

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

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

Family Caregiver Support in Other States

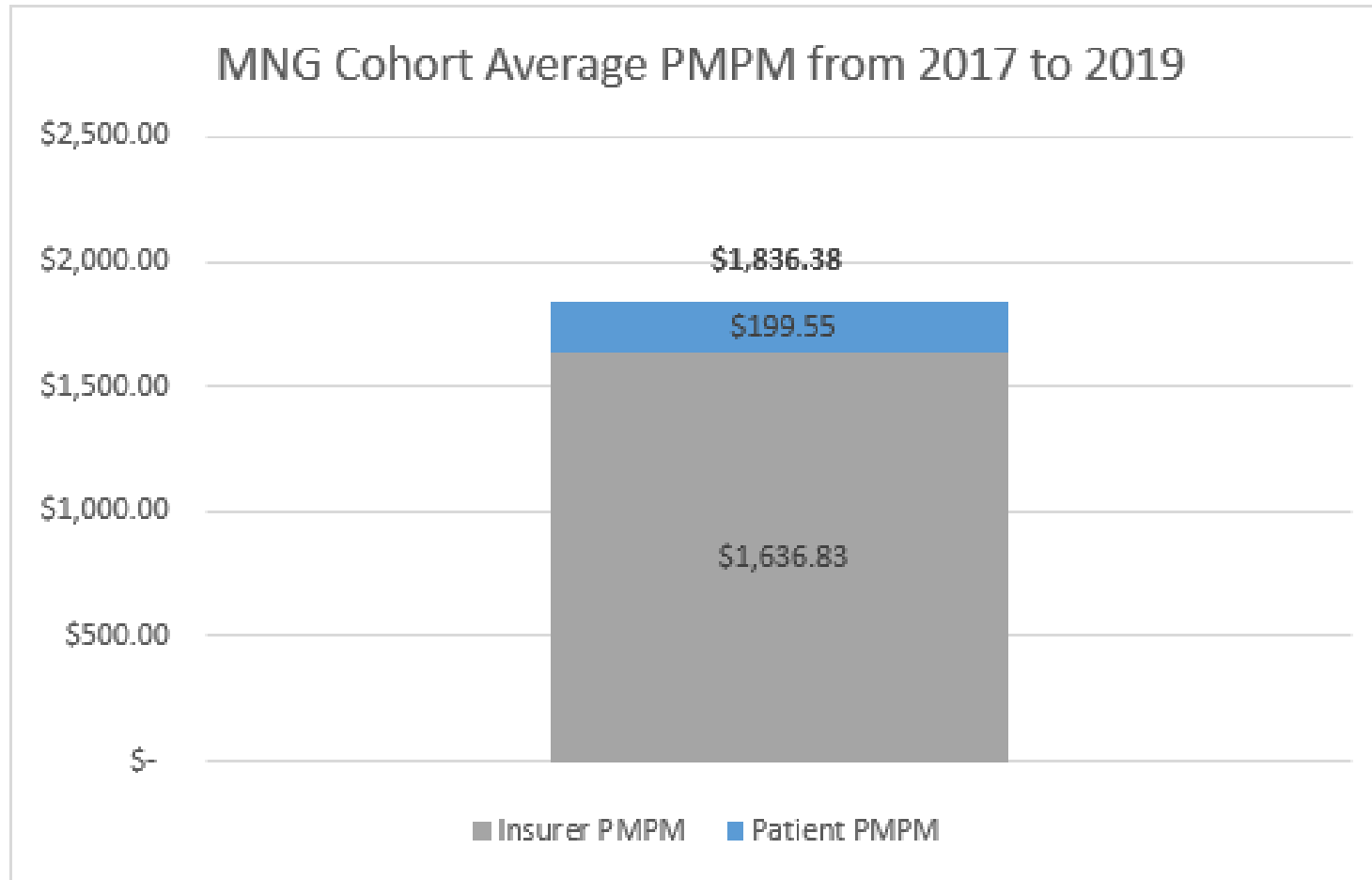
<i>State</i>	<i>Program Name</i>	<i>Eligibility Criteria</i>	<i>Maximum Annual Benefit</i>
<i>Oregon</i>	Family Caregiver Assistance Program	Adults with incomes up to 400% of the Federal Poverty Level (FPL) who pass a resource test and meet certain clinical eligibility criteria	\$6,000
<i>Washington</i>	Tailored Supports for Older Adults	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	\$7,500
<i>Arizona</i>	Family Caregiver Grant Program	Friends and family caring for Arizonans with incomes up to \$75,000 for a single person or \$150,000 for a couple	\$1,000
<i>Hawaii</i>	Kupuna Caregivers	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	\$25,000

Extending Moderate-Needs Supports

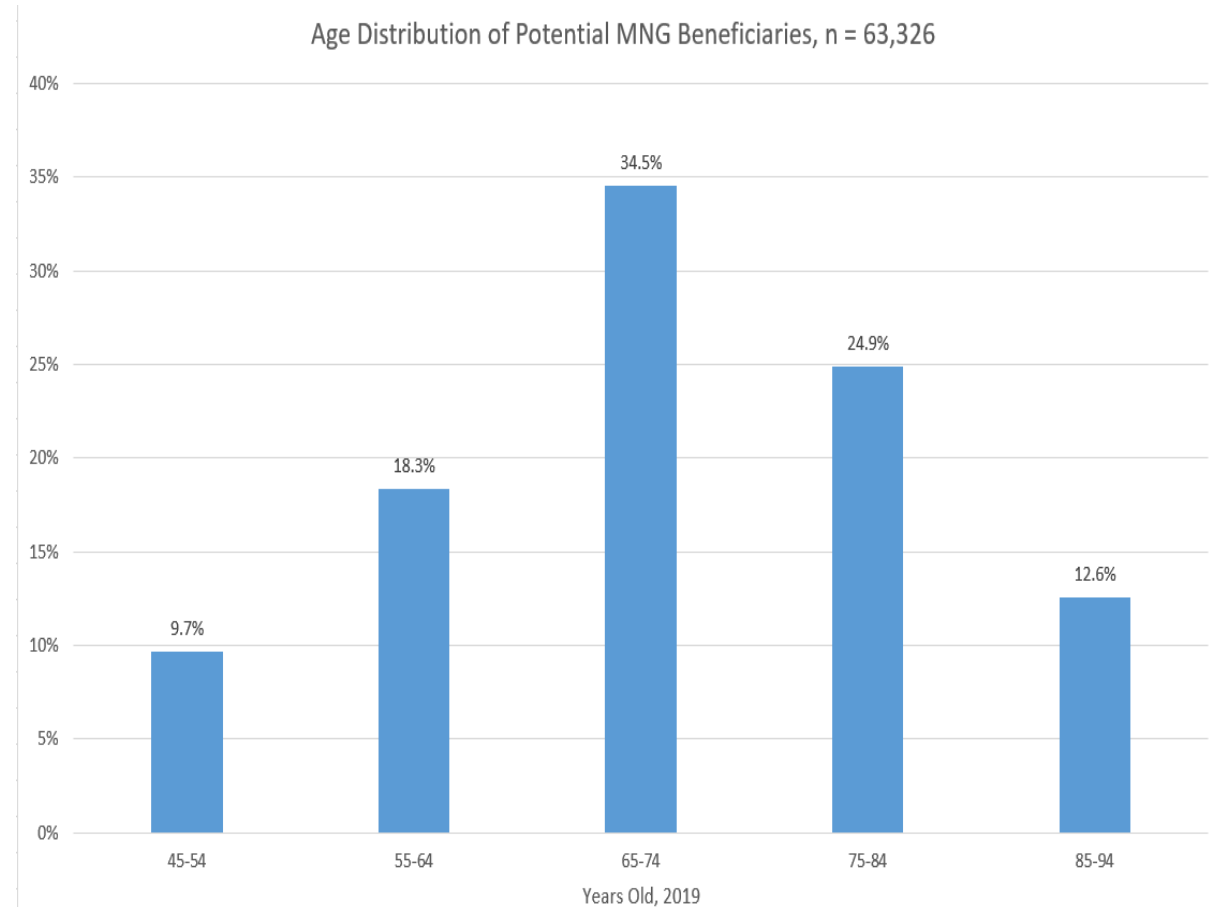
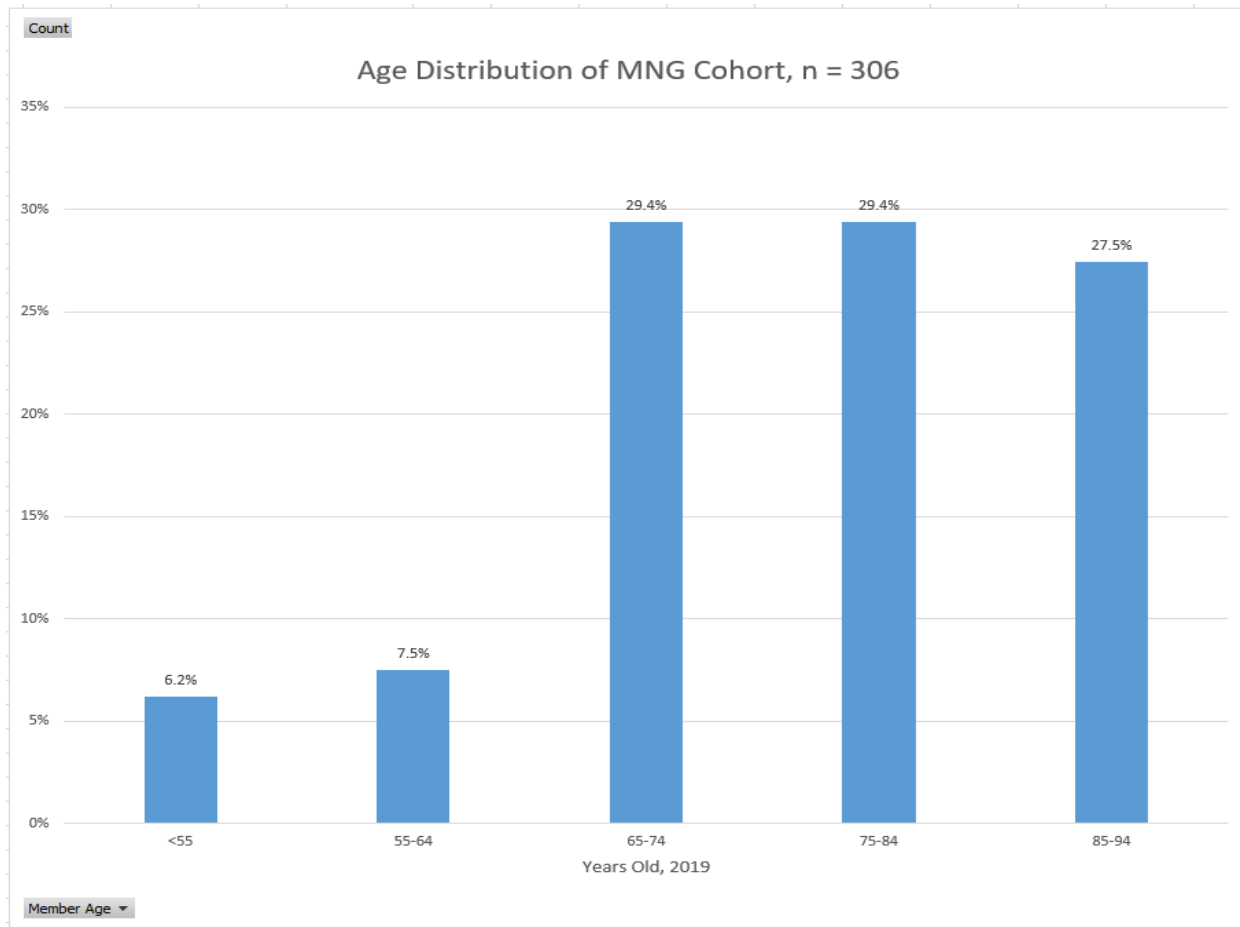
Key Advantages

- 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

Extending Moderate-Needs Supports Vermonters Served



Extending Moderate-Needs Supports Vermonters Served



Extending Moderate-Needs Supports Vermonters Served

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

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



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
patients

Makes traditionally
unusable data, useful

COMPLETE

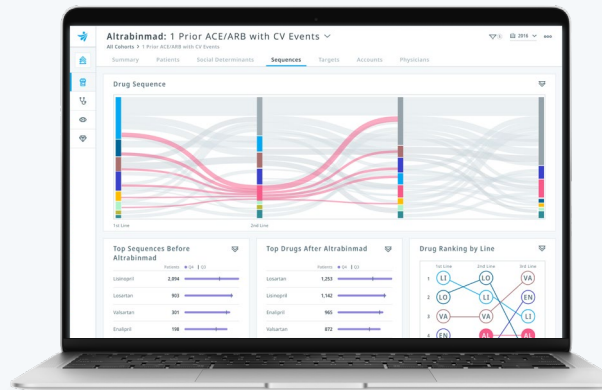
300M+
total lives

Builds longitudinal
patient journeys

LINKABLE

Zero effort
integration

Refreshes are
automated



Social and behavioral determinants overview

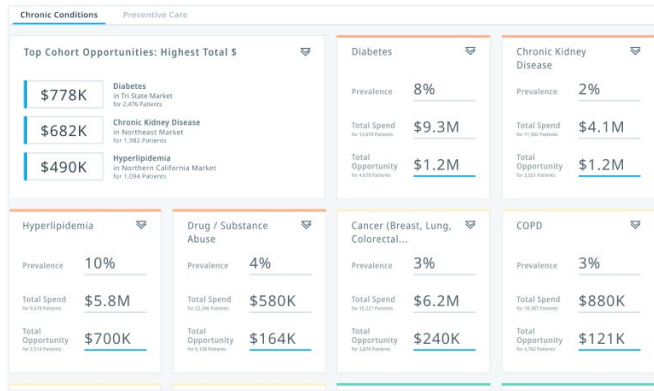
Sample of Clarify-available SDoH categories and attributes

Economic Stability & Education	Neighborhood & Physical Environment	Community Context & Social Support	Housing & Transportation	Behavioral Aspects
<ul style="list-style-type: none">• Income level• Accumulated wealth• Wealth stability• Employment status• Economic trajectory• Highest educational attainment	<ul style="list-style-type: none">• Neighborhood crime index• Neighborhood poverty index• Median area income• Percent of population with limited English	<ul style="list-style-type: none">• Age• Gender• Race breakdown• Marital status• Number of household members• Presence of caregiver• Number of children in household• Number of nearby relatives	<ul style="list-style-type: none">• Dwelling type• Homeowner or renter• Address stability• Length at current address• Number of registered vehicles	<ul style="list-style-type: none">• Use of smartphone• Use of credit card• Level of exercise• Interest in health products or services• Interest in outdoor activities

Identify cohorts where you can impact spend

Ex: Diabetics

MARKET



PHYSICIAN

Diabetes by Health System

Health System	Prevalence	# Patients w/ Condition	Mental Health %	Last 12mo: Comorbid %	Last 12mo: # w/ IP	Last 12mo: # w/ 2-ED	% Rx Adherent	Completed HbA1c %	Last 12mo: Last 12mo: EBM Visit	Avg Observed \$	Spend Distribution	Total \$ Oppty	# Patients w/ Oppty	Avg \$ Oppty	# Patients at High Risk
New York Health System	9%	9,326	11%	5%	11%	81%	81%	11%	\$9.5K	\$5,400K	13,326	\$1,691	2,873		
Unattributed	12%	1,567	14%	6%	14%	84%	84%	14%	\$11.1K	\$1,564K	1,467	\$351	410		
New York Health System	11%	1,410	10%	7%	10%	83%	83%	10%	\$9.8K	\$987K	910	\$366	892		
Syracuse Health System	9%	1,201	8%	3%	10%	82%	82%	10%	\$8.4K	\$888K	801	\$1,899	756		
Albany Health System	12%	1,164	8%	4%	8%	81%	81%	8%	\$9.2K	\$641K	864	\$864	173		
NY City Health System	11%	976	8%	4%	8%	75%	75%	8%	\$8.4K	\$714K	976	\$471	924		
Buffalo Health System	10%	853	6%	5%	6%	87%	87%	6%	\$7.6K	\$373K	453	\$1,453	138		
Adelphi Health System	9%	853	8%	4%	8%	76%	76%	8%	\$6.5K	\$373K	653	\$471	793		
Saracac Health System	8%	853	9%	4%	7%	76%	76%	7%	\$8.2K	\$373K	1,753	\$1,453	131		
Black River Health System	6%	853	9%	3%	6%	83%	83%	6%	\$7.6K	\$373K	853	\$1,453	831		
Hudson Health System	8%	853	11%	3%	9%	81%	81%	9%	\$6.5K	\$373K	2,153	\$1,453	831		

Diabetes by Medical Group

Medical Group	Prevalence	# Patients w/ Condition	Mental Health %	Last 12mo: Comorbid %	Last 12mo: # w/ IP	Last 12mo: # w/ 2-ED	% Rx Adherent	Completed HbA1c %	Last 12mo: Last 12mo: EBM Visit	Avg Observed \$	Spend Distribution	Total \$ Oppty	# Patients w/ Oppty	Avg \$ Oppty	# Patients at High Risk
New York Health System	9%	9,326	11%	5%	11%	81%	81%	11%	\$9.5K	\$5,400K	13,326	\$1,691	2,873		
Upper Lakes Medical Grp	12%	1,567	14%	6%	14%	84%	84%	14%	\$11.1K	\$1,564K	1,467	\$351	410		
West Albany Medical Grp	11%	1,410	10%	7%	10%	83%	83%	10%	\$9.8K	\$987K	910	\$366	892		
North Buffalo Medical Grp	9%	1,201	8%	3%	10%	82%	82%	10%	\$8.4K	\$888K	801	\$1,899	756		
Brookport Medical Grp	12%	1,164	8%	4%	8%	81%	81%	8%	\$9.2K	\$641K	864	\$864	173		
Queensbury Medical Grp	11%	976	8%	4%	8%	75%	75%	8%	\$8.4K	\$714K	976	\$471	924		
Saranac Lake Medical Grp	10%	853	6%	5%	6%	87%	87%	6%	\$7.6K	\$373K	453	\$1,453	138		
Five Ponds Medical Group	9%	853	8%	4%	8%	76%	76%	8%	\$6.5K	\$373K	653	\$471	793		
Burlington Medical Group	8%	853	9%	4%	7%	76%	76%	7%	\$8.2K	\$373K	1,753	\$1,453	131		
Cortland Medical Group	6%	853	9%	3%	6%	83%	83%	6%	\$7.6K	\$373K	853	\$1,453	831		
Jamestown Medical Group	8%	853	11%	3%	9%	81%	81%	9%	\$6.5K	\$373K	2,153	\$1,453	831		

Diabetes by Physician

Physician	Prevalence	# Patients w/ Condition	Mental Health %	Last 12mo: Comorbid %	Last 12mo: # w/ IP	Last 12mo: # w/ 2-ED	% Rx Adherent	Completed HbA1c %	Last 12mo: Last 12mo: EBM Visit	Avg Observed \$	Spend Distribution	Total \$ Oppty	# Patients w/ Oppty	Avg \$ Oppty	# Patients at High Risk
Upper Lakes Medical Grp	9%	9,326	11%	5%	11%	81%	81%	11%	\$9.5K	\$5,400K	13,326	\$1,691	2,873		
Watson, Ann	12%	1,567	14%	6%	14%	84%	84%	14%	\$11.1K	\$1,564K	1,467	\$351	410		
Black, Pat	11%	1,410	10%	7%	10%	83%	83%	10%	\$9.8K	\$987K	910	\$366	892		
Hawkins, Tyrone	9%	1,201	8%	3%	10%	82%	82%	10%	\$8.4K	\$888K	801	\$1,899	756		
Wilson, Jorge	12%	1,164	8%	4%	8%	81%	81%	8%	\$9.2K	\$641K	864	\$864	173		
Bell, Serenity	11%	976	8%	4%	8%	75%	75%	8%	\$8.4K	\$714K	976	\$471	924		
Flowers, Dwight	10%	853	6%	5%	6%	87%	87%	6%	\$7.6K	\$373K	453	\$1,453	138		
Webb, Zina	9%	853	8%	4%	8%	76%	76%	8%	\$6.5K	\$373K	653	\$471	793		
Mccoy, Brooklyn	8%	853	9%	4%	7%	76%	76%	7%	\$8.2K	\$373K	1,753	\$1,453	131		
McKinney, Aubrey	6%	853	9%	3%	6%	83%	83%	6%	\$7.6K	\$373K	853	\$1,453	831		
Murphy, Kathryn	8%	853	11%	3%	9%	81%	81%	9%	\$6.5K	\$373K	2,153	\$1,453	831		

PATIENT

Diabetes All Markets

Patient List

Patient Name	DOB	Market	Prevalence	Total Spend	Total Opportunity	Completed HbA1c %	Last 12mo: Last 12mo: EBM Visit	Avg Observed \$	Spend Distribution	Total \$ Oppty	# Patients w/ Oppty	Avg \$ Oppty	# Patients at High Risk		
All Markets	08/30/49	88,256	\$1,256	-	2.1	-	21d ago	Long name here	0.3	1.6	-	-	-		
Albatross, Juliana	08/30/49	88,256	\$1,256	Y	1	Condit...	N	21d ago	Long name here	2	2	0-40K	V Low	Y	Y
Alexander, Evan	08/30/49	88,256	\$1,256	Y	3	Condit...	N	21d ago	Long name here	1	1	60-80K	Low	N	N
Pena, Glady	08/30/49	88,256	\$1,256	N	3	Condit...	N	21d ago	Long name here	0	0	0-40K	Moderate	Y	Y
Steward, Jorge	08/30/49	88,256	\$1,256	Y	3	Condit...	Y	21d ago	Long name here	0	0	40-60K	High	N	N
Robertson, Tomothy	08/30/49	88,256	\$1,256	N	3	Condit...	Y	21d ago	Long name here	0	0	>120K	V High	Y	Y
Cooper, Bruce	08/30/49	88,256	\$1,256	Y	2	Condit...	N	21d ago	Long name here	0	0	40-60K	Moderate	N	N
Fox, Wendy	08/30/49	88,256	\$1,256	N	2	Condit...	N	21d ago	Long name here	0	0	40-60K	V Low	Y	Y
Howard, Ronald	08/30/49	88,256	\$1,256	Y	2	Condit...	N	21d ago	Long name here	0	0	40-60K	Low	N	N
Williamson, Cody	08/30/49	88,256	\$1,256	N	2	Condit...	N	21d ago	Long name here	2	2	0-40K	Moderate	N	N
Mehldau, John	08/30/49	88,256	\$1,256	N	2	Condit...	Y	21d ago	Long name here	1	1	40-60K	Moderate	N	N
Warren, Leslie	08/30/49	88,256	\$1,256	N	2	Condit...	Y	21d ago	Long name here	0	0	60-80K	Low	Y	Y
Watson, Ann	08/30/49	88,256	\$1,256	Y	2	Condit...	N	21d ago	Long name here	0	0	80-120K	High	Y	Y
Black, Pat	08/30/49	88,256	\$1,256	Y	2	Condit...	N	21d ago	Long name here	0	0	0-40K	Low	Y	Y
Bell, Serenity	08/30/49	88,256	\$1,256	Y	2	Condit...	N	21d ago	Long name here	0	0	80-120K	Moderate	N	N

1 Benchmark spend to find highest opportunity cohorts

2 Access metrics on utilization and quality for each disease

3 Identify SDOH characteristics, matched at a member-level

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 (co-morbidities, DRG, procedure types)
Demographics (age & gender)
SDoH (education, income, support status)



REGIONAL FACTORS

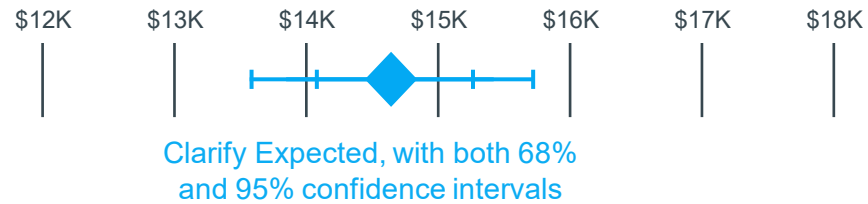
Rural versus urban
Academic centers versus medical centers



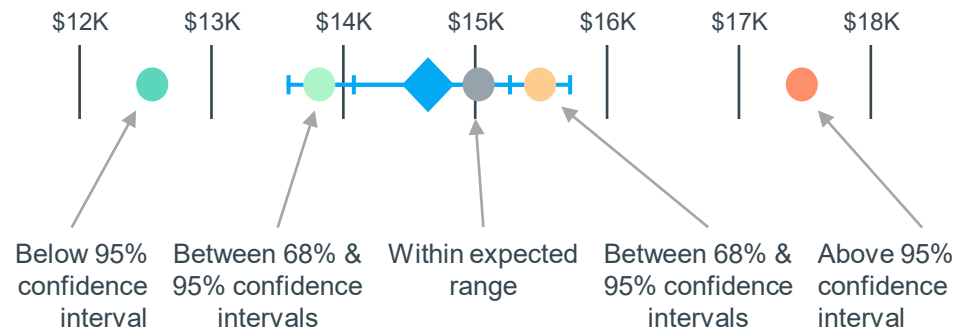
CLINICAL & FINANCIAL OUTCOMES

Leakage, Value-based program success

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



...and compared to the observed values to surface cost variation



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

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

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.

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

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 <i>(suggested by CMS CPC+ guidance)</i>	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

Thank You