

# Joint Task Force on Affordable, Accessible Health Care

 **Health System Transformation, LLC**

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FINAL REPORT JANUARY 13, 2022

# Agenda

- Task Force Charge and Membership
- Process
- Summary of Recommendations
- Policy Option Details
  - Cost Growth Benchmark and Affordability Standards
  - Extending Moderate Needs Supports
  - Public Option
  - Expand Vermont Blueprint for Health

# Task Force Charge

## Joint Task Force on Affordable, Accessible Health Care

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

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

# Process

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

# Process Continued

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 Policy Options
11. Review and focus on four Policy Options
12. Drafting of a white paper on the Medicare Savings Program (MSP)
13. Collection, analysis, and compilation of all the above
14. Development of a Final Report

# 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. Cost Growth Benchmark and Affordability Standards
2. Extend Moderate Needs Supports
3. Public Option
4. Expand Blueprint for Health

# Seven Preferred Options Continued

Options that are of interest to the Task Force and are the subject of current ongoing activity:

5. Postpartum Expansion
6. Remote Access to Care
7. Pharmacy Benefit Manager Regulation

Members of the Joint Task Force support legislation in these areas through their respective committees of jurisdiction, and will continue to advocate for these strategies.

# Policy Options Evaluated Together

Consider the Policy Options presented in this report as a suite of strategies that, if implemented strategically, will impact every Vermonter.

Implementation of these Options should also be evaluated in relation to the initiatives already underway or under consideration by Vermont agencies and legislative committees.

# Summary of Recommendations

## Policy Descriptions

Policy Option	Summary Program Description
Cost Growth Benchmark and Affordability Standards	A cost-containment strategy that: sets a limit on how much a state’s health care spending can grow each year; aligns costs with wage and income growth; avoids negative impacts to access or health inequities.
Extend Moderate-Needs Supports	The VT Choices for Care Moderate Needs Group (MNG) provides a limited Home and Community Services (HCBS) benefit to those with “Moderate Needs” for long-term services and supports. Includes: advanced analytic tools for identification, stratification, and return-on-investment analysis; the extension of the MNG to additional individuals; additional supports for family caregivers.
Public Option	A Public Option is an insurance coverage program 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 to either broaden coverage options or to enhance competition among carriers.
Expand Blueprint for Health	The Blueprint for Health is a well-respected state-run program that supports care management services in communities. This option recommends instituting population analysis of the current program to identify individuals for intervention and for return-on-investment analysis. This will help to make the case for targeted expansion.

# Summary of Recommendations

## Justifications

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. In order 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 (very large U.S. market of employer-sponsored health plans regulated under the federal Employee Retirement Income Security Act) 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.

# Policy Options Summary Table

Policy Option	Vermonters Served	Estimated Number	Key Advantage	Time Frame	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 target for growth and 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.

# Policy Options

## 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 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
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.	The literature is mixed on the range of financial outcomes for care management. A state-level ROI analysis is recommended.

# 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.”

The Task Force sought to avoid duplication of the work already accomplished and ongoing in their committees of jurisdiction related to **Health Equity**, including:

- Separate and parallel efforts toward supporting the **healthcare workforce**; and,
- Establishment of the **Health Equity Commission**

# Policy Options

## Health Equity Impacts

- **Cost Growth Benchmark and Affordability Standards** 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.
- **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.
- **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.
- **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.

# Policy Options Details

Details of the four Policy Options are presented in the following slides.

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

# Cost Growth Benchmark and Affordability Standards

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 and Affordability Standards

## 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 and Affordability Standards

## 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 and Affordability Standards 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.

# Extend Moderate-Needs Supports

The VT Choices for Care Moderate Needs Group (MNG) provides a limited Home and Community Services (HCBS) benefit to those with “Moderate Needs” for long-term services and supports, and whose income is at or below 300% of the SSI payment standard (about \$2,500/mo.). Supports include personal care services and adult daycare. This program is limited by available funding and serves about 1,000 Vermonters at any one time.

Extend 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.

# Extend Moderate-Needs Supports

## Family Caregiver Support in Other States

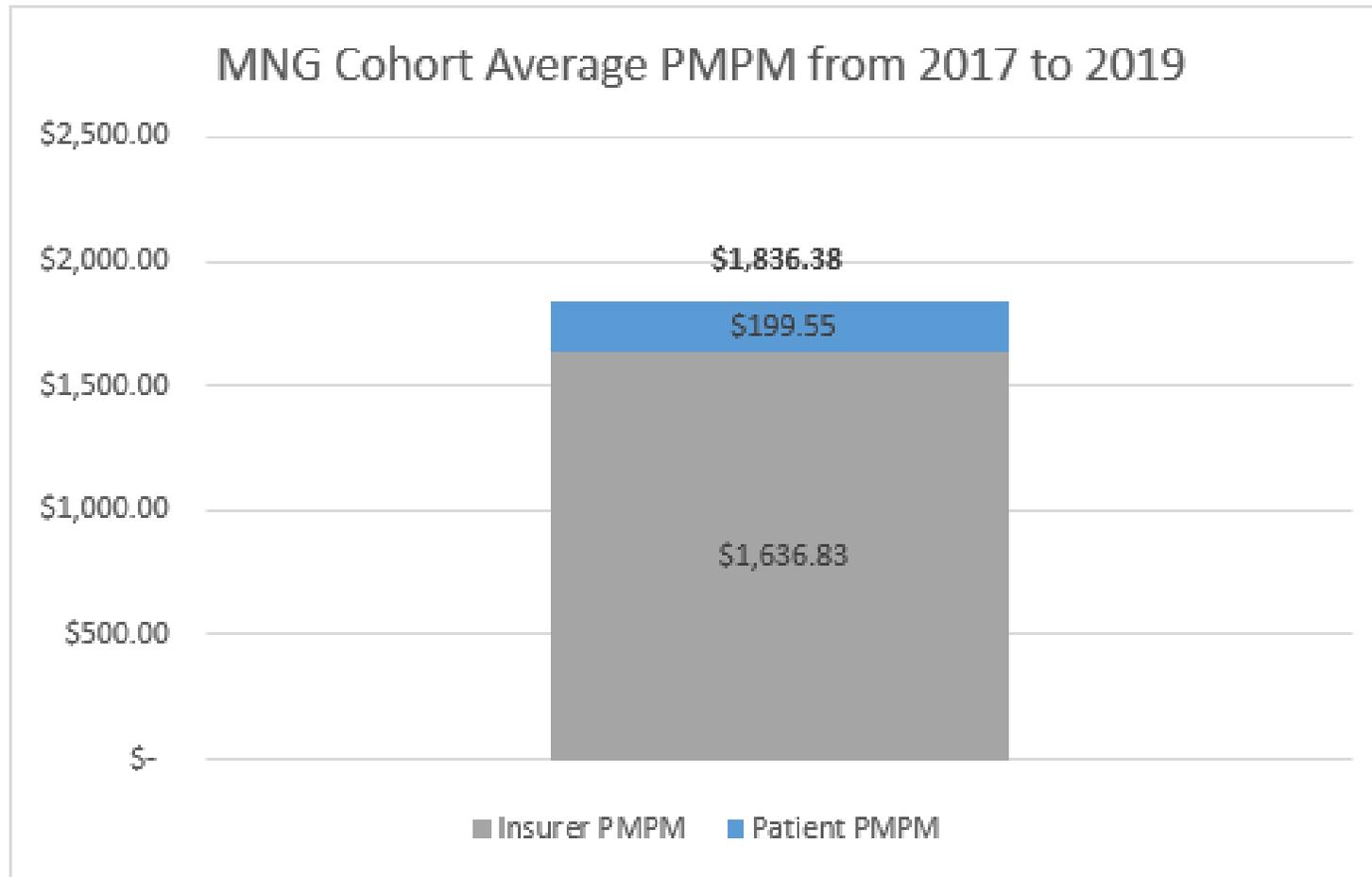
State	Program Name	Eligibility Criteria	Maximum Annual Benefit
Oregon	Family Caregiver Assistance Program	Adults with incomes up to 400% of the Federal Poverty Level (FPL) who pass a resource test and meet certain clinical eligibility criteria	\$6,000
Washington	Tailored Supports for Older Adults	People 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
Arizona	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
Hawaii	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

# Extend Moderate-Needs Supports

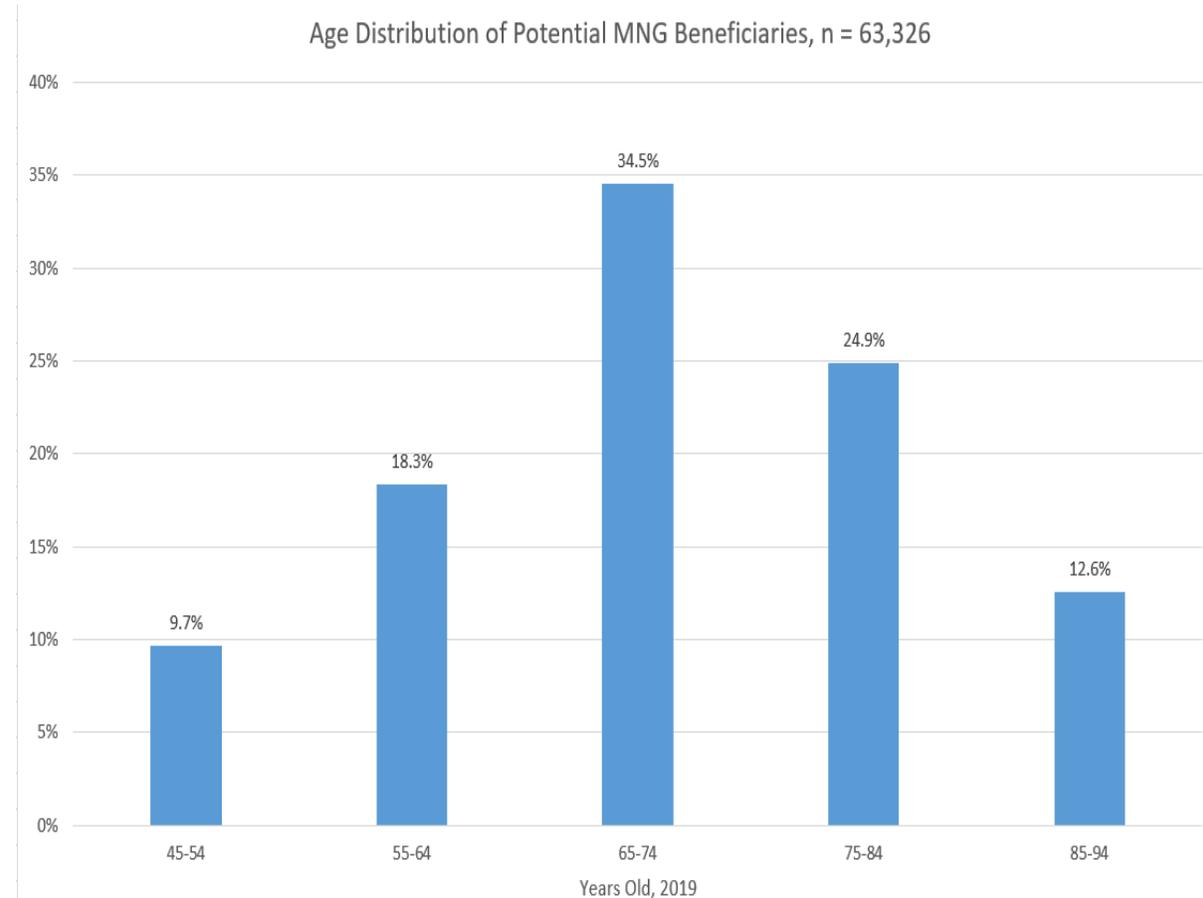
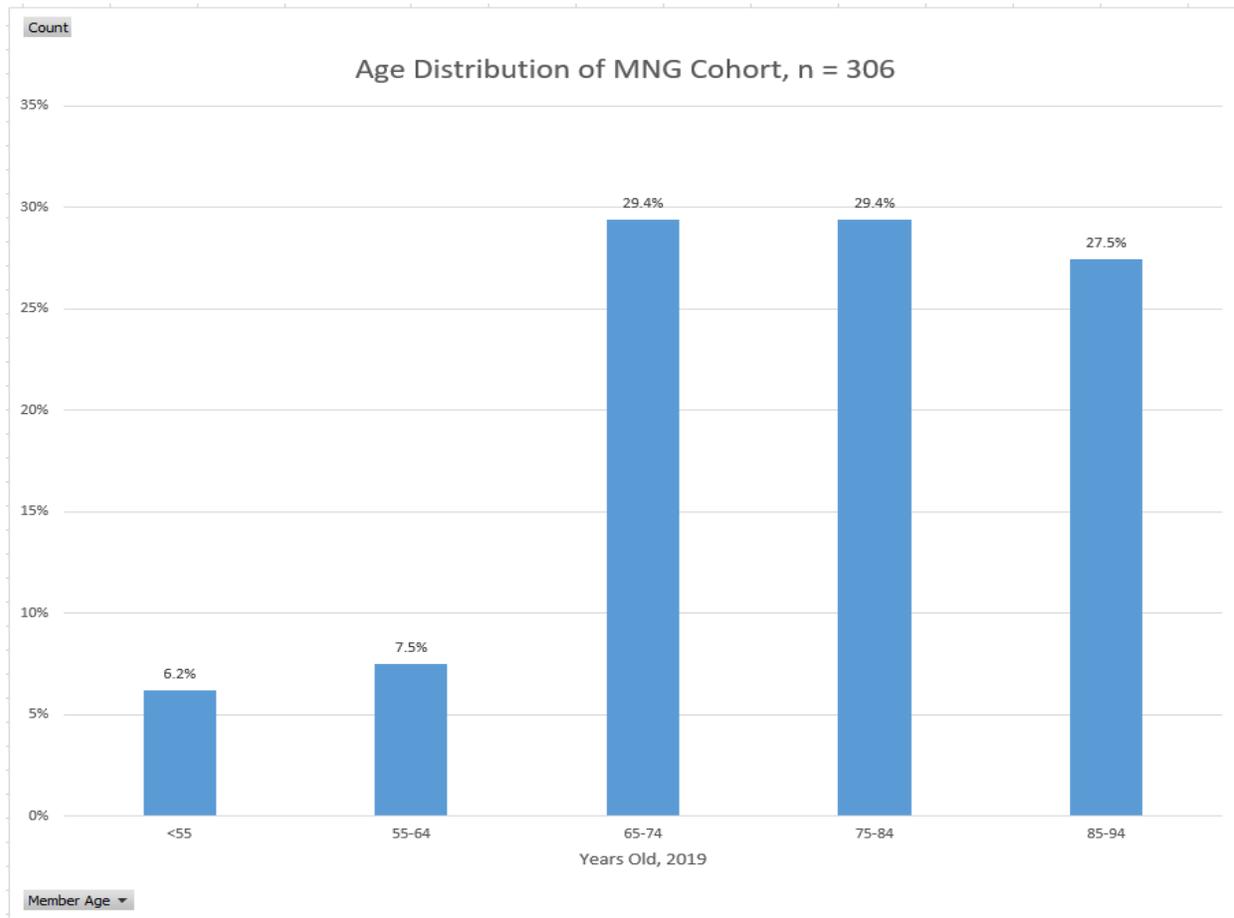
## Key Advantages

- 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

# Extend Moderate-Needs Supports Vermonters Served



# Extend Moderate-Needs Supports Vermonters Served



# Extend 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

# Extend Moderate-Needs Supports Federal Support

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.

# 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- to 18-month implementation, a study summer of 2022 in time for the 2024 plan year.

# 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 by supporting practices to become Patient Centered Medical Homes
- Addresses mental health, substance use, and unmet social needs with Community Health Team staff in practices

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

- \$9.4M for Community Health Team (CHT) staff capacity for care management
- \$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, seven were associated with favorable estimated cost and quality impacts:

### Three intervention components:

- Behavioral health
- Telehealth
- Health information technology

### Four 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

# Thank You

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