Joint Task Force on Affordable, Accessible Health Care
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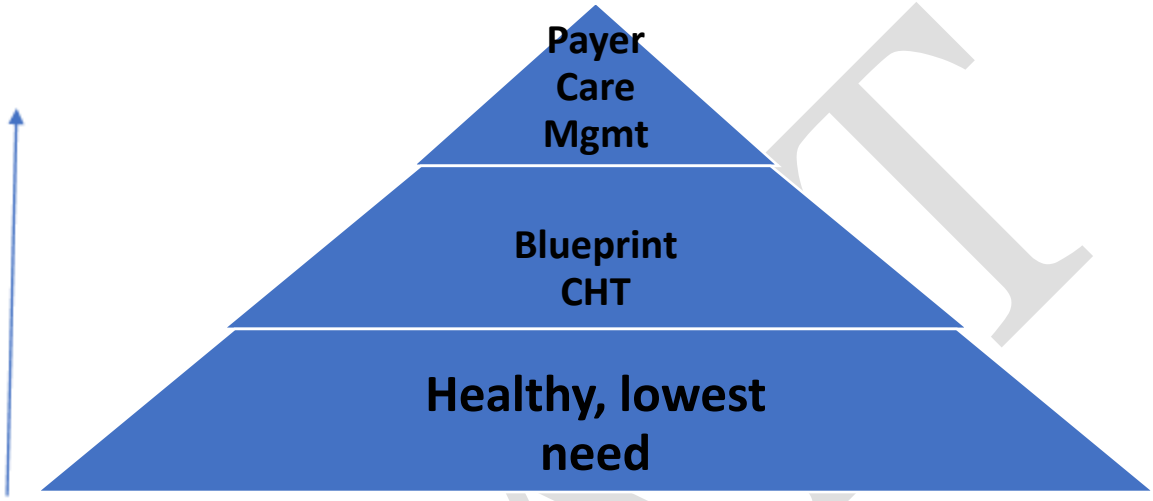
Policy Option: Blueprint for Health Expansion



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[1] 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 PCMH or identified with advanced analytics as needing care management and then referred to appropriate Blueprint for Health Community Health Teams (CHTs) across the state. Return on Investment (ROI) analysis will promote the uptake of Blueprint services, inform payer rate setting, and enable targeted quality improvement efforts.

[1] Throughout this document HST utilizes "care management" broadly to refer to care management, case management, and care coordination activities.

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 Administrative Entities to fund CHT staff capacity, $9,821,223 in quality payments to the Patient-centered Medical Home practices for 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[2].

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[3].

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

[2] https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf
[3] https://ratereview.vermont.gov/

Care Management (CMCM) Work Group report that inventoried existing programs in the state[4]. 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)[5], Blue Cross Blue Shield of Vermont integrated care management[6], and the Blueprint Community Health Teams (CHTs)[7] serve and will describe the services performed with shared definitions.

Health Equity

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."[8] 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. 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[9] (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 [10]) hire and manage an interdisciplinary care management team capable of furnishing an array of care coordination services to patients attributed to participating practices.

[4] https://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/3-09-15%20Care%20Management%20Inventory%20Survey%20Report.pdf
[5] https://dvha.vermont.gov/providers/vermont-chronic-care-initiative
[6] https://www.bluecrossvt.org/health-community/your-health-and-wellness/help-managing-your-health
[7] https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams
[8] https://www.cdc.gov/minorityhealth/publications/health_equity/index.html
[9] https://health.maryland.gov/mdpcp/Pages/home.aspx
[10] https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-transformation-network

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.[11]

In 2020, which was year 2 of the MDPCP, over 2,700,000 patients were served[12]. 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.[13]

In August 2020, 8 **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)[14]. 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.

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

[11] https://health.maryland.gov/mdpcp/Documents/MDPCP%20Pre-AH%20Risk%20Score%20Specifications%20and%20Codebook.pdf
[12] MDPCP_Year2_2020_Summary.pdf (maryland.gov)
[13] Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm - Milbank Memorial Fund
[14] https://www.hca.wa.gov/about-hca/value-based-purchasing/multi-payer-primary-care-transformation-model#resources

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

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[15].

Alignment with other 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.

Further research

Vermont-specific data analysis will surface 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.

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