraction. Amounts are currently allocated for 2021

[65] https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf

Joint Task Force on Affordable, Accessible Health Care

Health System Transformation, LLC

TASK FORCE MEETING OCTOBER 28, 2021

Purpose

Joint Task Force on Affordable, Accessible Health Care

Explore opportunities to make health care more affordable and accessible for Vermont residents and employers.

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Process

- Rank ordering of options presented at the September Task Force meeting by HST Subject Matter Experts, with seven options prioritized
- Initial research conducted to further describe those seven options
- 14 Informational interviews to date with high-level representatives of Vermont health care organizations

Cost/Benefit Variables Considered

1. Household affordability impact: # people x level of change
2. Accessibility impact: # people x level of change
3. Timeframe and legislative or programmatic lift
4. Health equity impact
5. Level of federal involvement needed
6. State/federal savings or cost

Overall Cost/Benefit Analysis – Top Third

1. Public Option
2. Medicaid Post-Partum Coverage
3. Remote Access to Health Care Services
4. Extend Moderate Needs Supports
5. Cost Growth Containment/ Affordability Boards/ Affordability Standards
6. Expand VT Blueprint for Health, e.g., improved analytics, reduce cost sharing, increase access to mental health and maternal health services
7. Legislation directed at Pharmacy Benefit Managers (PBMs)

Overall Cost/Benefit Analysis – Middle Third

8. Expanded Access to Primary Care without Cost Sharing
9. Episodes of Care across all payers
10. Community Benefits Reporting and Charity Care Requirements
11. Cost Growth Benchmark
12. Pharmacy Cost Sharing limits / reductions
13. Legislation to prohibit anticompetitive contracting
14. Reducing use of low value services

Overall Cost/Benefit Analysis – Bottom Third

15. Expand Medicaid to additional income levels for certain ages
16. Health insurance rate review
17. Premium and Cost Sharing Subsidies
18. Publish consumer-focused price data
19. Fines for Unsupported Price Increases
20. Reinsurance
21. Adjusted Plan Options (APO)
22. Draft a resolution to encourage the federal government to make temporary ACA premium subsidies permanent

Timeframes

Enactment/Implementation and **Impact** Timeframes	
Short Term	6 - 12 months
Medium Term	12 - 24 months
Long Term	24+ months

Public Option

Description: A public option is an insurance coverage program that leverages the state's position as a purchaser/regulator in order to create new or broader coverage options for state residents. Conceptually, States could finance a public option using federal demonstration authority (i.e., "section 1332 waiver"), where federal savings accruing from lower federal subsidies because of lower public option premiums would be refunded to the state in the form of "pass through" funding.

Who it will Affect: Depending on how it is structured, households and small employers may experience reduced premium costs.

Expected Outcomes: Reducing costs, increasing access, addressing market weakness.

Policy Considerations: Infusion of funding required, provider rate limitations risk provider participation/access; possible increased competition could reduce costs; appetite for state government intervention.

State Activities: To date, states have only requested 1332 demonstration waivers to finance reinsurance waivers: no state has made a request for pass-through funding to finance a public option.

Enactment/Implementation Timeframe: Medium term **Impact Timeframe:** Long term

Medicaid Post-Partum Coverage

Description: State option to extend Medicaid postpartum coverage to 12 months via a state plan amendment (SPA) or 1115 waiver; Takes effect on April 1,2022 and is available to states for five years.

Who it will Affect: In Vermont, over 40% of all births are funded by Medicaid. Currently Medicaid post-partum coverage is limited to 60 days.

Expected Outcomes and Policy Considerations: The Department of Vermont Health Access (DVHA) is in the process of conducting an analysis to understand the effects to the state if Vermont opted to expand coverage to the full 12 months.

State Activities: 27 states have adopted or proposed legislation to seek federal approval for the expansion through a SPA or 1115 waiver.

Enactment/Implementation Timeframe: Short term **Impact Timeframe:** Medium/Long term

Remote Access to Health Care Services

Description: Telehealth refers to a wide scope of remotely-provided healthcare services. While *telemedicine* refers specifically to remote clinical services, *telehealth* encompasses remote non-clinical services.

Who it will Affect: Increases access and promotes continuity of care for patients

Expected Outcomes and Policy Considerations: Preserving the gains in access to telehealth made during the temporary expansions authorized as a result of the pandemic will require infrastructure support, increasing the provider pool, reimbursement and payment parity strategies, assessment of treatment restrictions and removal of service barriers.

State Activities: 22 states changed laws or policies during the pandemic to enhance coverage of telehealth. Vermont is at the forefront of telehealth payment and coverage; A report from the Telehealth Working Group created by Act 21 of 2021 is due December 15, 2021.

Enactment/Implementation Timeframe: Short term **Impact Timeframe**: Medium/Long term

Extending Moderate-Needs Supports

Description: A limited package of home- and community-based services (HCBS) that will improve quality of life, promote health and wellbeing, and stave off the need for more intensive long-term services and supports (LTSS). Using advanced analytic tools, these services would be targeted at individuals who are predicted to need more intensive services in the future.

Who it will Affect: Vermonters with any health insurance, who are identified as needing home and community-based services (HCBS) by their health care providers via provider referrals and data-driven risk stratification tools.

Expected Outcomes and Policy Considerations: An investment of federal dollars will be needed to provide additional benefits to this targeted population, with the expectation of future savings. State dollars will need to be invested as well.

State Activities: As part of the Choices for Care program Vermont offers a limited HCBS benefit to those with "Moderate Needs" whose income is at or below 300% of the SSI payment standard. This program is limited by available funding.

Enactment/Implementation Timeframe: Medium term **Impact Timeframe**: Long term

Cost Growth Benchmark

Description: A cost-growth benchmark program is a cost-containment strategy that limits how much a state's health care spending can grow each year.

Who it will Affect: Households and small business that pay insurance premiums, as well as the state Medicaid

Expected Outcomes and Policy Considerations: Slow the growth of health care costs to more closely align with wage and income growth so that healthcare can remain affordable for individuals, businesses and states. Setting a public target for spending growth alone is not sufficient in slowing the rate of growth; a benchmark needs to be complemented by strategies designed to move the needle.

State Activities: An analysis of five states' cost growth containment strategies illustrates a variety of approaches, accountability measures, enforcement and performance outcomes.

Enactment/Implementation Timeframe: Short/Medium term **Impact Timeframe**: Long term

Expand Vermont Blueprint for Health

Description: The Blueprint supports primary care practices to become recognized Patient Centered Medical Homes and provides multi-disciplinary community health teams (CHTs) at participating practice sites. This option expands the use of data to identify patients needing care and tracks services to reduce gaps in care, eliminate duplication, and assess outcomes. It may include reduced cost sharing for primary care visits and increased CHT capabilities for mental health and maternal health services

Who it will Affect: Primary care and women's specialty patients with any or no health insurance, identified via risk stratification, provider referrals and screening for health-related social needs (HRSN), including mental health (MH) services.

Expected Outcomes and Policy Considerations: Increased access to primary care and CHT services to targeted patients, reduced costs to payers and patients with more appropriate and less intensive care.

State Activities: Many states have programs that fund Blueprint-type services including screening for HRSN and embedding care management and behavioral health services in primary care practices.

Enactment/Implementation Timeframe: Short/Medium term **Impact Timeframe**: Medium/Long term

Pharmacy Benefit Managers (PBMs)

Description: Pharmacy benefit managers (PBMs) are third-party administrators of prescription drug coverage for insurers and employers. They develop and maintain formularies, process claims and negotiate discounts and rebates between payers and manufacturers.

Who it will Affect: Payers and consumers of prescription drugs

Expected Outcomes and Policy Considerations: Requirement of increased operational transparency by PBMs, which may provide opportunities for cost reductions

State Activities: Many states have put forth legislation regulating the licensing or registration of PBMs, requiring more transparency in the drug supply chain, and adding protections for independent pharmacies

Enactment/Implementation Timeframe: Short term **Impact Timeframe**: Medium

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Joint Task Force on Affordable, Accessible Health Care

Health System Transformation, LLC

TASK FORCE MEETING DECEMBER 15, 2021

Agenda

- Introduction/Process
- Cost Growth Benchmark
- Extending Moderate Needs Supports

Lunch Break

- Identification and Risk Stratification demonstration by Clarify Health
- Public Option
- Expand Vermont Blueprint for Health

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Purpose

Joint Task Force on Affordable, Accessible Health Care

Explore opportunities to make health care more affordable and accessible for Vermont residents and employers.

Process

- Rank ordering of 22 options presented at the September Task Force meeting by HST Subject Matter Experts, with seven options prioritized
- Initial research was conducted, and an October 28 meeting of the Task Force further reduced the seven options to four
- 24 informational interviews with 28 high-level representatives of Vermont health care organizations
- Conducted Vermont data analysis using VHCURES (limited somewhat by access issues)

Cost/Benefit Variables Considered

1. Household affordability impact: # people x level of change
2. Accessibility impact: # people x level of change
3. Timeframe and legislative or programmatic lift
4. Health equity impact
5. Level of federal involvement needed
6. State/federal savings or cost

Seven Preferred Options

1. Public Option
2. Extend Moderate Needs Supports
3. Cost Growth Benchmark
4. Expand Blueprint for Health
5. Postpartum Expansion*
6. Remote Access to Care*
7. Pharmacy Benefit Manager Regulation*

* Options that are of interest to the Task Force and are the subject of current ongoing activity elsewhere in the Vermont Legislature and/or Administration

Cost Growth Benchmark

A Cost Growth Benchmark program is a cost-containment strategy that

- Sets a limit on how much a state's health care spending can grow each year at the state, provider and insurer level.
- Aligns costs with wage and income growth so that healthcare can remain affordable for individuals, businesses and states.
- Avoids negatively impacting access or health inequities.

Vermont can expand its current cost growth benchmark to:

- Extend to cover all populations.
- Provide clear authority to the Green Mountain Care Board (GMCB) to use additional tools to drive payers and providers to meet the cost growth benchmark.
- Assess emerging technologies and best practices with potential for a return on investment (ROI) and implement initiatives over a rolling three-year period, with identification of opportunities in year one, implementation in year two, and incorporation of savings into cost growth target/rates in year three.

Cost Growth Benchmark
Expected Outcomes/ Policy Considerations

- Consider options and determine a cost growth target methodology
  - Define Total Health Care Expenditures; Population whose spending is measured; data used to measure total health care expenditures; Criteria for selecting a cost growth target indicator
- Setting the value of the target, after finalizing a methodology
  - Historical vs forecasted values; Adjustments to the target, including consideration of mitigation strategies to reduce growth; Possible target values; Frequency the target be adjusted; Will methodology be re-opened when considering the target?
- Performance Assessment.
  - How cost growth is measured at the state, insurance market, insurer and provider levels; patient attribution; minimum payer and provider size for reporting; mechanisms for risk adjusting; methodology for calculating percentage change in health care expenditures

Cost Growth Benchmark
Expected Outcomes/ Policy Considerations

- Authority and Governance.
  - Collecting data to assess performance; Calculating and analyzing data on performance; Publishing performance and other data analysis; Procedures and timing for modifying the cost growth target; Health care entities required to report; Measures to ensure compliance with reporting requirements.
- Initiatives to Support Efforts to Reduce Cost Growth
  - Publishing Reports on Performance; Setting Quality Targets; Provider and/or Insurer Collaborative; Performance Improvement Plans; Concurrent effort
- Implementation Strategy
  - Legislation; Modifications to existing strategy; Requesting data submission; Analyzing performances; Publishing performance; Annual review

Cost Growth Benchmark
Legislative Options

- The GMCB, through 18 V.S.A. § 9375(b)(1) is charged to oversee the development and implementation of health care payment and delivery system reforms
- Utilize a different section of the statute to provide this authority so that it is separate from other activities that the GMCB could implement relative to alternative payment methodologies (APMs)Performance Assessment.
- Strengthen language to require the GMCB to set a comprehensive statewide benchmark as part of its regular review process, which would allow for a public vote after a public comment period.
- Require through legislation that GMCB will work annually with health plans, providers and other stakeholders to develop initiatives that can help reduce spending growth in the state.
- Clear statutory language which allows GMCB to condition budgets and explicitly put corrective action plans into place to require hospitals to meet cost targets.
- Provide GMCB will resources to conduct these new activities.

Cost Growth Benchmark

Discussion

Extending Moderate-Needs Supports

The VT Choices for Care Moderate Needs Group (MNG) provides a limited HCBS benefit to those with "Moderate Needs" whose income is at or below 300% of the SSI payment standard. This program is limited by available funding and serves about 1,000 Vermonters at any one time

Extending Moderate Needs Supports would include:

- **The use of advanced analytic tools for identification, stratification, and ROI analysis**. Looking at Vermonters across all payers, using all available claims and clinical data as well as any publicly available data, Vermont can target services to those who are most in need.
- **The extension of the MNG to additional individuals; on the wait list, on Medicare, and on Commercial insurance.** Provides services that address nutrition, dehydration, falls prevention, social isolation, medication management, case management and other needs typically not covered by standard insurance plans.
- **Additional supports for family caregivers.** Support for family caregivers is especially important given the current healthcare workforce shortage. Vermont would need to assess the best approach. Many states are beginning to offer training, respite, home modifications, and payments to family caregivers.

Extending Moderate-Needs Supports
Key Advantages

- Addresses the reality that the lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68% for people aged 65 and older
- Reduces or eliminates high out of pocket costs for unfunded HCBS
- Limited HCBS services now may stave off the need for more intensive services later
- May reduce or eliminate the incentive to spend down assets to access full Medicaid for long term services and supports
- Support for family caregivers encourages Vermonters to care for loved ones and may ease some workforce shortage issues

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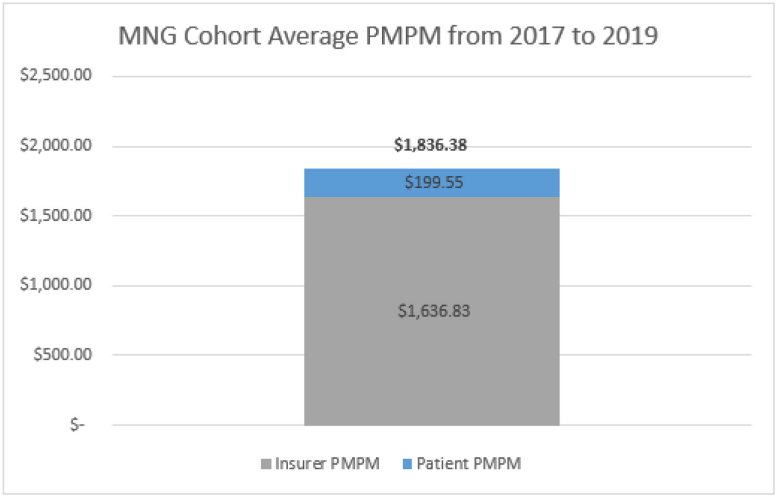
Extending ModerateNeeds Supports
Vermonters Served



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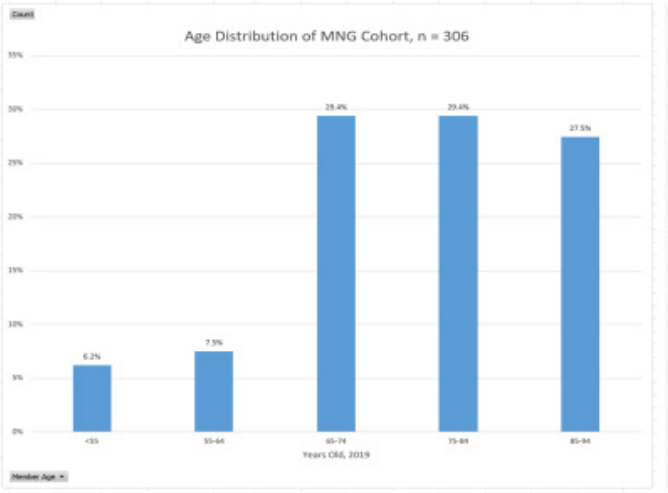
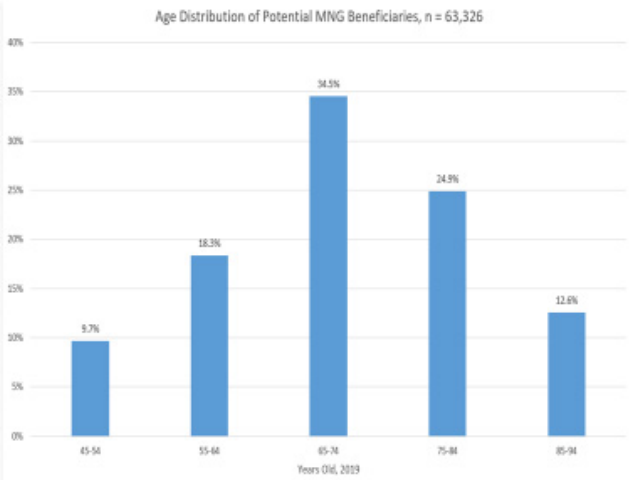
Extending Moderate-Needs Supports Vermonters Served





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Extending Moderate-Needs Supports Vermonters Served

Population Group	Estimated Number of Vermonters	Estimated Annual Cost
Vermonters who meet Moderate Needs Group (MNG) clinical criteria with incomes below 300% SSI FBR and are currently on the MNG wait list	500-700	**$1.7 -- $2.4 million**
Medicare Members who meet MNG clinical criteria with incomes above the MNG cut off ($2,523 per month per individual)	11,587-14,715	**$20 -- $25 million**
Commercially insured who meet MNG clinical criteria with incomes above the MNG cut off ($2,523 per month per individual)	2,589-3,371	**$4.5 -- $5.9 million**

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Extending Moderate-Needs Supports
Federal Support

- The Build Back Better Act, if passed, would provide a permanent 6 percentage point increase in federal Medicaid matching funds for HCBS. To qualify for the enhanced funds, states would have to maintain existing HCBS eligibility, benefits, and payment rates and have an approved plan to expand HCBS access, strengthen the direct care workforce, and monitor HCBS quality .
- A detailed financial model analysis would show the potential for future savings to both the state and federal government. With that in hand, Vermont could negotiate with CMS for federal support for this option via an amendment to Vermont's current 1115 Global Commitment for Health waiver, a separate demonstration project, or some combination of the two.

Extending Moderate-Needs Supports

Discussion

Health Equity Impacts

The United States Centers for Disease Control and Prevention (CDC) describes Health Equity as "…action to ensure all population groups living within an area have access to the resources that promote and protect health."

- **Public Option /** Addresses economic, racial, or geographic disparities or access issues by setting cost sharing or network requirements or by adding benefits on top of essential benefits to compliment other programs.
- **Extend Moderate Needs Supports /** Reduces disparities and promotes access by making home and community based supports available to more Vermonters, regardless of insurer or income level. Reduces gaps in care, avoids duplication of services, and supports family caregivers enabling more families to care for their loved ones in culturally familiar ways.
- **Cost Growth Benchmark /** By managing the growth in overall costs, this option will promote access and improve equity by making healthcare more affordable for Vermont households. To the extent that growth in out-of-pocket costs are targeted to a lower overall rate than the benchmark the impact on individuals may be impacted positively over time.
- **Expand Blueprint for Health /** Designed to serve all Vermonters, regardless of insurance status. Patients who receive any service from a Blueprint-funded behavioral-health specialist are not subject to out-of-pocket cost sharing. The use of publicly available, social determinant of health data to identify Vermonters needing services will help to address the bias inherent in traditional claims data centric analysis toward people who are already utilizing the health care system.

Lunch Break

Lunch Break, followed by Clarify Health demonstration of Identification and Risk Stratification

Clarify Heath – Introduction for Vermont Legislative Session

Clarify

Draw insights from the most trusted patient journeys

PATIENT-LEVEL
100%
tokenized
Ensures precise case-mix adjustment

SDoH
400+
factors
Includes patient-level social and clinical needs

CLEAN
10
patents
Makes traditionally unusable data, useful

COMPLETE
300M+
total lives
Builds longitudinal patient journeys

LINKABLE
Zero effort
integration
Refreshes are automated

Clarify

Confidential 23

Social and behavioral determinants overview

Sample of Clarify-available SDoH categories and attributes

Economic Stability & Education	Neighborhood & Physical Environment	Community Context & Social Support	Housing & Transportation	Behavioral Aspects
• Income level • Accumulated wealth • Wealth stability • Employment status • Economic trajectory • Highest educational attainment	• Neighborhood crime index • Neighborhood poverty index • Median area income • Percent of population with limited English	• Age • Gender • Race breakdown • Marital status • Number of household members • Presence of caregiver • Number of children in household • Number of nearby relatives	• Dwelling type • Homeowner or renter • Address stability • Length at current address • Number of registered vehicles	• Use of smartphone • Use of credit card • Level of exercise • Interest in health products or services • Interest in outdoor activities

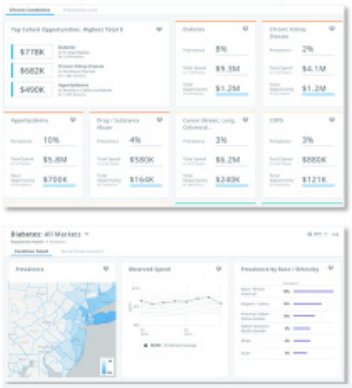
Clarify

Clarify Populations

Identify cohorts where you can impact spend

Ex: Diabetics

MARKET

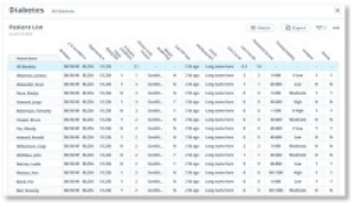


1 Benchmark spend to find highest opportunity cohorts

PHYSICIAN

2 Access metrics on utilization and quality for each disease

PATIENT



3 Identify SDOH characteristics, matched at a member-level

Clarify

CLARIFY DIFFERENTIATORS

Patient-level benchmarking with case-mix adjusted models for fair physician assessment

Benchmark models account for >600 variables of each individual member…

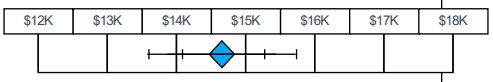
…which are rolled up to the physician level and combined with confidence intervals to assess performance

MEMBER CHARACTERISTICS
Clinical (comorbidities, DRG, procedure types)
Demographics (age & gender)
SDoH (education, income, support status)

REGIONAL FACTORS
Rural versus urban
Academic centers versus medical centers

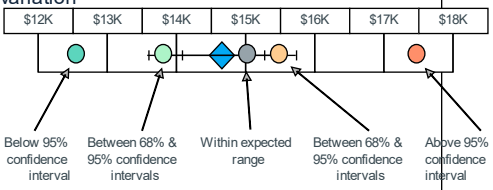
CLINICAL & FINANCIAL OUTCOMES
Leakage, Value-based program success

Expected values are generated specific to patient and provider and regional characteristics…



Clarify Expected, with both 68% and 95% confidence intervals

…and compared to the observed values to surface cost variation



Clarify

WHY THIS MATTERS

Fair:
The more data used to develop benchmarks, the better, and Clarify has a market-leading dataset

Accurate down to the physician level:
Physician-level insights require patient-level case mix adjustment. Otherwise, those who treating unique populations will be unfairly assessed

Granular:
Analysis generated at individual patient level, accounting for hundreds of individual factors; allows for high fidelity patient cohorting

Clarify Health

Demo

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Public Option

A Public Option is an insurance coverage program that is designed to leverage the state's position as a purchaser/regulator to create coverage options for Vermonters.

Approaches to a public option include:

- Government intervention and control are maximized by creating a new government administered insurance offering.
- Government is in partnership with private plans, where private plans administer and deliver benefits and are subject to oversight and guidance by the state.
- Existing state programs are made available to a broader section of state's residents, e.g., a Medicaid or state employee benefits buy-in program.

Public Option
Impact Considerations

- **Consumers** – There are about 69,000 Vermonters in the small group and individual market combined, split evenly. Another 3.9 percent of Vermonters are uninsured. If premiums are held to 95 percent of historic increases, the public option could save Vermont households hundreds of dollars per year, and year over year that could be as much as $1,300.
- **Insurers** – They would likely resist a government-run plan designed to compete with commercial plans and be more open to a partnership in a more lightly regulated market.
- **Providers** – They would be in favor of more patients with insurance and therefore less uncompensated care. But would not be in favor of reduced premiums and other cost sharing being achieved through provider payment limitations.

Public Option
Financing Considerations

- **Provider reductions** - Recouping state expenditures through provider rate limitations would generate an estimable level of savings, although at the risk of provider participation and potential access issues.
- **Competition** - It is theoretically possible, although hard to estimate, that through benefit design and by stabilizing the risk pool (by increasing consumer participation) it is possible that increase competition alone could reduce costs.
- **New appropriations/State only dollars**
- **Federal dollars** - A public option initiative leveraging federal 1332 demonstration waiver authority could allow the state to re-capture Advanced Premium Tax Credits (APTC) and cost sharing subsidy savings accruing to the federal government as the result of the program in the form of federal pass-through payments.

Public Option
Implementation Considerations

What Type of Public Option?

- Public/private partnership (like Washington and Nevada)
- Public program buy in, either via Medicaid or the state employee program,
- A new state-run plan is likely not viable for Vermont

What is the Most Appropriate Plan Benefit Design?

- Must meet the requirements of a Qualified Health Plan
- May set cost sharing or network requirements to address economic, racial, or geographic disparities or access issues
- May add benefits to compliment other programs, such as long-term services and supports
- May use performance-based contracting with providers to drive clinical improvement and cost savings via shared risk or other arrangements

Public Option
Implementation Considerations

How Will Premium Savings and Financing be Established?

- A public option will need to compete on premium. The state could seek a Section 1332 waiver to recoup the difference in costs in the form of pass-through funding if the state-sponsored plan is the new benchmark or becomes the lowest-cost plan.
- Two levers available to the state to drive premium savings: provider rate limitations or **premium regulation**.
  - Impact of extended ARPA premium subsidies
  - Impacts on small employers of premium reductions and enrollment changes.
  - Opportunity to tie premium growth or reduction targets for a public option to a broader scheme of growth limitations

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Public Option
Implementation Considerations

What Market/Resident Eligibility is Most Appropriate for Vermont?

- The small group and individual markets in Vermont are combined,
- Insurance coverage and offerings in Vermont are fairly stable
- Only two issuers in the state
- Information and comparison tools for small employers on the value of providing coverage or having employees seek coverage in the marketplace
- **State Administration** - Interplay of marketplace oversight, provider rate setting, access and beneficiary protections will require consultation across all relevant state agencies.
- **Executing Agency**: Potentially the Department of Vermont Health Access, in coordination with the Green Mountain Health Board and the Department of Financial Regulation
- **Timing** - With a 12-18 month implementation, a study summer of 2022 in time for the 2024 plan year.

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Public Option

Discussion

Expand Vermont Blueprint for Health

Expanded and improved use of claims and other patient-level data, in addition to publicly available social determinants of health data, to:

- Enhance the referral of Vermonters to Blueprint Community Health Teams (CHTs) for care management
- Make the connection to ongoing return on investment (ROI) analysis

Resulting in:

- Increased payer investment in the Blueprint to fund the expansion of cost-effective Blueprint services
- Observed savings incorporated into reductions of health insurance premiums

Expand Vermont Blueprint for Health
Current State

The Blueprint for Health is a well-respected state-run program that supports care management services in communities, at the practice level, enabling local communities to develop their system as needed.

- Promotes primary care transformation
- Addresses mental health, substance use, and unmet social needs

Vermont's payers (Medicaid, Medicare, and Commercial Payers) make direct payments to support Blueprint services. In 2020, these payments amounted to:

- $9.4M for CHT staff capacity
- $9.8M in quality payments to the Patient-centered Medical Home practices for NCQA Recognition, and
- $6.6M to support Medication Assisted Treatment in Vermont's Hub and Spoke model.
- Vermont Medicaid contributes additional resources to support other programs as well as administrative and some analytic capacity

Expand Vermont Blueprint for Health
Collaboration with Other Payers and Providers

In collaboration with other payer and provider care management activity (such the Vermont Chronic Care Initiative, BCBSVT Integrated Care Management, and OneCare) and utilizing informed patient identification, the Blueprint can:

- Inventory existing programs and to put in place a mechanism for referral to the Blueprint and other care management resources
- Describe the care management services performed with shared definitions
- Move toward a common reporting process to identify gaps in care and avoid duplication of services
- Conduct consistent ROI analysis to provide data driven effectiveness information

Expand Vermont Blueprint for Health
Learning from Programs in Other States

14 interventions funded under the second round of CMS Health Care Innovation Awards were reviewed in a November 2021 report. Of the 23 program features examined, 7 were associated with favorable estimated cost and quality impacts:

3 intervention components:

- Behavioral health
- Telehealth
- Health information technology

4 program design and organizational characteristics

- Having prior experience implementing similar programs,
- Targeting patients with substantial nonmedical needs in addition to medical problems
- Being focused on individual patient care rather than transforming provider practice
- Using nonclinical staff as frontline providers of the intervention

Expand Vermont Blueprint for Health
Learning from Programs in Other States

Maryland's Primary Care Program (MDPCP) is a key element of Maryland's Total Cost of Care (TCOC) All-Payer Model.

- Voluntary program open to all qualifying primary care providers that provides funding and support for the delivery of advanced primary care throughout the state.
- Care Transformation Organizations hire and manage an interdisciplinary care management team capable of furnishing an array of care coordination services to patients attributed to participating practices.
- Uses data from several sources, including claims and publicly available data, for risk stratification and assignment to care.
- Patient outcomes are optimized by focusing care coordination resources on the patients for whom the resources will generate the most benefit.

Expand Vermont Blueprint for Health
Learning from Programs in Other States

Washington Primary Care Transformation Model (PCTM) . The Model, which is targeted for implementation in January 2023, includes the following components:

- Primary care as integrated whole-person care, including behavioral and preventive services
- Patients are assigned to care teams based on level of need
- Aligned payment and incentives across payers to support model.
- Financing. Payers agree to an incremental and defined percent (%) of spend on primary care as a proportion of total cost of care.
- Improved provider capacity and access.
- Application of actionable analytics (clinical, financial, and social supports.) Payers and providers together use cost and utilization data that is interoperable with and across EHR systems to develop, implement, and document interventions to improve performance.
- Aligned measurement of "value" from the model. Primary care is defined as integrated whole-person care, including evidence-based behavioral and preventive services.

Expand Vermont Blueprint for Health
Learning from Programs in Other States

The Centers for Medicare and Medicaid Innovation's Comprehensive Primary Care Plus (CPC+) is the largest and most ambitious primary care payment and delivery reform model ever tested in the United States and is currently operating in 2,610 primary care practices and 18 regions across the country.

Key innovations include:
- Multi-payer payment reform
- Actionable data feedback
- Robust learning supports
- Health information technology (IT) vendor support

CPC+ requires practices to transform across five care delivery functions:
- Access And Continuity,
- Care Management,
- Comprehensiveness And Coordination,
- Patient And Caregiver Engagement
- Planned Care And Population Health

Expand Vermont Blueprint for Health

Discussion

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Option	Vermonters Served	Estimated Number	Key Advantage	Expected Time Frame	Alignment with other Options
Cost Growth Benchmark	All employers and individuals that have any health care expenses	600,000 (all Vermonters)	Reduction of premium rate increases across all payers	12-18months	Provides for statewide analysis of system costs and savings. Allows for stakeholder input on options. Establishes a target for growth and the process for moving savings from discrete initiatives into the rate setting process.
Moderate Needs Group Expansion	Vermonters who need support with activities of daily living (bathing, eating, dressing, toileting, transferring, walking), and their family caregivers	500 -18,000	More Vermonters supported with activities of daily living needs; Savings from delay or avoidance of future more costly utilization	6 months	Savings identified in ROI calculations for Moderate Needs Group expansion options can be 'booked' as savings in Cost Growth Option and used to reduce the Public Option premiums
Public Option	Small businesses and their employees	Up to 35,000	Premium savings to small businesses and employees	12-18 months	Savings identified in Cost Growth Target performance improvement plans, Moderate Needs Group, and Blueprint Expansion Options can be used to reduce the Public Option premiums
Blueprint for Health Expansion	All Vermonters that need care management	Approximately 10% of Vermonters (65,000) may benefit from care management services *(suggested by CMS CPC+ guidance)*	Reduced duplication and gaps in care mgmt. programs; ROI showing outcomes and savings; increase in number of people served in successful community based program.	12-18 months	A statewide ID and stratification vendor can also identify Vermonters for the Moderate Needs Expansion option. ROI experienced via the Blueprint can be 'booked' as savings in Cost Growth Option and used to reduce the Public Option premiums

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Thank You

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Medicare Savings Program Whitepaper

Description
According to the Social Security website, Medicare Savings Programs (MSPs) are federally-funded programs administered by each individual state.[66] The programs are designed to assist individuals with limited income in paying for Medicare premiums, deductibles, copays, and coinsurance. The programs vary by state and utilize different standards and methods to determine eligibility. There are four different Medicare Savings Programs:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI-1)
- Qualified Disabled & Working Individuals (QDWI)[67]

Who will it affect, and how?
In order to qualify for a program, individuals generally must meet the following requirements:

- Reside in a state or the District of Columbia
- Be age 65 or older
- Receive Social Security Disability benefits[68]
- Have certain disabilities or permanent kidney failure (even if under age 65)[69]
- Meet standard income and resource requirements[70]

What has Vermont done?
In Vermont the 2021 maximum income levels for individuals to qualify for MSP are:

Medicare Savings Program (MSP)	Federal Poverty Level (FPL)	VT 2021 Maximum Monthly Income Levels to Qualify
QMB	100%	$1,074 Individual / $1,452 Couple
SLMB	120%	$1,288 Individual / $1,742 Couple
QI-1	135%	$1,449 Individual / $1,960 Couple

Vermont has no asset test / limit for the MSP.

According to information from Department of Vermont Health Access (DVHA), the following data pertains to the current MSP.

[66] https://www.benefits.gov/benefit/4396 — accessed online 12-28-2021
[67] https://vtlawhelp.org/medicare-savings-buy-programs — accessed online 12-28-2021
[68] https://www.ssa.gov/benefits/disability/
[69] https://dcf.vermont.gov/dds/laws-rules
[70] https://www.benefits.gov/benefit/4396 — accessed online 12-28-2021

From the Department of Vermont Health Access
Budget Recommendation State Fiscal Year 2019[71]

Program	Who Is Eligible?	Benefits and Cost Sharing
Medicare Savings Programs	≥ age 65, blind, or disabled Active Medicare beneficiaries QMB: ≤ 100% FPL SLMB: 100.01 - 120% FPL QI-1: 120.01 - 135% FPL QI-1 Not eligible for Medicaid	• QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing • SLMB and QI-1 cover Medicare Part B premiums only • No monthly premium • QMB may still have to pay Medicare co-pay, and not eligible for retroactive payments • 3 months retroactive payments are possible for SLMB and QI-1

DVHA-reported expenditures and caseload: QMB, SLMB, QI-1, and QDWI

Program[72]	SFY-20 Total Medicaid Spend	State	Federal	Enrollment as of June 23, 2021
SLMB	$31,709,254	$14,628,271	$17,080,982	3,614
QMB	$32,573,018	$15,026,747	$17,546,270	8,349
QI-1	$4,868,755	-	$4,868,755	1,914
QDWI	-	-	-	-
	$69,151,026	**$29,655,019**	**$39,496,008**	**13,877**

The average PMPM for the total VPharm enrollment from the above data is $415.26. The individual PMPMs are QMB / $325.12, SLMB / $731.17, and QI-1 / $211.98.

[71] https://dvha.vermont.gov/sites/dvha/files/documents/Budget_Legislative_Rules/1sfy-2019-budget-book-final.pdf, p. 31
[72] DVHA email to LJFO Thursday, July 1, 2021 12:46 PM

CMS reporting includes the following information on the Vermont MSP.

CMS Data: Medicare-Medicaid Enrollment (MME): Original Medicare Enrollees by Type of Eligibility and Area of Residence, Calendar Year 2019[73] VERMONT	
Total MMEs	25,673
Full-Benefit MMEs	18,782
Qualified Medicare Beneficiaries (QMBs) Plus	13,320
Specified Low-Income Medicare Beneficiaries (SLMBs) Plus	2,384
Other Full-Benefit MMEs With Medicaid	3,079
Partial-Benefit MMEs	6,891
Qualified Medicare Beneficiaries (QMBs)	2,005
Specified Low-Income Medicare Beneficiaries (SLMBs)	2,632
Qualified Disabled and Working Individuals (QDWIs) & Qualifying Individuals[74]	2,254

As of this writing, the Vermont and CMS caseload information has not been reconciled by HST.

VPharm

In addition to the MSP, Vermont provides access to VPharm (a State Pharmaceutical Assistance Program, SPAP) for these same individuals, which covers pharmacy costs with modest copay requirements. The VPharm program provides pharmacy supports to individuals eligible for the MSP, and also to individuals at higher levels of income. The following tables are from the DVHA 2019 Budget Book.

[73] Centers for Medicare & Medicaid Services, Office of Enterprise and Data Analytics, Chronic Conditions Data Warehouse.

[74] QDWIs and Qualifying Individuals are combined for privacy reasons. The total count for QDWIs nationally is fewer than 100 beneficiaries.

Department of Vermont Health Access
Budget Recommendation State Fiscal Year 2019[75]

Program	Who Is Eligible?	Benefits and Cost Sharing
VPharm1, 2 & 3 State pharmacy assistance program (SPAP) "wrap-around" Medicare drug benefit, pays Part C/D cost-share[76]	Eligible and enrolled in Medicare PDP or MAPD **VPharm1**: ≤ 150% FPL Must apply for LIS **VPharm2**: 150.01% - 175% FPL **VPharm3**: 175.01% - 225% FPL	**VPharm1** (after primary LIS reductions): • Medicare Part D cost-sharing • Excluded classes of Part D meds • Diabetic supplies • Eye exams **VPharm2 & 3** • Maintenance meds • Diabetic supplies **Monthly premium per person**: • VPharm1: $15 • VPharm2: $20 • VPharm3: $50 **$1/$2 prescription co-pays** **No retroactive payments**

VPharm Caseload, Expenditure, and PMPM Comparison by State Fiscal Year
Pharmacy Only Programs[77]

		DVHA Only		All AHS and AOE	
SFY	Caseload	Expenditures	PMPM	Expenditures	PMPM
SFY 2015 Actual	11,978	$ 4,914,695	$ 34.19	$ 4,914,695	$ 34.19
SFY 2016 Actual	11,593	$ 2,302,437	$ 16.55	$ 2,302,437	$ 16.55
SFY 2017 Actual	11,399	$ 3,155,724	$ 23.07	$ 3,155,724	$ 23.07
SFY 2018 As Passed	11,640	$ 6,375,171	$ 45.64	$ 6,375,171	$ 45.64
SFY 2018 BAA	11,182	$ 4,678,042	$ 34.86	$ 4,678,042	$ 34.86
SFY 2019 Gov. Rec.	10,913	$ 6,134,624	$ 46.84	$ 6,134,624	$ 46.84

[75] https://dvha.vermont.gov/sites/dvha/files/documents/Budget_Legislative_Rules/1sfy-2019-budget-book-final.pdf, p. 31
[76] Ibid, p. 80.
[77] Ibid, p. 46

Population, Eligibility, and Costs

According to the Current Population Survey (CPS):[78]

1. Nationwide there are 15,998,000 individuals over 65 and under 200% of federal poverty, this represents 28.7% of all individuals over 65;
2. In Vermont, there are 141,000 individuals over 65;
3. VT has 141,000 individuals over 65
4. Below 50% FPL — 4,000/3.2%
5. Below 100% FPL — 12,000/8.8%
6. Below 125% FPL — 18,000/13%
7. Below 138% FPL — 21,000/14.8%
8. Below 150% FPL — 23,000/16.3%
9. Below 175% FPL — 28,000/20.2%
10. Below 185% FPL — 30,000/20.9%
11. Below 200% FPL — 31,000/22.3%

For our purposes here we are seeking to provide a high-level bound for the number of individuals that could benefit from an increase in the level of federal poverty at which people qualify for the MSP. The population between 138% and 200% of FPL is estimated by CPS to be 10,000 Vermonters. While inexact, using this 10,000 number is a reasonable upper bound for an increase in the MSP to that level. We know that not everyone who is eligible will sign up.

A dated study for the Medicaid and CHIP Payment and Access Commission (MACPAC) identified Maine as the state with the highest take-up rate, at 78% of the eligible population.[79] If we use 78% as the take-up rate and assume that the program is expanded by raising the QMB from 100 to 165, the SLMB from 120 to 185 and the QI-1 from 135 to 200 we can use 7,800 ([31,000-21,000=10,000]*.78= 7,800) as the number of individuals who would be newly eligible and who would access the program. Using the blended cost $415.26 PMPM times 7,800 the cost estimate is $38,868,336 annually. This could be reduced by increasing the coverage by a smaller amount or by instituting an asset test. The increased costs could also be offset by reducing the VPharm offering and aligning that coverage directly with the MSP poverty levels. HST does not recommend reducing VPharm coverage nor implementing an asset test. HST believes that either option would cause more damage than good to the affordability and accessibility of healthcare.

What have other states done?

The vast majority of states provide coverage at the same FPL levels as Vermont does today. HST has included the New England states along with the states that have increased coverage through a State Plan Amendment (SPA) above the levels Vermont covers individuals and couples at today (QMB 100% , SLMB 120%, and QI-1 135%).

[78] https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-46.html -- accessed online 12.29.2021

[79] https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf -- accessed online 12.29.2021

Comparison of 2020 Medicare Savings Programs

State	QMB limit % of FPL	QMB income limit (indiv.)	QMB income limit (couple)	SLMB limit % of FPL	SLMB income limit (indiv.)	SLMB income limit (couple)	QI limit % of FPL	QI income limit (indiv.)	QI income limit (couple)	MSP asset limit (indiv.)	MSP asset limit (couple)	Asset Test / Limit (Y/N)
Connecticut	211%	$2,244	$3,031	231%	$2,456	$3,319	246%	$2,616	$3,534	N/A	N/A	N
District of Columbia	300%	$3,190	$4,310	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N
Indiana	150%	$1,595	$2,155	170%	$1,808	$2,443	185%	$1,968	$2,658	$7,860	$11,800	Y
Maine	150%	$1,595	$2,155	170%	$1,808	$2,443	185%	$1,968	$2,658	$58,000	$87,000	Y
Massachusetts	130%	$1,382	$1,868	150%	$1,595	$2,155	165%	$1,718	$2,326	$15,720	$23,600	Y
New Hampshire	100%	$1,064	$1,437	120%	$1,276	$1,724	135%	$1,436	$1,940	$7,860	$11,800	Y
Rhode Island	100%	$1,064	$1,437	120%	$1,276	$1,724	135%	$1,436	$1,940	$7,860	$11,800	Y
Vermont	100%	$1,064	$1,437	120%	$1,276	$1,724	135%	$1,436	$1,940	N/A	N/A	N

Health Equity

The Medicare Savings Program can improve health equity by supporting elderly and disabled individuals at the lower end of the income spectrum across Vermont by paying for Medicare premiums and cost sharing.

Discussion

Vermont currently provides MSP supports at the level the vast majority of states do for QMB, SLMB, and QI-1's, 100, 120, and 135% of FPL, respectively. Vermont currently is more generous than most states in the treatment of assets, disregarding all assets in determining eligibility. Vermont also is among the minority of states that provide wrap-around SPAP benefits to this population cohort (14 states provide this type of program today).[80] A policy decision to increase the FPL for the MSP should take into account the full range of supports provided to the population and the impact that other programs the Task Force is considering would have on this particular population cohort.

[80] https://www.medicareinteractive.org/pdf/SPAP-Chart.pdf -- accessed online 12-29-2021

Acronyms

Acronym	Reference
AAA	Vermont Area Agencies on Aging
ACA	Affordable Care Act
ACO	Accountable Care Organization
ACSC	Ambulatory Care Sensitive Conditions
ADLs	Activities of Daily Living
APMs	Alternative Payment Methodologies
APO	Adjusted Plan Options
APTC	Advanced Premium Tax Credits
ARP	American Rescue Plan
BCBSVT	Blue Cross Blue Shield of Vermont
CDC	United States Centers for Disease Control and Prevention
CGT	Cost Growth Target
CHT	Community Health Team
CMS	Centers for Medicare and Medicaid Services
CPC+	Comprehensive Primary Care Plus
CPI	U.S. Consumer Price Index
DAIL	Vermont Department of Disabilities, Aging and Independent Living
DVHA	Department of Vermont Health Access
ERISA	Employee Retirement Income Security Act of 1974
FPL	Federal Poverty Level
GMCB	Green Mountain Care Board
GSP	Gross State Product
HCBS	Home- and Community-Based Services
HHS	U.S. Department of Health and Human Services.
HST	Health System Transformation, LLC
KC	Kupuna Care (Hawaii)
LJFO	Vermont Legislative Joint Fiscal Office
LTSS	Long-Term Services and Supports
MACPAC	Medicaid and CHIP Payment and Access Commission
MDH	Maryland Department of Health
MDPCP	Maryland's Primary Care Program
MNG	Moderate-Needs Group
MSP	Medicare Savings Program
NCQA	National Committee for Quality Assurance
Non-QHP	Non-Qualified Health Plan
OHIC	Office of the Health Insurance Commissioner (Rhode Island)
OPI	Oregon Project Independence
PBM	Pharmacy Benefit Manager
PCMH	Primary Care Medical Home
PCTM	Primary Care Transformation Model (Washington State)
PGSP	Potential Gross State Product
PMPM	Per Member Per Month
PPACA	Patient Protection and Affordable Care Act

Acronym	Reference
QDWI	Qualified Disabled & Working Individuals
QHP	Qualified Health Plan
QI-1	Qualifying Individual
QMB	Qualified Medicare Beneficiary
ROI	Return on investment
SLMB	Specified Low-Income Medicare Beneficiary
SPA	Medicaid State Plan Amendment
SPAP	State Pharmaceutical Assistance Program
TCOC	Total Cost of Care (Maryland All-Payer Model)
TPA	Third Party Administrator
TSOA	Tailored Supports for Older Adults (Washington State)
VHCIP	Vermont Health Care Innovation Project
VHCURES	Vermont Healthcare Uniform Reporting and Evaluation System