Blueprint for Health Report on Payments to Patient-Centered Medical Homes

Executive Summary

The Vermont Blueprint for Health is a statewide program that supports providers in delivering high quality, whole-person care that is evidence based, patient-centered, and cost-effective. The program's initiatives include multi-payer funding for primary care practices that have been recognized as Patient-Centered Medical Homes and regional Community Health Teams. In 2022, over 75% of Vermonters with claims submitted to the Vermont All Payer Claims Database visited Blueprint for Health affiliated practices.

Support for Blueprint initiatives has taken the form of per-member per-month payments from Medicaid and commercial insurers since 2010. Act 51 of 2023 requires that the Blueprint for Health report on any increases to the amount of these payments and evaluate the potential to support Blueprint initiatives through the health care claims tax. This report suggests increasing the payments made by commercial insurers to parity with those made by Medicaid. The report also discusses different mechanisms for contributions on behalf of commercial insurers, including using the health care claims tax to equitably collect and distribute these payments.

1. Introduction

Act 51 of 2023 requires that the Blueprint for Health report on *"...the amounts by which health insurers and Vermont Medicaid should increase the amount of the per-person, per-month payments they make to Blueprint for Health patient-centered medical homes...."* In addition, Act 51 requires this report to include an evaluation of *"potential mechanisms for ensuring that all payers are contributing equitably to the Blueprint on behalf of their covered lives in Vermont, including a consideration of supporting Blueprint initiatives through the health care claims tax established in 32 V.S.A. chapter 243."*

The Vermont Blueprint for Health is a statewide program that supports medical professionals in delivering high quality, whole-person care that is evidence based, patient-centered, and cost-effective. The program's initiatives include multi-payer funding for primary care practices that have been recognized as Patient-Centered Medical Homes (PCMHs) and regional Community Health Teams (CHTs). Primary care practices become recognized as PCMHs after meeting rigorous quality standards, while CHTs provide additional staffing and support to address the needs of PCMH patients. In addition, CHTs complement the Vermont Chronic Care Initiative (VCCI) and provide care coordination services to Vermonters who may not qualify for VCCI. In 2022, over 330,000 Vermonters visited Blueprint PCMH primary care practices, making up over 75% of Vermonters with medical claims submitted to the Vermont All Payer Claims Database (VHCURES).

Since 2013, Blueprint initiatives have had a demonstrated impact on healthcare utilization and costs. In a 2023 internal study of the prior four fiscal years of claims data reported to VHCURES, the Blueprint team found the following among key insights into the effectiveness of the initiatives.

- Patients attributed to Blueprint PCMHs had an average of $2,600 less in annual medical and pharmacy claims costs per person compared with patients attributed to non-Blueprint primary care practices.

- The annualized rate of increase of overall medical and pharmacy claims was 1.6% for Blueprint attributed individuals compared to 1.9% for non-Blueprint attributed individuals (not adjusted for inflation).
- A higher proportion of Blueprint attributed individuals visited their primary care practitioner each year; this finding is statistically significant at the p=0.01 level.

These findings reflect the continued positive impact of Blueprint PCMH and CHT initiatives on both the cost and the quality of primary care in Vermont that was first explored in a collaborative paper published in 2016 [1].

Sustaining these initiatives necessitates supporting practices to meet the rigorous quality standards required to become PCMHs. The cost to earn and maintain PCMH status varies depending on the size of the practice but is nontrivial. A 2019 Milliman report estimated an annual cost of between $13,000 and $16,000 per clinician for a practice to maintain certification as a PCMH [2]. In 2015, a paper studying PCMHs in Utah and Colorado found that practice costs to maintain PCMH recognition ranged from $3.85 to $4.83 per-patient per-month [3]. This report will discuss options for practice payments to Blueprint affiliated PCMHs to support continuation of the PCMH program and its quality care in Vermont.

2. Current Practice Payment Methodology

The Blueprint PCMH initiative is supported through per-member per-month (PMPM) payments made to practices by insurers, including Medicaid, Medicare, and commercial insurers. These payments are intended to provide support for practices to maintain PCMH status. Currently, Medicaid pays $4.65 PMPM, commercial insurers pay $3.00 PMPM, and Medicare payments are negotiated annually. Commercial insurers and Medicaid also contribute a performance payment of up to $0.50 PMPM based on the practice's improvement in health care resource utilization and quality; this payment is separate from the PCMH payment and averages $0.30 PMPM.

Since the start of payments to support PCMHs in 2010, payment rates for Medicaid and commercial insurers have only changed twice. In 2016, the PCMH payment rate was set to $3.00 PMPM for both Medicaid and commercial insurers. The Medicaid rate was increased to $4.65 PMPM in 2019, while commercial insurers continue to pay $3.00 PMPM. Based on the Consumer Price Index, the commercial insurer contribution has lost 22% of purchasing power since it was set in 2016, causing strain on practice resources used to keep up with evolving PCMH standards.

The Blueprint for Health recommends creating parity between Medicaid and commercial insurer contributions before considering another increase in Medicaid PCMH payments. Once parity is achieved, attention may be turned to constructing a sustainable method to ensure all insurers' practice payments keep pace with inflation.

A second priority for PCMH payments is to ensure that contributions are being made on behalf of all covered populations. Currently, some commercial insurers are not issuing any payments for Blueprint initiatives and no commercial insurers contribute to the CHT Expansion Pilot, Spoke Opioid Use, or Pregnancy Intention initiatives. In addition, payments are not made by third-party administrators of self-funded health plans or Medicare Advantage plans. Discussion with the Department of Financial Regulation indicates that there is potential to require third-party administrators to contribute to Blueprint payments (see Appendix A for DFR summary on the issue). Legislative clarification may be necessary to ensure equitable participation by all insurers and plan types.

3. Options for Future PCMH Payments

Several options exist to bring Medicaid and commercial PCMH payments to levels necessary to sustain the program. These can be divided into short- and long-term considerations, allowing for both immediate implementation of measures to correct inequity between payments made by Medicaid and commercial insurers and ongoing improvement to the payment methodology.

3.1 Short-Term Priorities

The short-term goal to create parity between Medicaid and commercial insurers may be achieved by two steps:

1. Increasing the commercial insurer PCMH payment to $4.65 through a two-year increase of $0.83 in FY2025 and $0.82 in FY2026.
2. With input from the Department of Financial Regulation, implementing legislative clarification of contributions by third-party administrators of self-funded plans and a renewed focus on engaging all commercial insurers in all Blueprint initiatives.

These initial measures have no direct cost to the state as they do not include an increase to Medicaid PCMH payments. Indirect costs include staff time devoted to communication and discussion with insurers for implementation, which is part of the ordinary scope of staff work.

The increase in commercial insurer PMPM may impact insurance premiums. Insurers account for Blueprint contributions in different ways, depending on their actuarial processes and the insurance product. Based on the 2022 and 2023 actuarial memorandums provided to the Green Mountain Care Board by major commercial insurers, most major insurers utilize a direct application of 50% to 100% of the PMPM in the formulae used to calculate premiums. For some insurance products, there is no direct application of Blueprint PMPM fees to premiums; they are instead grouped with other taxes and fees. For insurers who use a direct application of the entire Blueprint contribution to premiums, the increase in PMPM would cause a corresponding increase of $1.65 per month in insurance premiums. This increase represents less than 0.22% of the total monthly premium for most insurance products and would bring total Blueprint contributions to between 0.7% and 0.9% of monthly premiums, depending on the insurance product.

The two-step, two-year plan to achieve parity between Medicaid and commercial insurer contributions for the PCMH program will support the high-quality standard of care provided by Blueprint PCMHs to Vermonters while preventing a tax increase and minimizing impact on the Medicaid budget. Once this goal has been accomplished, the final step to achieve parity between Medicaid and commercial insurer contributions is to ensure commercial insurer support of all Blueprint initiatives. This may be achieved by further legislation and engagement with insurers, or through another means. After parity in contributions is attained, attention may be turned solutions to ensure that Blueprint PCMH and CHT payments keep pace with increasing costs in staffing and programmatic requirements.

3.2 Long-Term Considerations

Continuing support for Blueprint initiatives, including the PCMH and CHT initiatives, should take a form that adjusts regularly for inflation since these initiatives support staff who provide critical services to Vermonters. One option for achieving this goal is funding the Blueprint initiatives through the health care claims tax.

The goals of standardizing commercial insurers' contributions to Blueprint initiatives, ensuring all insurers contribute to all Blueprint initiatives, and ensuring the payments keep pace with inflation may be accomplished by collecting these contributions through the health care claims tax. The health care claims tax, authorized by 32 V.S.A. 243, currently levies a 0.8% tax on all health care claims and is paid by commercial insurers. In 2022, this tax was paid by insurers on $2.32 billion in paid claims. Switching commercial contributions for PCMH payments, performance payments and CHTs to contributions through the health care claims tax would likely require an increase in the tax rate to replace these contributions. Current commercial funding for Blueprint initiatives, assuming the commercial payer PMPM rate is increased to match the Medicaid rate of $4.65 PMPM and including CHT payments, is approximately 0.53% of the total paid claims.

Currently, commercial insurers do not contribute to three of the Blueprint's initiatives, though commercially insured individuals utilize all Blueprint initiatives. If commercial insurers are required to contribute to all Blueprint initiatives, including the CHT Expansion Pilot, Spoke Opioid Use Disorder Treatment Centers (Spokes), and the Pregnancy Intention Initiative, the simplification of turning a variety of differing PMPM fees into a single tax may ease the administrative burden of these contributions. Including estimated costs of all Blueprint initiatives, replacing PMPM fees with the health care claims tax would require a tax of approximately 0.75% on claims. Table 1, below, gives a breakdown of all Blueprint initiatives, estimated commercial utilization, and the tax percentage of claims required to fund the commercial utilization.

Blueprint Initiative	**Estimated FY2024 Commercial Utilization**	**Equivalent PMPM Contribution***	**Percentage of Health Claims to Match**
PCMHs	$7,300,000.00	$4.65	0.32%
Performance Payments	$500,000.00	$.30	0.02%
CHTs	$4,300,000.00	$2.77	0.19%
CHT Expansion Pilot^	$3,100,000.00	$1.94^	0.13%
Pregnancy Intention Initiative^	$400,000.00	$0.23^	0.02%
Spokes^	$1,700,000.00	$1.09^	0.07%
TOTAL	**$17,000,000.00**	**$10.98***	**0.75%**

Table 1: Estimated Commercially Attributed Costs of Blueprint Initiatives and Equivalent Health Claims Tax to Match. *Based on currently participating commercial insurers only. ^Commercial insurers currently do not contribute to these programs.

Changing commercial insurer contributions from separately paid PMPMs to the health care claims tax would simplify the contribution process for commercial insurers, ensure all insurers are contributing equitably to the Blueprint initiatives, and allow payments to automatically adjust for inflation as health claims adjust for inflation. Based on the recent actuarial memorandums, most insurers use an application of taxes and fees to insurance premiums based on the estimated claims cost of an individual. Actuarial memorandums submitted to the Green Mountain Care Board in 2022 and 2023 give a range of these estimated claims costs of $700 to $800 per member per month, resulting in the addition of a claims tax of approximately $5.62 to the monthly premium paid by Vermonters.

Because the health claims tax is paid by all insurers, the tax results in an estimated $5.62 PMPM cost to commercially insured Vermonters to support all current Blueprint initiatives, significantly less than the equivalent $10.98 PMPM payment otherwise required and less than the FY2024 $6.07

PMPM paid by Vermonters with insurance through participating commercial insurers. This difference is because commercial insurers are only contributing to Blueprint initiatives on behalf of approximately 110,000 Vermonters, yet over 210,000 Vermonters are commercially insured. The gap in participation is caused by smaller insurers and third-party administrators of self-funded insurance plans not contributing to Blueprint initiatives.

If the tax was designed to include support for all Blueprint initiatives, premiums for some Vermonters may increase by a small amount, as some commercial insurers do not currently participate in these payments. Simultaneously, premiums for Vermonters currently part of contributing health plans may decrease. However, since the health care claims tax is paid by all insurers, the impact would be less for all Vermonters than the equivalent increase caused by concentrating this amount on the three insurers currently contributing to Blueprint initiatives.

Furthermore, the lower rate of growth of health care claims costs for Blueprint attributed patients suggested by the previously cited evaluations may help offset the impact of the health care claims tax increase on the premiums of insured Vermonters. Patients attributed to Blueprint affiliated practices showed a 0.3% lower annualized rate of health care claims growth than those attributed to non-Blueprint affiliated practices over the past four years. Computations based on claims costs given in the recent actuarial memorandums suggest that this could reduce premium growth by $2.08 in the first year and up to $4.17 in the second year, countering the estimated increase in premiums due to the tax.

One consequence of utilizing the health claims tax to collect commercial payments for Blueprint initiatives is the additional administrative burden this approach places on the State. As the State would have to administer the payment amounts, this approach would require the establishment of funding flows from the Department of Tax through the Agency of Human Services and to Blueprint for Health regional Administrative Entities and practices. While establishing this funding flow would result in additional work for the State, once established, the mechanism may make up for this drawback in uniformity of application of Blueprint payments to all insurers and automatic adjustments with inflation.

Vermont is exploring the potential to participate in a new federal alternative payment model proposed by the Centers for Medicare and Medicaid Services (CMS), the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. The shift to a tax-based methodology would align with one of the important goals of the AHEAD model, increasing investment in primary care by providing an immediate, clear, and achievable all-payer primary care investment target.

4. Conclusion

Blueprint for Health initiatives have proven efficacy in controlling health care costs and delivering high quality care to Vermonters. These initiatives are currently funded via PMPM contributions by Medicaid and some participating commercial insurers, although commercial insurers only contribute to the PCMH and original CHT initiatives.

The commercial insurer PCMH contribution has not kept pace with inflation and remains $1.65 PMPM below the Medicaid payment. To continue supporting PCMH practices, the Blueprint recommends creating parity between commercial and Medicaid contributions via a two-step increase to bring the commercial PCMH contribution to $4.65 PMPM, equivalent with the Medicaid

PMPM. The increase may be phased in with an increase of $0.83 in the first year and $0.82 in the second year. By making this increase, Vermonters insured by commercial insurance may experience an increase in insurance premiums of approximately $1.65 per month but would avoid an increase in taxes necessary to support an increased Medicaid payment.

Secondly, the Blueprint encourages consideration of equitable funding mechanisms to ensure all commercial insurers are contributing to all Blueprint initiatives. This may require alterations in legislative language to support the additional initiatives or a reconsideration of the PMPM as a funding mechanism. Currently, commercial insurers are required to contribute by statute; however, the Blueprint lacks any leverage to enforce this contribution mandate for smaller insurers, those who insure primarily as third-party administrators for self-funded insurance plans, or those who insure primarily through Medicare Advantage plans. In addition, no commercial insurers fund the CHT Expansion Pilot, Spoke, or Pregnancy Intention initiatives, forcing the burden of supporting these initiatives onto Medicaid alone.

Achieving the second aim may be done via additional support in legislation or by funding Blueprint initiatives through the health care claims tax. The latter approach would require a tax of approximately 0.75% on health claims and require the State to administer the funding. This approach would allow for the elimination of commercial PMPM payments, alleviate the administrative burden on insurers, and ensure equitable contributions on behalf of all insurers in alignment with the AHEAD model. The overall financial impact on commercially insured Vermonters would be approximately $5.62 per month, replacing the $7.72 per month otherwise levied on only half of commercially insured Vermonters, which does not support all initiatives.

The Blueprint encourages careful consideration of options for creating a sustainable payment methodology for supporting all Blueprint initiatives that results in equitable payment by commercial insurers and regular adjustments for inflation.

Appendix A: Department of Financial Regulation Evaluation of Commercial ERISA Plans

Currently, Blueprint initiatives are funded by per-member-per-month fees paid by insurers on the number of members covered by their health insurance plans. Commercial insurers are required by statute to participate in these payments, though many smaller insurers are not participating. In addition, these fees have not been extended to third-party administrators of self-funded health plans or to Medicare Advantage plans. Consultation with the Department of Financial Regulation indicated that there is potential to require such third-party administrators to participate in the Blueprint for Health; this potential is summarized below.

Under 8 V.S.A. §4088h, health insurers must participate in the Blueprint for Health as a condition of doing business in this State. Insurers must make "per-person per-month payments to medical home practices...for their attributed patients and for contributions to the shared costs of operating the community health teams." [18 V.S.A. §706(c)(1).] Because of the Supreme Court's ruling in *Rutledge v. PCMA*, it is likely that the requirement to financially support the Blueprint for Health could be extended to third-party administrators (TPA) of self-funded health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA includes a broad preemption clause that precludes state regulation of most self-funded employee benefit plans due to federal occupation of the field. [29 U.S.C. § 1144(a).] In *Rutledge*, however, the U.S. Supreme Court concluded that state laws "that merely increase costs or alter incentives for ERISA plans without

forcing plans to adopt any particular scheme of substantive coverage are not preempted by ERISA." [141 S.Ct. 474, 480 (2020).] Although *Rutledge* involved state regulation of pharmacy benefit managers (PBMs), it is likely the same logic would apply to any TPA of an ERISA plan – so long as the plan is not required to be structured in a certain way, an assessment that increases the plan's costs would not be preempted. [*Cf. PCMA v. Mulready*, No. 22-6074, slip op. at 28 (10th Cir. Aug. 15, 2023).]

The Department of Financial Regulation already has legislative authority under 18 V.S.A. §9417 to charge a $600 licensure fee for TPAs that are not otherwise licensed as an insurer or insurance producer. Vermont could model any legislation for financial support of the Blueprint for Health on Maine's regulation specifically requiring "Third-party administrators and carriers that provide only administrative services for a plan sponsor" to make payments to support the Maine Health Data Organization (MHDO). [90-590 C.M.R. Ch. 10, §2.]

References

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[2] Magill M K, Ehrenberger D, Scammon D L, Day J, Allen T, Reall A J, Sides R W, Kim J. "The Cost of Sustaining a Patient-Centered Medical Home: Experience from 2 States." *The Annals of Family Medicine* 2015; 13 (5): 429-435

[3] Philip S, Govier D, Pantely S, "Patient-Centered Medical Home: Developing the business case from a practice perspective." Milliman White Paper submitted to National Committee for Quality Assurance, 2019.
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