Vermont Blueprint for Health Manual

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Department of Vermont Health Access
Agency of Human Services
Blueprint for Health
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1 Introduction to Blueprint for Health Manual

1.1 Intent

The Blueprint is a state health care reform initiative focused on changing how health care is delivered. It provides Vermonters with integrated health and human services and advanced primary care. This nationally recognized program is implemented regionally with primary care practices, community health teams, community service providers, specialists, hospitals, and insurers. The Blueprint works with a broad range of stakeholders to implement a health services model that is designed to:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce or control the per capita cost of care.

that encompasses prevention services as well as integration of care and services for people with complex health and social needs. Supported by multi-payer participation, the Blueprint has built a foundation of advanced primary care based on the Patient-Centered Medical Home (PCMH) model and bolstered by multi-disciplinary Community Health Teams (CHTs) that provide care coordination and linkages to services across the care continuum and in the community. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators. This network is integral to facilitating local transformations and increasing collaboration across community partners.

This Manual is a guide for primary care practices, health centers, hospitals, payers, and providers of health services (medical and non-medical) to implement the Blueprint's Multi-payer PCMH model in their community, and to become part of a statewide Learning Health System.

For Blueprint policy sources, please see Title 18 V.S.A. Chapter 13, Sections 702-709 (available at https://legislature.vermont.gov/statutes/chapter/18/013), DVHA Rules 8100-8105.2 (PDF), and this Blueprint Manual.

1.2 Process for Updating Blueprint for Health Manual

Department of Vermont Health Access (DVHA) rules direct the process for amending the Blueprint for Health Manual. This Manual shall only be amended after a thorough public process for comment, discussion, and consensus building. The public input process shall include an internet posting of draft revisions to the Manual, distribution of the draft to the Blueprint Executive Committee, the Payer Implementation Work Group, and discussion of proposed Manual revisions at a minimum of two meetings of the Executive Committee. Written and oral comments on proposed Manual revisions may be submitted to the Department within 30 days of the internet posting of the draft.

2 ADVISORY GROUPS

2.1 BLUEPRINT EXECUTIVE COMMITTEE

Purpose: The Blueprint Executive Committee shall provide high-level multi-stakeholder guidance on complex issues. The Blueprint Executive Committee shall advise the Blueprint Director on strategic planning and implementation of a statewide system of well-coordinated health services with an emphasis on prevention. The Blueprint Executive Committee Members shall be selected to represent a broad range of stakeholders including professionals who provide health services, insurers, professional organizations, community and nonprofit groups, consumers, businesses, and state and local government.

Committee Make-up: The Blueprint Executive Committee shall include:

- the Commissioner of Health;
- the Commissioner of Mental Health;
- a representative from the Green Mountain Care Board;
- a representative from the Department of Vermont Health Access;
- an individual appointed jointly by the President Pro Tempore of the Senate and the Speaker of the House of Representatives;
- a representative from the Vermont Medical Society;
- a representative from the Vermont Nurse Practitioners Association;
- a representative from a statewide quality assurance organization;
- a representative from the Vermont Association of Hospitals and Health Systems;
- two representatives of private health insurers;
- a consumer;
- a representative of the complementary and alternative medicine professions;
- a primary care professional serving low-income or uninsured Vermonters;
- a licensed mental health professional with clinical experience in Vermont;
- a representative of the Vermont Council of Developmental and Mental Health Services;
- a representative of the Vermont Assembly of Home Health Agencies who has clinical experience;
- a representative from a self-insured employer who offers a health benefit plan to its employees; and
- a representative of the State employees' health plan, who shall be designated by the Commissioner of Human Resources and who may be an employee of the third-party administrator contracting to provide services to the State employees' health plan.

Member Responsibilities: Members are expected to attend all meetings; however, occasional circumstantial absences are accepted.

2.2 Blueprint Payment Implementation Work Group

Purpose: The purpose of the Blueprint Payment Implementation Work Group is to implement payment reforms that support PCMHs and CHTs, design the payment mechanisms and patient attribution strategies, make modifications to payment methodologies over time, and make recommendations regarding payment to the Blueprint Executive Committee.

Work Group Makeup: The Blueprint Payer Implementation Work Group is composed of, but not limited to, the following individuals:

- Representatives of participating health insurers (public and commercial)
- Representatives of participating PCMHs and community health teams
- Administrative and project management leadership in each Health Service Area
- Commissioner of the Department of Vermont Health Access or designee

Meeting Frequency: The Blueprint Payer Implementation Work Group shall meet no fewer than six times annually. The work group shall comply with open meeting and public records requirements. Meeting schedules, work group membership, minutes and updates shall be posted at: https://blueprintforhealth.vermont.gov/workgroups-and-committees/payment-implementation-workgroup.

Member Responsibilities: Members are expected to attend all meetings; however, occasional circumstantial absences are accepted.

3 Health Service Area Organization

3.1 Administrative Entity

Key stakeholders in each health service area (HSA) must agree upon and identify at least one administrative entity accountable for leading implementation and ongoing operations of the Blueprint program and related health reform initiatives in their HSA. Lead administrative entities within each HSA will also receive multi-insurer payments to support hiring of Community Health Team staff and, therefore, must be Centers for Medicare and Medicaid Services (CMS)-eligible providers. 1.1 HEALTH SERVICE AREAS

3.2 Health Service Area Designation

To achieve statewide population health outcomes and clinical priorities, the Blueprint has focused on supporting communities to innovate and organize their health services. Thirteen communities or geographic regions, known as health service areas (HSAs), have emerged in Vermont. These health service areas are roughly based around the areas served by Vermont's hospitals and their associated primary care services and have significant overlap with State of Vermont human services districts and the regions served by the designated mental health and home health agencies. A listing of HSAs by town names is found in Appendix 6.

4 DESIGN AND IMPLEMENTATION

4.1 STATEWIDE HEALTH REFORM

The Vermont Blueprint for Health is a State of Vermont program created to work with health and human service providers to design, test, and implement innovative health care strategies. Goals include exploring new ways of delivering and paying for health services, implementing prevention projects targeting improved health for all Vermonters, and reducing growth in health care costs. To achieve these goals, the Blueprint works with local, state, and national partners to advance health care reform statewide.

Building on the PCMH and CHT model, the Blueprint program has expanded to include the Hub and Spoke System of Care for individuals with opioid use disorder and specifically supports primary care practices providing medication for opioid use disorder. The Blueprint also created the Pregnancy Intention Initiative (formerly the Women's Health Initiative) to ensure access to services that support pregnancy intention. In 2023, the Blueprint program further expanded to include a CHT Expansion Pilot Program to address mental health, substance use disorder, and social determinants of health within primary care.

Through the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement, specific target population health outcomes were set for Vermont to improve access to primary care, reduce deaths from suicide and drug overdose, and reduce prevalence and morbidity from chronic disease. To achieve these outcomes, OneCare Vermont, the participating ACO in the state, established clinical priorities with their members, and the Blueprint supports these efforts. Similarly, the Blueprint will support and help to implement subsequent statewide health reform efforts as directed by the Administration and the Vermont Legislature.

4.2 COMMUNITY COLLABORATIVES

To help coordinate efforts in each Health Service Area, a governance body and associated work group structure known as a Community Collaborative exists for achieving the state population health and health reform goals within the community.

The intent of the Community Collaboratives is to:

- understand the current health status of the residents of the Health Service Area, the costs of health care services used by those residents, and the structure of available health services;
- identify opportunities to improve health, lower costs, and improve the delivery of health care services;
- establish clear, measurable, and actionable goals for improvement;
- design, test, and implement interventions intended to achieve goals; and
- measure progress and outcomes in achieving established goals.

Community Collaboratives often use the Accountable Community for Health (ACH) framework, addressing the medical and non-medical needs that affect health outcomes, including social, economic,

and behavioral factors. These needs and the impact they have on population health are routinely referred to as the Social Determinants of Health. Interventions may include the integration of high-quality medical care, mental health services, substance use treatment, long-term services and supports, social services, and community-wide primary prevention efforts.

4.2.1 Community Collaboratives

Based on this breadth of focus, a local governance body in each health service area is structured to balance the interests and influence of the community and includes representation by medical, social, mental health, long-term support services, and public health leaders. The governance body of the Community Collaborative is comprised of the senior-level leaders from the major health service organizations and other significant community organizations in each health service area and typically includes one of each of the following:

- Hospital CEO or CEO's designated senior clinical leader from the hospital;
- Federally Qualified Health Center CEO or CEO's designated senior clinical leader;
- Senior clinical leader representing independent primary care practices;
- Senior clinical leader representing pediatric practices;
- CEO or CEO's designated senior leader from the home health agency;
- CEO or CEO's designated senior leader from the designated mental health and substance use disorder treatment agency;
- CEO or CEO's designated senior leader from the designated regional housing authority or organization;
- CEO or CEO's designated senior leader from the area agency on aging;
- Public Health District Director;
- Agency for Human Services (AHS) Field Director; and
- Blueprint Program Manager.

The Community Collaborative is usually led by the Blueprint Program Manager, although other AHS local leaders (AHS Field Directors, Public Health District Directors) may serve this function if agreed upon by community leaders. Additional members may be included as necessary to achieve the goals established by the community.

The governing body works across organizational boundaries to assess the outcomes in the Health Service Area, compare outcomes to state population health goals in a community health needs assessment, establish local goals, monitor progress towards those goals, creates plans and workgroups to achieve the goals, allocate financial and human resources from individual organizations to achieve collective outcomes, and jointly seek funding and support for local projects. The Blueprint Program Manager often facilitates Community Collaborative meetings and workgroups in their HSA.

The governing body may establish project-based workgroups with representation across community organizations. These workgroups are responsive to the consensus-based vision of the governing body and work to design, test, implement, and scale interventions intended to achieve the goals and to measure intervention outcomes.

The Community Collaborative also provides local oversight and coordination for current health care reform initiatives and investments being made in the local HSAs.

4.3 Community Health Team

The Administrative Entity shall have primary oversight for the Community Health Team (CHT) including acting as the fiscal agent for CHT funding received by the insurers, maintaining a community health team plan which is shared with the Community Collaborative, and ensuring the CHT is fully staffed.

4.3.1 Community Health Team Staffing

In consultation with Community Collaborative advisors, community partners, and participating practices, the Program Manager shall update the CHT staffing plan annually. Community Health Team staffing detail shall be submitted to the State using the Blueprint portal. The CHT staffing information shall include a list of CHT staff, including roles, credentials, staffing locations, and FTEs. The State may request this information as part of HSA quarterly reports.

4.3.2 Community Health Team Budget

The Program Manager shall maintain an active budget for CHT staffing and operations, including the ratio and actual expenses of clinical time to administrative cost, and shall share this budget via the Community Collaborative to obtain community agreement on the CHT staffing plan and the intended allocation of available resources and funding. This budget shall be provided to the State upon request.

4.3.3 Community Health Team Evaluation

The Program Manager shall evaluate the effectiveness of the current CHT model using qualitative and quantitative methods for obtaining provider, consumer, and community stakeholder feedback. This evaluation will identify training needs and expected skills of CHT staff members. The Program Manager shall develop a mechanism for CHT communication back to primary care providers to monitor the status and resolution of referrals (e.g., documentation in the electronic health record).

4.3.4 Community Health Team Staffing

The Administrative Entity shall have primary oversight implementing the CHT staffing plan.

- The Administrative Entity will provide CHT staff based on the CHT staffing plan.
- The Administrative Entity will provide organizational support for the operations of the CHTs, including ongoing mentoring and supervision of team members. The Program Manager or a designated CHT Leader will be responsible for the day-to-day supervision of CHT staff members.
- The Administrative Entity will work collaboratively with the State to prepare and launch new initiatives and service layers as they arise. The Program Manager will coordinate recruitment and hiring or subcontracting of those resources according to State direction.
- Community Health Team vacancies, including those created when additional CHT funding becomes available through new initiatives, will be filled within 60 days. If this is not possible, the Administrative Entity must notify the State and changes to funding amounts could apply.

4.3.5 Community Health Team Integration

The Administrative Entity will ensure coordination of services and activities and collaboration between the CHT staff (supported by the multi-insurer payments) and additional service layers and care managers for targeted populations, such as:

- Medication for Opioid Use Disorder MOUD licensed, registered nurses and master's prepared or licensed mental health counselors, or social workers for office-based treatment of opioid use disorder;
- Pregnancy Intention Initiative (PII) licensed, master's prepared mental health professionals to work in PII practices;
- SASH® (Support and Services at Home) teams of wellness nurses and Community Health Workers throughout the state for Medicare and Medicaid beneficiaries living in affordable congregate housing and Medicare beneficiaries in surrounding communities for assistance with health promotion and aging safely at home;
- Vermont Chronic Care Initiative (VCCI) nurse case managers for intensive, short-term treatment of certain Medicaid patients;
- Commercial payer case managers;
- Recovery Centers;
- Agency of Human Services Field Service Directors;
- Designated Agencies;
- Parent Child Centers;
- Home Health and Hospice providers; and
- Other community partners.

Coordination of services and activities and collaboration between the CHT staff shall involve:

- Identification of case managers in the Health Service Area for different populations of patients;
- Determination of lead care coordinator for shared patients;
- Shared care plans and agreements for managing shared patients;
- Reciprocal referral protocols and methods of communication;
- Mechanisms for risk stratification and algorithms for determining which care managers will provide care for different patient populations and at what level of acuity and complex care needs;
- Care team conferences; and
- Team based care.

The Program Manager shall document and report to the State:

- Respective roles of all CHT-funded positions;
- Care management providers;
- CHT model evaluation results and specific plans to address gaps;
- Alignment with care coordination models;
- Clear referral protocols and methods of communication between area care management programs; and

- Well-coordinated and non-duplicative services for participants.

4.3.6 Medication for Opioid Use Disorder

Vermont's Hub and Spoke program for treating opioid use disorder has garnered national attention for its comprehensive approach to providing Medication for Opioid Use Disorder (MOUD). Hub and Spoke integrates programs providing higher levels of care (opioid treatment programs [OTPs], called "Hubs") with programs offering treatment in general medical settings (office-based opioid treatment programs [OBOTs], called "Spokes").

More detailed information about the MOUD program is found in Section 6.

The Blueprint, in collaboration with the Vermont Department of Health, offers training and support for practices to implement MOUD protocols with the help of Blueprint Practice Facilitators and learning collaboratives designed to advance prescriber and team knowledge and confidence in the provision of care. These opportunities provide Spoke nurses and counselors with the support necessary to implement best practices, design workflows in advance of seeing patients for MOUD, set up program protocols, and begin the process of providing team-based, patient-centered care for Vermonters with opioid use disorder.

4.3.7 Pregnancy Intention Initiative

Women and other people who can become pregnant receive substantial preventive care services in various settings. Through the Pregnancy Intention Initiative (PII) (formerly called the Women's Health Initiative), obstetrics and gynecology (OB/GYN) providers and Blueprint Patient-Centered Medical Homes provide enhanced social determinants of health screenings and access to comprehensive family planning counseling. PII providers also supply access to long-acting reversible contraception (LARC), as well as other effective methods of contraception. The Blueprint supports this model through staffing for specialty practices, training for LARC-insertion providers, and payments. The enhanced staffing allows effective follow-up through brief, in-office interventions and referral to services for mental health, substance use, inter-partner violence, and food and housing assistance. The PII helps ensure that OB/GYN providers, Patient-Centered Medical Homes, and community partners have the resources they need to help women and other people who can become pregnant be well, avoid unintended pregnancies, and build thriving families.

4.4 Blueprint Program Management

Each Administrative Entity receives a grant to hire a Blueprint Program Manager to oversee the Blueprint activities in an HSA. The Program Manager will be the primary local contact responsible for management of all programmatic and administrative components of the grant agreement. If more than one individual is sharing this role, a single point of contact will be named. If there is a vacancy, Blueprint leadership and the Administrative Entity will meet and plan for replacing the position.

4.4.1 Program Management—Program Monitoring

The Program Manager will meet regularly with a Blueprint Assistant Director, or a designee of the Blueprint Executive Director, either in-person or via video conference, according to a schedule established by the State. The Program Manager will follow duties spelled out in the HSA grant agreement, which include: preparing and submitting to the State quarterly reports describing program progress, successes, and challenges, and other duties as described in the HSA grant and Blueprint manual. The State reserves the right to request updates on specific activities within the Health Service Area either in advance of or during regularly scheduled meetings.

4.4.2 Program Management—State Meetings

The Program Manager will participate at regularly scheduled statewide program activities and meetings including, but not limited to:

- Blueprint Executive Committee meetings;
- Blueprint Payment Implementation Work Group meetings;
- Program Manager meetings;
- ACO Clinical Committees;
- Care Coordination Core Team meetings;
- Information Technology meetings;
- Bi-Monthly Spoke meetings;
- Bi-Monthly Pregnancy Intention Initiative meetings;
- Ad hoc meetings for new initiatives; and
- In-person meetings as required.

4.4.3 Program Management—Community Collaboratives

The Program Manager role includes supporting the Community Collaborative/ACH.

Support may include the following:

- Recruiting relevant committee members;
- Working with committees to set agendas;
- Recording decisions made during meetings;
- Monitoring progress on work to be completed by members between meetings, including what will be completed, by whom, and by when, and following up with members between meetings to ensure progress is being made;
- Identifying and preparing presenters prior to meetings;
- Ensuring effective communication between members during meetings; and
- Reporting progress of the Community Collaborative to committee and workgroup members.

4.4.4 Program Management—Practice Outreach and Participation in Health Reform

The Program Manager shall maintain ongoing relationships with all primary care (internal medicine, general medicine, geriatric medicine, family medicine, pediatric medicine), OB/GYN providers, and

substance use disorder treatment practices within the HSA. This includes at least annual outreach to non-Blueprint practices and ongoing outreach to Blueprint practices, in order to encourage their participation in the broad set of health reform initiatives (PCMH, CHT, MOUD, PII, self-management, and health reform initiatives) and Community Collaborative activities. Annual outreach shall include an in-person meeting with each practice, or, if the practice declines to meet, documentation of an electronic or paper memo.

The Program Manager shall:

- Assign, if the QI facilitator is hired by the Administrative Entity, each practice a QI facilitator. If the QI facilitator is contracted by the State, the Program Manager will work with the State to make the assignments;
- Integrate CHT staff into practice workflows;
- Invite practices to join the appropriate Community Collaborative workgroups;
- Keep practices informed of Community Collaborative workgroup projects; and
- Recruit practices to participate in statewide learning collaboratives and new health reform initiatives.

The Program Manager will monitor the status of each practice's participation as a PCMH, integration of the Community Health Team, participation in statewide and Community Collaborative quality improvement projects, implementation of the care model, MOUD, and PII. The Program Manager shall report on the status of each practice during monitoring meetings with the State and will report on any issues encountered by practices to the State and as they arise. The Program Manager will ensure alignment with other care coordination activities and requirements, serving as the local point person for communications between local care coordination teams and other care coordination teams, and providing project management support as needed for care coordination efforts in the HSA.

4.4.5 Program Management—Recruit Participation in Quality Improvement

In collaboration with the QI facilitators, the Program Manager will support primary care, OB/GYN, and MOUD delivery practices in implementing quality improvement initiatives by:

- Educating practices about the quality improvement services they are eligible to receive from participating in the Blueprint for Health;
- Providing access, interpretation, and quality improvement support or relevant reports about their patient population such as clinical and claims outcome measures, Emergency Department (ED) utilization, inpatient admissions, hospital readmissions, cost outcomes, patient experience survey results, and other relevant patient data;
- Evaluating practices' effective use of analytic resources that provide timely data to assess their performance and goals and to evaluate and address health trends and disparities for populations served, such as the practice's EMR functionality, immunization registry reports, prescription monitoring system reports, or other analytics tools;
- Discussing at check-in meetings progress on practice quality improvement projects aimed at improving direct outcomes for the patient populations served.

- Building referral processes and workflows to Blueprint-sponsored programs into primary care, OB/GYN, and Spoke practices, including a feedback loop back to primary care providers about the outcomes of program involvement;
- Providing education on and CHT staff support for key functions Patient-Centered Medical Home, Spoke, and Pregnancy Intention Initiative models, such as patient access, comprehensive screening and assessment, panel management, care management, care coordination, and mental health and substance use treatment integration, and navigation to services including providing resources on best practices and technical assistance as needed;
- Organizing learning events (using training funds to support speaker costs), such as providing logistical support for local meetings of participating practices and creating innovative opportunities for learning and shared quality improvement between participating practices;
- Developing and coordinating co-management and referral agreements with specialty providers and community services in the health home neighborhood (integrated community); including but not limited to self-management programs, mental health providers, SASH, Home Health, and service agencies (e.g. food programs, housing programs, etc.)
- Discussing at check-in meetings the progress of population quality improvement projects (between practices, specialists, hospitals, and community organizations) based on core clinical measures and State healthcare reform initiatives, including Blueprint and APM measures, ACO clinical priorities, and population health measures;
- Documenting and disseminating information on practice involvement and progress on quality improvement activities, for both reporting and learning purposes; and
- In association with the State, evaluating the effectiveness and experience of quality improvement offerings.

4.4.6 Program Management—MOUD and PII Practice Contacts

The Program Manager shall be in contact with all practices and programs providing Medication for Opioid Use Disorder (MOUD) within the Health Service Area on an at least quarterly basis to encourage their participation in the statewide “Hub & Spoke” Initiative. The Program Manager shall also be in contact with practices to encourage their participation in the Pregnancy Intention Initiative (PII). Program Managers will assist practices involved in these initiatives by coordinating hiring and deployment of Spoke and PII staff and supporting quality improvement projects to improve care and patient outcomes. The Program Manager will also collaborate with local leadership to encourage the recruitment of additional providers to offer MOUD and PII services.

4.4.7 Program Management—Health Reform Communication

The Program Manager shall be responsible for communicating directly with practices as frequently as necessary on changes in statewide health care reform policies and procedures, especially as they affect practice processes, participation requirements, Blueprint program payment levels and practice eligibility criteria, involvement in other State or national reform or billing efforts, and ACO activities. The Program Manager shall communicate updates received from the State in a timely fashion.

4.4.8 Program Management—Unified Performance Reporting and Data Utility

In the Administrative Entity's Health Service Area, the Program Manager shall coordinate, support, and partner with others in activities that strengthen data connections between Vermont's Health Information Exchange and practice and HSA level health information technology and data infrastructure.

4.4.8.1 Community Health Team Recording of Patient Encounters

To ensure coordination of care, CHT staff who are providing services to a patient on behalf of a practice or organization shall document that activity in that practice's or organization's clinical record to the extent possible. The Program Manager shall monitor CHT activities within the electronic health record, or patient record as applicable, and assess the effectiveness of the CHT in each region, including identification of areas for quality improvement, additional evidence-based interventions, and resource requirements.

4.4.9 Program Management—Payment Processes

4.4.9.1 Data Collection and Entry

The Program Manager shall have primary oversight and responsibility for data collection, data entry, and completion of reports as required by the State for the continuation of multi-insurer funded payments to the Administrative Entity to support CHT and to PCMHs within the Health Service Area.

Detailed information on providers, practices, and CHT administrative entities is required by commercial and public payers in order to implement enhanced payments. The State provides the Blueprint Provider Directory, colloquially known as the Blueprint Portal, to Program Managers as the data collection tool. Required information in the Portal shall be updated according to the following schedule:

CHT/MOUD/PII Staffing and Practice Information:	
Enter updated CHT/PII/MOUD staffing and Practice information. This includes practice closures, mergers, and openings, all provider information including credentials, NPI and start/end dates.	October 15 January 15 April 15 July 15
Monitor NCQA PCMH Recognition:	
Each quarter, the State shall notify and identify to the Program Manager a cohort of Practices which are scheduled to undergo NCQA PCMH recognition approximately 6 months in the future. For those identified Practices, the Program Manager, in partnership with the assigned Blueprint QI Facilitator, shall closely monitor and report on progress toward reviewing and updating policies, protocols, and practices for the reporting date,	October 15 January 15 April 15 July 15 (for each such date, with respect to

including indicating which Quality Improvement Projects/Measures are being selected as part of PCMH recognition. The Program Manager and QI Facilitator will ensure all appropriate Practice and provider information is updated in the Blueprint Portal (or other data reporting system) accordingly.	Practices identified to Subrecipient within the prior quarter)
Total Unique Patient Counts: For practices new to the Blueprint, enter Practice-level patient counts, which will be used to determine CHT staffing ratios. Update existing practices TUP, as necessary.	December 15 March 15 June 15 September 15
CHT Encounters Enter CHT encounter numbers by payer, Spoke and PII encounters TBD.	October 15 January 15 April 15 July 15

The Administrative Entity, via the Program Manager or designee, shall report practice changes such as, but not limited to, provider transitions or attrition, or practice billing national provider identifier changes or additions, to the State and all payers as they occur via the Blueprint Portal or other State-designated data system.

The Administrative Entity, via the Program Manager or designee, along with the assigned QI Facilitator, will assist practices to understand NCQA's Reportable Events Policy to ensure that any PCMH-recognized practice involved in a merger, acquisition, consolidation, or reorganization is reviewed within the required timeframe by NCQA to determine the transition's impact on the recognition status.

The State reserves the right to require the Administrative Entity to provide additional payment-related information or to require that the information described in this section be provided according to a different schedule or via an alternate set of data collection tools. Failure to meet deliverables associated with payment processes in a timely manner could lead to a discontinuation of funding for CHT, PCMH, and PII operations until the information is collected, updated, and submitted.

4.4.9.2 Payment Communication

The Program Manager shall be responsible for communicating updates on payment-related processes to practices as they occur based on updates received from the State. The Program

Manager shall also be responsible for working with practices and parent organizations to identify and communicate questions, concerns, risks, and issues to the State as they arise, with follow up completed as appropriate.

4.5 Patient-Centered Medical Homes

4.5.1 Definition

A Patient-Centered Medical Home (PCMH) is a primary care practice that has completed the program eligibility requirements outlined in this document, including achieving official recognition based on National Committee for Quality Assurance – Patient-Centered Medical Home (NCQA PCMH) standards.

Patient-centered medical homes are central to the advanced primary care model of the Blueprint. For low-risk patients, PCMHs promote healthy behaviors and preventive health screenings; for moderate risk patients, PCMHs assist with self-management support to prevent chronic diseases from progressing; for high-risk and very high-risk patients, PCMHs are an integral part of care teams, providing a lead care coordinator for people who have complex medical conditions.

Primary care practices receive per member per month payments in exchange for providing enhanced services as a PCMH, integrating a CHT into their practice, connecting to the health information technology infrastructure, and participating in the Community Collaborative efforts. The overarching goal, mandated in Act 128, is to extend the program to all willing primary care providers.

4.5.2 NCQA Recognition

Overview: The starting point for a practice to participate in the Blueprint PCMH Program is becoming recognized as a patient-centered medical home by the National Committee for Quality Assurance (NCQA).

With the support of a Blueprint Quality Improvement Facilitator, new practices work to understand, integrate/implement, and demonstrate. Once the practice achieves recognition as a PCMH from NCQA, they are required maintain their recognition status as Blueprint Patient-Centered Medical Homes on an annual basis through a process called Annual Reporting. The standards can be found on the NCQA website at http://www.ncqa.org. All transformation and annual reporting requirements for an upcoming calendar year are published by NCQA in July.

Cost: Participating practices are responsible for paying all required fees to NCQA for their review and recognition as a PCMH. HRSA will pay for the cost of renewal or new PCMH recognition for FQHCs who have notified HRSA via submitting a Notice of Intent in the Electronic Handbook System. http://www.ncqa.org/

Completion of the initial survey and submission of payment to NCQA on the Q-PASS Portal marks the start date of the NCQA recognition process. . From that date, practices have 12 months to meet and demonstrate core and credit requirements and enhanced PCMH payments can be initiated by the Blueprint for Health. Details regarding payments related to the PCMH program can be found in Section 5 of this manual.

4.6 Quality Improvement Program

The Blueprint for Health Quality Improvement program creates capacity, supports, and coaches primary and specialty care providers, practice staff, and community partners to achieve improved outcomes in:

- health and wellbeing;
- experience of care; and
- value of care.

The QI program facilitates practices and communities to achieve care transformation and implementation of selected models of care, improve quality measures (clinical, patient experience of care, and utilization), and improve health equity and reduce variation in outcomes. It does this through building ongoing relationships between stakeholders and Quality Improvement Facilitators that are flexible to individualized needs and connected to quality improvement efforts and priorities at the community and state levels.

4.6.1 Quality Improvement (QI) Facilitation

The Quality Improvement Facilitator will have the primary responsibility of coordinating quality improvement (QI) activities and projects at several primary care practices, specialty practices, and community collaboratives.

The Quality Improvement Facilitator will help engaging practices/organizations work through the continuous quality improvement process to:

1. Achieve, maintain, and continue improvement on practice transformation as a Patient-Centered Medical Home;
2. Meet Health Home criteria (Spokes);
3. Meet Pregnancy Intention Initiative requirements;
4. Meet standards and continue improvement on population health quality and payment reform efforts, defined by Blueprint, Green Mountain Care Board, State or Federal requirements, or Accountable Care Organizations (ACOs); and
5. Achieve and continue improvement on clinical, cost, or patient experience priorities identified by the practice.

Practices may choose to engage with a Blueprint for Health Quality Improvement Facilitator. Practices engaging in QI agree to meet with Quality Improvement Facilitators on a weekly, biweekly, or monthly basis and commit a quality improvement team to work through the quality improvement process in order to design, test, and implement changes in workflows, activities, and processes towards quality improvement aims.

Quality Improvement Facilitators will work with each engaging practice to:

- Assess the practice using quality improvement assessment tool(s) recommended by the State;
- Compile assessment and relevant data for the practice to assist with identifying potential opportunities for quality improvement;
- Assist a practice to convene a quality improvement team;

- Coach the practice through data-driven decision making, goal and priority setting, action planning, change management, and change measurement;
- Research best practices on quality improvement strategies to address problem areas or opportunities identified by the practice; and
- Engage expert consultation, share best practices, and/or connect practices with necessary resources to assist with achieving quality improvement aims.

The Quality Improvement Facilitators will help practices/organizations prepare for and maintain National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) or Patient-Centered Specialty Practice (PCSP) Recognition:

- Identify applicable clinical standards;
- Assess the practice's current workflows against standards;
- Develop a work-plan and timeline for achieving standards and/or recognition;
- Determine which current policies, processes, and systems meet the applicable standards and which do not;
- Provide guidance on what changes would meet the standard or improve the chance of recognition;
- Assist practices in assembling documentation needed for submission to NCQA or other accountable body; and
- Assist practices with submitting materials and support phone calls for recognition on an ongoing basis to NCQA or other applicable recognition body.

QI Facilitators will visit/meet with each of their assigned sites or organizations at least monthly. QI Facilitators will provide appropriate levels of consultation based on factors such as the practice's available internal and additional external resources and the length of time until the standards and/or QI goals are met. QI Facilitator Staff provide regular consultation in response to practice questions between meetings via phone and email.

To support communities, the Blueprint or other State Health Care Reform partners may host learning collaboratives or group learning activities for communities or healthcare affiliated organization. As required, QI Facilitators will:

- Help design and/or implement learning collaboratives or statewide learning activities;
- Participate in regularly scheduled planning meetings as frequently as once per week for up to 4 months prior to and during the collaborative;
- Assist practice teams participating in the learning collaborative to establish group goals and norms;
- Assess differences between how care is being delivered and best practices or clinical standards;
- Provide guidance on what changes would improve the identified measure of clinical process;
- Develop a work plan and timeline to meet between learning sessions and to implement quality improvement cycles with the current practices;
- Complete assigned deliverables between meetings. Deliverables may include researching best practices, developing power points, preparing data collection sheets, and producing tools to assist communities in implementing the target strategies; and

- Quality Improvement Facilitators will, during the period of a learning collaborative, develop expert level knowledge of the content area and QI processes. As they gain expertise, the QI Facilitator will provide peer-to-peer mentoring and support, which may include sharing information and examples of processes that have worked in other practices or communities, reviewing sample documents and quality improvement cycles from other facilitators and providing feedback, being available for shadowing opportunities, and hosting education sessions during facilitator and field staff meetings.

The QI Facilitator will also support Community Collaboratives/Accountable Communities for Health to improve performance on State health care reform priorities, including All-Payer Model objectives and ACO clinical priorities. QI Facilitators work with Community Collaboratives to:

- Research best practice clinical standards in the areas identified for improvement.
- Assess differences between how care is being delivered and best practices or clinical standards;
- Provide guidance on what changes would improve the identified measure or clinical process;
- Develop a work plan and timeline to implement changes to the current practices.
- Assist communities in identifying process measures to track whether the changes have achieved the intended outcomes; and
- Provide support when a QI Facilitator, Blueprint representative, or ACO or stakeholder representative identifies a need for facilitation.

A comprehensive list of services that a quality improvement facilitator may offer to a practice and/or community can be found in Appendix 7.

4.6.2 Quality Improvement Facilitator—Caseloads and Coverage

Quality Improvement Facilitators will be assigned to a set of practices and/or a geographic area of coverage. Quality Improvement Facilitators typically carry a caseload of between eight and fifteen practices; this number may vary depending on the level of engagement of the practices and specific focus areas of the Facilitator. Facilitators may be asked to provide coverage beyond their geographic areas to allow support for vacancies, scheduled time off, and fluctuating demands for Facilitation support in quality improvement activities.

4.6.3 Quality Improvement Facilitator—Requirements and Reporting

In order to provide QI support, QI Facilitators are expected to maintain expert level knowledge in Patient-Centered Medical Home (PCMH), Patient-Centered Specialty Practice (PCSP), and other standards, as applicable. QI Facilitators are also expected to develop expert level skills in QI processes and techniques, as well as a high level of knowledge of Vermont's Quality and Health Reform efforts.

QI Facilitators provide peer-to-peer mentoring and support to other QI Facilitators, ACOs, health care reform stakeholders, and Blueprint staff, based on expert level knowledge and experience in the NCQA PCMH and PCSP or other standards, which may include sharing information and examples of processes that have passed review, interpreting feedback from NCQA or another body, providing shadowing opportunities, and hosting education sessions during facilitator and field staff meetings.

QI Facilitators shall be responsive to other Facilitators, ACO, stakeholders, and Blueprint staff questions, providing consultation through phone, email, and meetings. QI facilitators are expected to attend facilitator meetings, field staff meetings, regional check-in meetings, and meetings with Blueprint staff as needed.

QI Facilitators are expected to submit all required QI plans and progress reports within the timelines specified in Blueprint grants/contracts.

4.7 Community-Based Self-Management Peer Support Programs

The Blueprint and the Vermont Department of Health maintain a Memorandum of Understanding to work closely together for the provision of Self-Management Programming through My Healthy Vermont workshops. While the Blueprint still provides the funding and oversight of the programming, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers (FQHCs). This partnership takes advantage of the additional funding and content expertise that exists within HPDP through the My Healthy Vermont program, and pairs it with Blueprint's influence at the local level.

5 Patient Attribution and Enhanced Payments

Two Blueprint-specific forms of payment shall be received from Blueprint-participating insurers, or payers, to support high quality advanced primary care and well-coordinated health services: payments to PCMHs and payments to support Community Health Teams (CHTs). The PCMH payment is made to primary care practices, contingent on their NCQA engagement or recognition under medical home standards. In effect, this represents a payment for the quality of services provided by the practice as assessed by the NCQA standards. The CHT payment is a payment to support community health team staff as a shared cost with other insurers. This represents an up-front investment in capacity by providing citizens with greater access to multi-disciplinary medical and social services in the primary care setting. Both are capitated payments applied to the medical home population.

Current Blueprint-participating payers in Vermont include Medicaid, Medicare, Blue Cross Blue Shield of Vermont (BCBSVT), MVP, and Cigna.

5.1 Patient-Centered Medical Home (PCMH) Payments

The Blueprint will provide payers with practice roster information received from practices and NCQA recognition status for all Blueprint practices. Payers will use the practice roster information to calculate claims-based Blueprint patient attributions for each practice, as specified in Appendices 1 and 3. Based upon the NCQA PCMH recognition status, as described earlier, the insurers will multiply the number of a practice's attributed beneficiaries by the appropriate dollar amount to generate a PCMH per member per month (PMPM) payment for each practice. This PCMH PMPM payment will be sent directly to the practice or parent organization. Updates to the patient panel lists will be based on claims attributions

and done on at least a quarterly basis. Upon request of the practices or their parent organizations, the payer will provide the list of attributed patients for review and reconciliation if necessary.

The definition of a “current active patient” is as follows: The patient must have had a majority of their primary-care visits in the primary care practice (based on claims codes) within the 24 months prior to the date that the attribution process is being conducted, in accordance with the algorithms presented in Appendices 1, 2, and 3. If a patient has an equal number of qualifying visits to more than one practice, they will be attributed to the one with the most recent visit. Patient attributions for members of Blueprint-participating self-insured plans will be included. Attribution is recalculated at least quarterly.

Each insurer will send a list of the number of attributed patients to each PCMH (or parent organization) when the attribution is first conducted or refreshed, providing an opportunity to reconcile differences. The insurer and practice should agree on the number of attributed patients within 30 days of the date that the insurer sends an attribution list to the practice in order to support an efficient and uninterrupted payment process.

In addition, each insurer will report practice level patient attribution to the Blueprint. At the beginning of each calendar quarter (generally within 15 days of the start of each calendar quarter), each insurer will send to the Blueprint a list of the counts of attributed patients and PCMH PMPM payments made for the prior calendar quarter, for Blueprint practices, broken out by practice (including Blueprint Practice ID) and payment month. This reporting will enable payment verification at the practice and Health Service Area levels across payers.

The per member per month (PMPM) payment for PCMHs is intended to help the practice, in conjunction with the Community Health Team, provide well-coordinated preventive health services for all their patients. At this time, the payment is in addition to any payment that the practice receives based on existing agreements (e.g. Fee-for-Service or ACO payments).

The PCMH PMPM payment is based on the number of patients that are attributed to the practice by each insurer. The attribution method used by all insurers is intended to determine the practice’s active caseload. At present, insurers attribute to a practice all patients that have had a majority of their primary-care visits (based on claims codes) at that practice in the last 24 months. Vermont’s insurers to apply these lookback periods based on their beneficiaries’ demographics, recommended health maintenance, and health related risks.

The PCMH PMPM payment is designed to support the operations of a Patient-Centered Medical Home and is contingent on each Blueprint practice’s engagement with NCQA and subsequent PCMH NCQA recognition, under medical home standards. The payer will provide the enhanced PCMH PMPM payment for all of its attributed patients in the practice. The algorithm to identify attributed patients for Commercial and Medicaid payers is presented in Appendix 3. Upon request of the practices or their parent organizations, the payer will provide the list of attributed patients for review and reconciliation if necessary. To calculate the total amount of the PCMH PMPM payment for each practice, the payer will multiply the number of attributed patients in the practice by the PCMH PMPM amount, determined by a composite of medical home recognition, collaborative participation, and performance, as described in Section 5.1.1.

The attribution methodology found in Appendices 2 and 3 are the current algorithms generated in collaboration with the Payment Implementation Work Group and approved by consensus by the Blueprint Executive Committee. The attribution methodology can be revised after seeking input from the Blueprint's Payment Implementation Work Group, Expansion Design and Evaluation Committee, and Executive Committee. The PCMH PMPM amounts can be revised if the applicable NCQA standards change; in addition, PCMH PMPM amounts can be changed by the Blueprint Director after seeking input from the Blueprint's Payment Implementation Work Group, Expansion Design and Evaluation Committee, and Executive Committee.

Payment for newly engaging practices or practices required to undergo new PCMH recognition (due to consolidation, merger, or acquisition) will be effective on the first of the month or quarter (dependent on payer) after the date that the Blueprint transmits the NCQA engagement date to payers. Changes in payment resulting from subsequent receipt of the key PCMH NCQA dates will be implemented by the payer on the first of the month or quarter after the NCQA dates are received by the payer from the Blueprint. Practices must maintain their NCQA PCMH recognition in accordance with NCQA's policies and procedures (except as otherwise specified in Section 5.3).

Exception for Medicare PCMH payments. Medicare PCMH payments will be fixed annually and based on the latest available All-Payer Claims Dataset (VHCURES) Medicare patient attribution counts and on All-Payer Model Accountable Care Organization shared-savings investments approved by the Green Mountain Care Board. This will occur until the end of the All-Payer Model.

5.1.1 PCMH PMPM Payment Model (Medicaid and Commercial Insurers)

The PCMH PMPM payment model is designed to more adequately fund medical home costs, and to directly align medical home incentives with the goals of the collaboratives and statewide healthcare reform efforts. For Medicaid and commercial insurers, the total capitated payment to medical homes is based on a composite of medical home engagement or recognition, collaborative participation, and performance. The outcome measures driving the performance component include a Quality Index comprised of core quality measures, and a Total Utilization Index. Improvement on these metrics, such as higher scores on the quality index and less variation on the utilization index, is directly aligned with the goals of Vermont's health reforms. The medical home payment model for Medicaid and commercial insurers includes the following elements:

- Base Component:
  - Based on NCQA engagement or recognition and Community Collaborative participation;
  - Requires successful engagement or recognition on current NCQA PCMH standards;
  - Requires active participation in the local Community Collaborative including orienting practice and CHT staff activities to achieve the goals that are prioritized by the local collaboratives. Minimum requirement is active participation with at least one priority initiative each calendar year; and
  - All qualifying practices receive a base payment of $3.00 PMPM (or more for Medicaid, as approved by that payer).

- Quality Performance Component:

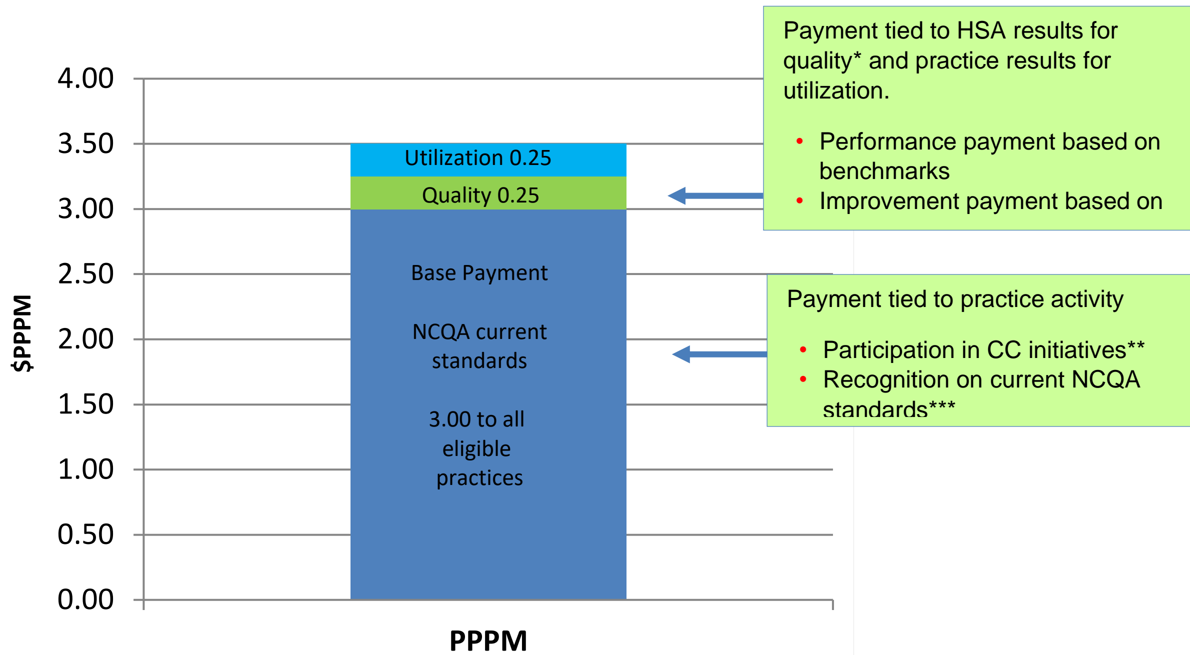
- Based on Hospital Service Area (HSA) results for Quality Index;
- Multiple payment levels up to $ 0.25 PMPM based on total score of the four quality performance measures;
- Points for each measure are achieved through meeting or surpassing benchmarks and through improving from one twelve-month period to the next twelve-month period; and
- Scores are reassessed annually based on the latest available valid measurement data.

- Utilization Performance Component:
  - Based on Practice results for Total Resource Utilization Index (TRUI);
  - Multiple payment levels up $ 0.25 PMPM for the top three quartiles with the lowest TRUI scores; and
  - Scores are reassessed annually based on the latest available valid measurement data.

Total Payment = Base + HSA Quality Performance + Practice TRUI Performance

Total Payment ranges from $3.00 to $3.50 PMPM for commercial payers (or a higher base payment for Medicaid, as approved by that payer).

Figure 2. Patient-Centered Medical Home (PCMH) Payments



*Incentive to work with CC partners to improve service area results.

**Organize practice and CHT activity as part of at least one CC quality initiative per year.

***Payment tied to engagement and subsequent recognition on current NCQA PCMH standards

The PCMH practice payment model is designed to promote collaboration and interdependent work by linking a portion of each practice's potential earnings to measure results for the whole service area (HSA). It is also intended to more directly focus efforts on improved health outcomes and reduced growth in health expenditures

The incentive structure that is woven into the payment model:

- Requires active and meaningful participation in community collaboratives including attention to variable and unequal outcomes on core measures and coordination with collaborative partners to improve services;
- Requires that practices engage and maintain NCQA recognition;
- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization);
- Rewards coordination with Community Collaborative partners to achieve better results on service area outcomes for a composite of core quality measures (directly links incentives for medical homes to statewide healthcare reform priorities); and
- Rewards coordination with Community Collaborative partners to achieve better practice results for the total resource utilization index (TRUI) (case mix adjusted), which has a predictable impact on healthcare expenditures (directly links incentives for medical homes to statewide healthcare reform priorities).

Opportunity to improve care and reduce variation. It is important to note that across Vermont there is significant variation in the results of quality and utilization measures after adjustment for important differences in the populations served. Unequal quality and utilization, for comparable populations with comparable health needs, provides an opportunity to examine differences in regional health services and to plan strategies that improve the overall quality of healthcare that citizens receive. The Blueprint currently publishes Profiles displaying adjusted comparative measure results for each hospital service area. The profiles include the results of core quality measures which have been selected through a statewide consensus process. The objective display of the variation that exists across service areas, and across practices within each service area, can support the work of the Community Collaboratives including identification of opportunities where quality and utilization should be more equal, and implementation of targeted strategies to reduce undesirable variation.

5.2 Community Health Team Payments

The purpose of Community Health Teams and of Community Health Team payments, is to serve the general population regardless of insurance status. The insurers will share the costs associated with the Community Health Team staffing and will send their share of CHT costs to the Administrative Entity or entities in each HSA that are responsible for hiring CHT members.

To estimate the size of the population that will be served by CHTs and the number of CHT members that will serve the population, participating practices and participating payers will calculate and report the number of active Blueprint-attributed patients seen in Blueprint practices in the previous two years. One of the goals of the CHT is to work with practices to optimize the number of patients that engage in preventive care and recommended health maintenance. The 24-month look back period is an attempt to estimate the number of active patients in a practice that can potentially be engaged in preventive care with effective outreach from PCMHs and Community Health Teams.

All participating payers will share in the cost of the CHTs, proportional to their share of the payer-reported, claims-attributed, Blueprint patient population (claims-attributed total unique patients). Patient volume and payer contribution proportions will be derived from the attribution and PCMH payment reports submitted quarterly by payers to the Blueprint, and payment calculation updates will be lagged by at least one quarter to allow for the receipt of complete attribution reports.

The State will ensure that there is at least one CHT in each of the Blueprint Health Service Areas (HSAs) in Vermont to provide support services for the population of patients receiving their care in Blueprint PCMHs. As the Blueprint continues to expand to all willing primary care practices and the number of patients changes, the size of and financial support for the CHT(s) in each HSA will be scaled up or down based on the number of patients in the Blueprint-participating practices that the CHT(s) supports in the HSA.

For purposes of the Blueprint payment specifications, “number of patients” means the number of total unique Vermont patients attributed to Blueprint-participating practices with a majority of their primary-care claims-coded visits to these practices during the previous 24 months. Appendix 2 contains the algorithm to be used by Blueprint practices to calculate and report total unique Vermont Blueprint patients, and Appendix 3 contains the algorithm to be used by payers to calculate and report total

unique Vermont Blueprint patients. Patient attributions for members of Blueprint-participating self-insured plans will be included.

CHT payments are scaled based on the population of payer-claims-attributed Blueprint patients per month (PMPM). Commercial and Medicaid payers will pay $2.77 per payer-claims-attributed patient per month (PMPM), and Medicare will pay approximately $2.47 per payer-claims-attributed patient per month (PMPM) dependent on approvals by the Green Mountain Care Board of prepaid Medicare shared-savings investments in Blueprint CHTs.

The payer will make CHT payments monthly or quarterly, as determined by the payer in conjunction with the Blueprint Director, upon receipt of an invoice sent by the CHT administrative entity to the payer (if an invoice is required by the payer) by the 15th calendar day of the month or the 15th calendar day of each quarter. Payers will not be required to make CHT payments for invoices more than 180 days past due. Invoices will reflect the administrative entities' CHT payments as determined by the Blueprint based on the total unique Vermont patients in Blueprint-participating practices. Changes in the amount of financial support due to scaling up or down of CHT capacity will be made by the Blueprint quarterly and will be reflected in invoices from the CHT administrative entity (if applicable) and payments from the payer.

The Blueprint will provide reports to the payers and to CHT administrative entities reflecting changes in total unique Vermont patients and CHT financial support for each HSA no later than the fifth business day of each calendar quarter. The information in these reports will be based on total unique Vermont patient data provided by payers to the Blueprint, based on claims attributions[1], using the algorithm in Appendix 3, or for new-to-Blueprint practices, based on practice self-reports of attributed patients using the algorithm in Appendix 2 and adjusted downward to account for the historically-observed average ratio of 1.85 practice-reported attributed patients for each payer claims-attributed patient. The Blueprint will also provide payers with a monthly practice roster and NCQA recognition status.

Payments supporting new CHT capacity will begin on the first day of the month or quarter after (or on which) the payer receives information from the Blueprint indicating that practices affiliated with the new CHT have either engaged with NCQA to undergo PCMH transformation or have carried over existing PCMH recognition (due to merger, acquisition, or consolidation of practices). As is the case for existing CHTs, the amount of financial support for new CHTs will be based on the number of total unique Vermont patients in Blueprint-participating practices. If the payer makes quarterly CHT payments, payment amounts will be pro-rated if a CHT begins clinical operations after the start of the quarter. Changes in payments related to scaling up or down of CHT capacity will begin on the first day of the quarter after (or on which) there are changes in the number of patients in Blueprint-participating practices.

CHTs under the same administrative entity within an HSA that are geographically dispersed throughout the HSA or otherwise segmented will be treated as a single CHT for payment purposes, regardless of the CHT's capacity and the number of patients in Blueprint-participating practices. If there is more than one

[1] In the absence of complete patient-attribution data from insurers broken out at the Blueprint practice level, the Blueprint will use the latest available practice-level patient-attribution counts derived from the Vermont All-Payer-Claims Dataset (VHCURES) to proportionally subdivide insurer CHT payments by HSA.

administrative entity in the HSA, the CHTs for each administrative entity will be treated as individual CHTs for payment purposes. In the event that there is more than one administrative entity, each practice in the HSA will be assigned to one CHT and one administrative entity; a practice will not be split among administrative entities and CHTs.

5.3 NCQA Recognition and PCMH PMPM and CHT Payments

To be eligible for Blueprint PCMH PMPM and CHT payments practices must engage and maintain NCQA Patient-Centered Medical Home recognition.

The start of the engaging process is defined by NCQA as the date that a practice submits their initial documentation and payment to NCQA on the Q-Pass portal.

5.3.1 Procedure for sustaining NCQA PCMH recognition and PCMH PMPM and CHT payments if current NCQA recognition lapses

If a practice does not maintain NCQA recognition as scheduled (due to either a voluntary, intentional postponement of the scoring date such that NCQA recognition will lapse, or failure to achieve recognition), the practice will develop an action plan with the State with a clear timeline for achieving subsequent recognition. For CHT payments to continue, the practice must share this action plan with the Blueprint Executive Director.

The action plan must have the following 3 components:

1) Identification of the reason(s) for the practice not achieving NCQA PCMH recognition;
2) A clear plan for targeted improvement with identification of parties responsible for the steps to take; and
3) A clear timeline for targeted improvement.

The action plan will be developed within 30 days of failure to achieve recognition, or within 15 days of the decision to postpone the scoring date resulting in NCQA recognition lapse.

Regardless of whether an action plan is developed, insurers will terminate practice PMPM payments on the last day of the month following the date on which NCQA recognition lapses, if the practice does not achieve recognition during that time period.

If an action plan is not developed as stated above, the additional CHT payments related to that practice's patients will end on the last day of the quarter during which NCQA recognition lapses. If an action plan is developed, the additional CHT payments related to that practice's patients will remain in place for the quarter following the date on which NCQA recognition lapses and will then decline by 25% for each quarter thereafter, until recognition is achieved, at which time full CHT payments and PCMH payments will be restored.

If the practice submits additional payment to NCQA for extended time for PCMH recognition, insurers will pay (or continue to pay) both PCMH PMPM and CHT payments for the practice, starting on the date of the payment to NCQA for extended time for PCMH recognition.

If the practice does not achieve recognition within the additional 90 day time period for extended recognition set by NCQA, insurers will have the option of recouping the practice's PCMH PMPM payments back to the date on which those payments would have ended (i.e. – the last day of the month following the date on which NCQA recognition lapsed).

6 SPOKE SYSTEM OF CARE FOR OPIOID USE DISORDER

The Hub and Spoke System of Care for opioid use disorder (OUD) is designed to create an integrated system between the two settings where Medication for Opioid Use Disorder (MOUD) is provided. In this system, both MOUD treatment settings coordinate with the broader health and human services systems. The two MOUD settings currently available in Vermont are: Opioid Treatment Programs (OTPs) where medications are dispensed and patients can be seen daily, and Office-Based Opioid Treatment (OBOT) practices where medications are prescribed, and patients are seen less frequently. The OTPs are addiction specialty programs best suited for patients who are experiencing a more severe course of addiction and/or who are best treated with methadone; they are often called "Hubs." The OBOTs in Vermont are called "Spokes" and may be outpatient primary care medical practices, or outpatient specialty medical practices including OB/GYN, psychiatry, or addictions practices.

6.1 HUB & SPOKE SYSTEM OF CARE

The Hub & Spoke system of care is supported by a Health Home State Medicaid Plan Amendment that provides categorical eligibility for Health Home services for Medicaid members with OUD. The Hubs are overseen by Vermont Department of health; the Spokes are overseen by the Blueprint for Health.

6.1.1 Staffing

The Blueprint directs Medicaid funds to support Spoke staffing through its existing Community Health Team payment structure with the Administrative Entities in each Health Service Area.

- Prescribers in Spoke settings are physicians, nurse practitioners, and physician's assistants;
- Spoke care teams include one nurse and one licensed mental health or addictions counselor per 100 patients. These Spoke staff provide specialized nursing, counseling, and care management to support patients in recovery; and
- The staffing model enhances care and supports primary care providers to balance MOUD patient care with the needs of their full patient panel.

Spoke RN	Spoke Counselor
• Assures patient has active relationship with PCP • Coordinates and provides access to high quality health care services according to evidence-based clinical practice guidelines.	• Must be either a licensed Social Worker, Mental Health Counselor, Marriage and Family Counselor, Psychologist, or other related Masters prepared and licensure recognized professional in Vermont.

Examples of healthcare issues that might be addressed: o Prevention of infectious diseases ▪ HIV/AIDS ▪ Tuberculosis ▪ STDs ▪ Hepatitis C • Additional indications for RN assessment, planning, intervention, and evaluation: o Pregnancy/Pre-natal Care o Parenting Skills o Tobacco use/cessation o Co-occurring Mental Illnesses o Dental Health o Chronic Illnesses: HTN, Diabetes, Obesity, CAD, Chronic Pain, Depression o Nutrition o Personal Hygiene • **Health Home Services:** o Comprehensive Care Management o Care Coordination o Health Promotion o Comprehensive Transitional Care ▪ ER Utilization ▪ Hospital Re-Admission o Individual Family/Support o Referral to Community Services o Referral to Community Health Team o Referral to Primary Care Provider	• Provides initial cognitive/behavioral risk assessments • Observes, describes, evaluates, and interprets behavior as it relates to substance abuse. • Constructs with client an action plan based on client needs • Counsels and works with patients to modify harmful, addictive behaviors/lifestyle • Facilitates and supports the client's choice of strategies that maintain treatment progress and prevent relapse • Conducts home visits as needed • **Health Home Services:** o Comprehensive Care Management o Care coordination o Comprehensive Transitional Care ▪ ER Utilization ▪ Hospital Re-Admission o Individual/Family Support o Referral to Community Services (such as transportation, housing, parenting supports, job skills) o Referral to Community Health Team o Referral to Primary Care Provider o Self-management skills • **HEDIS Measure (to be required):**

○ Self-management skills • **HEDIS Measures (To be required):** ○ Health Screenings ○ Tobacco Cessation Screenings ○ Controlling High Blood Pressure (Hypertension Control)	○ Depression Screening

All Spoke practices must utilize and implement the following:

- Program Manager will integrate Spoke staffing as part of the Community Health Team.
- Participate in Learning Collaboratives, training events, and other educational and networking opportunities.
- Regular communication and collaboration with their regional Blueprint Program Manager, especially if a Spoke practice is new and /or receives pass through dollars.
- Spoke practices are expected to connect the practice's electronic medical record to the Vermont Health Information Exchange and the clinical data warehouse at Vermont Information Technology Leaders (VITL) to allow clinical data to be collected, analyzed, and utilized for reporting and quality improvement purposes.
- Spoke practices will implement continuous quality improvement into the practice, including tracking Spoke practice data and conducting regular analysis to identify opportunities for interventions and improved outcomes.
- Full implementation and documentation of the required Health Home Services (HHS) and Health Home Measures (HHM).

6.1.2 Health Home Services

Medicaid members who receive MOUD at a Spoke must be provided with at least one health home service monthly. Non-Medicaid insured patients receive health home services based on their need, and the State's intent to treat the whole population. The Health Home services are detailed in table below.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,
4. Coordinate and provide access to mental health and substance abuse services,
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,
8. Coordinate and provide access to long-term care supports and services,
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Health Home Services Medicaid beneficiaries receiving MOUD are eligible for the following services. The services are detailed in the Affordable Care Act (ACA) and are designed to parallel the types of services and supports available in primary care patient centered medical homes. Vermont's Medicaid State Plan Amendment for the Hub and Spoke initiative offers these six Health Home services. These services must be documented in the clinical record of each Hub program and Spoke practice. CMS requires that Health Homes select from established HEDIS (Healthcare Effectiveness Data and Information Set) and other standardized measures to measure outcomes and quality. These measures include claims-based measures and "hybrid" measures. The hybrid measures require information from clinical records; as such need to be documented in the clinical records system of each Hub program and Spoke practice.

Claims-Based Measures:

There are additional standardized Health Home measures that are reported from claims data. Blueprint will generate these on behalf of Hub and Spoke Providers. The following Health Home Measures will be reported by Blueprint based solely on claims.

1. Colorectal Cancer Screening (COL)
1. Use of Pharmacotherapy for Opioid Use Disorder (OUD)
2. Prevention Quality Indicator 92: Chronic Conditions Composite (PQI92) (ACSC/Preventable Hospital Admissions) (PQI92)
3. Admission to an Institution from the Community (AIF)
4. Breast Cancer Screening (BCS)
5. Cervical Cancer Screening (CCS)
6. Follow-Up After Emergency Department Visit for Substance Use (FUA)
7. Follow-Up After Hospitalization for Mental Illness (FUH)
8. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
9. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
10. Inpatient Utilization (IPU)
11. Plan All-Cause Readmission (Avoidable/30-day Hospital Readmissions) (PCR)

12. Ambulatory Care: Emergency Department (ED) Visits (AMB)

Hybrid Quality Measures:

The following Health Home Measures include information from both claims and the clinical record. Blueprint Project Managers, participating Spoke practices, and HUBs shall design methods to capture this information in current EMR/Registry systems.

1. Screening for Clinical Depression and Follow-Up Plan – Percent screened for clinical depression using standardized tool with follow up documentation;
2. Tobacco Cessation Screening – Receipt of advice to quit smoking;
3. Tobacco Cessation Screening – Receipt of information on smoking cessation Medications; and
4. Controlling High Blood Pressure – Percentage with adequately controlled hypertension during the year.

6.1.3 Payments

Payments are based on the average monthly number of unique patients in each Health Service Area (HSA) for whom Medicaid paid a Buprenorphine or Vivitrol pharmacy claim during the most recent three-month period. This is designed to reflect the active caseload for each provider and for the region. The pharmacy claims include information that identifies the provider, the patient, and the medication prescribed. The total number of unique patients served is rounded to the next increment of 25 to arrive at a total count in the region for staffing purposes. For example, a count of 167 patients in active treatment is rounded to 175 for the staffing model. This allows staff to be hired and deployed increments of 50% Full Time Equivalent (FTE). The pharmacy claims show the unique member and associated provider allowing the Blueprint to establish a staffing ratio and associated funding amount for each Health Services Area. The staffing ratio is 1 FTE RN and 1 FTE Master's Licensed social worker, counselor, or drug and alcohol counselor per 100 Medicaid members with pharmacy claims for MOUD, as displayed in the table below. This results in a total funding amount and FTE staffing expectation for each Health Services Area. The current PMPM is $163.75. Blueprint will reduce the funding amount in the event of staff vacancies. The Blueprint Program Manager may request additional funding at the beginning of each quarter for planned expansions of caseloads or providers.

Spoke Staffing at 100 Medicaid Patients	**Total Estimated Annual Costs**
1 FTE RN Care Manager	$196,500
1 FTE Licensed Social Worker or Counselor	

The patient counts for each Health Service Area (HSA) are calculated annually and the Blueprint provides Medicaid with that calculation based on the above staffing cost model. Medicaid makes the payments to the lead administrative agent in each Blueprint Health Service Area as part of the Medicaid Blueprint Community Health Team payment every quarter. The Blueprint Program Manager in each HSA is responsible for organizing both the Community Health Team staff and the Spoke Staffing on behalf of the practices and programs in the region. The prescribers bill evaluation and management codes for seeing patients and the pharmacy claims are also billed as usual. Spoke staff do not bill for their services

as their salaries are supported by the Community Health Team payments. The Spoke RN and Counselor bring distinct and unique skills to the Spoke milieu. These skills are complimentary to each other and as a result create an interdisciplinary team that has the potential to engage the patient in an effective holistic treatment plan.

7 Pass-Through Funding and Waivers

7.1 Pass-Through Funding

The Department of Vermont Health Access makes monthly payments to 13 Administrative Entities to support Medicaid's portion of the Community Health Team (CHT), the Spoke staff, and the Pregnancy Intention Initiative (PII) staff. The local administrative entity, under the direction of the Blueprint Program Manager, is responsible for hiring and supervising the CHT, PII, and Spoke staff in collaboration with participating providers. The intention is to build integrated teams in each local Health Service Area that can address medical, mental health and substance abuse conditions, as well as social determinants of health risk factors.

The staffing ratios for each program (CHT, Spoke, and PII) often result in shared staff between participating providers. The Administrative entity may, at the discretion of the Blueprint Program Manager, create an agreement to "pass-through" funds to a participating provider organization that becomes the hiring entity for Spoke, CHT or WHI staff.

Provider(s) receiving pass through funding must be enrolled in the Vermont Medicaid Program and be in good standing with relevant licensing, professional boards, and with the Vermont Medical Practice Board. The provider(s) must have appropriate human resource systems to support interdisciplinary staffing. This includes recruitment procedures, job descriptions, qualifying credentials, performance review processes, and clinical and administrative supervision staff. The provider must demonstrate a clinical records system capable of documenting and reporting services and measures as required. The provider(s) must agree to reports as requested by the Blueprint Program Manager and Administrative Entity. A provider or specialty practice will consult with the Blueprint Program Manager on proposed staff hires. The allocation of pass-through staffing dollars is based on the overall needs of the HSAs and the PCP or Specialty practice's existing resources, workflows, capability to integrate staff into the facility. The decision about pass-through payments is the sole discretion of the Blueprint Program Manager in collaboration with the Blueprint Administrative Entity and Blueprint Executive Director as the accountability for the funding, staffing levels and credentials, Health Home program requirements, and development of the integrated local system of care rests with the Blueprint Program Manager and Administrative Entity.

7.2 Staffing Waivers for Spoke or PII Program

Requests for waivers for credentialing/staffing requirements must be made in writing by the Blueprint Program Manager to the Blueprint Executive Director and Assistant Director.

The staffing expectation for PII is a Licensed Mental Health staff.

The staffing expectation for Spoke sites is a RN and a Licensed Mental Health staff. There must be the 2 different credentials per 100 patients.

If there is a request to modify the staffing credential that requires waiver, the request should address the following:

- Why there is a request to hire or employ someone with a lower credential?
- What is the timeframe for employing the person of lower credential?
- Spoke If asking for utilizing one credential. Why are you unable to fill the counsleor/nurse?
- A summary of the candidate's work and education experience, and why the Blueprint Program Manager thinks he or she would be an appropriate hire.
- The candidate's resume and/or curriculum vitae (CV).

If the individual is unlicensed, there must be an indicated plan for this individual to receive sufficient clinical hours and supervision in order to obtain licensure. There could be other circumstances or specific difficulties hiring in some communities that the Blueprint team can review and discuss exceptions. The Blueprint Executive Director will review and respond to the request.

8 Pregnancy Intention Initiative

The PII helps ensure that health providers, primary care practices, and community partners have the resources they need to help women and other people who can become pregnant be well. This initiative includes supporting healthy pregnancies, avoiding unintended pregnancies, and building thriving families through enhanced screenings, brief in-office interventions, comprehensive family planning counseling and referrals to services for mental health and substance use disorders, interpersonal violence, food insecurity, and housing instability once identified. Persons who can become pregnant receive substantial preventive care services in various settings. A complete list of Vermont Blueprint practices that participate in the Pregnancy Intention Initiative is available with a link to their website.

8.1 PII Practices

Practices attest to implementing and maintaining the PII strategies (section 8.2) and receive PII payments (section 8.3). Eligible medical practices or clinics include:

- gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practices, specializing in providing OB/GYN health preventive services as defined by the American College of Obstetricians and Gynecologists (ACOG); OR
- mixed practices or clinics that employs at least one board-certified obstetric or gynecology provider whose primary scope of practice is OB/GYN preventive services as defined by ACOG.

8.2 PII Expectations and Strategies

PII strategies are identified to address the risks for unintended pregnancy and to improve the health of persons who can become pregnant and their children. The strategies focus on improving health and

reducing health risk, enhancing family planning services, addressing barriers to accessing most and moderately effective contraception, long-acting reversible contraception (LARC), and patients' contraceptive choices. Practices who choose to participate in the PII agree to implement and maintain the PII strategies. Blueprint Assistant Directors and the Community QI Facilitator meet regularly with Program Managers and key stakeholders to implement PII.

8.2.1 Expectations of Participating Practices

Participating practices sign and submit a Pregnancy Intention Initiative attestation form. The attestation form describes the expectations for participating practices and for adoption and implementation.

A participating practice will implement the PII based on their practice type:

- Blueprint PCMH practices will incorporate their Community Health Team member in support of PII goals and strategies that include screening, brief intervention and navigation to services.
- Specialty clinics will work with their Blueprint Program Manager to hire a mental health specialist who will be incorporated into the practice in support of PII goals and strategies.

All participating practices agree to:

- Provide Family Planning Counseling: The PII practice will update and/or implement a policy and procedure for evidence-based, comprehensive family planning counseling including implementing "One Key Question" or age-appropriate question and support around contraception; and
- Implement continuous quality improvement, including tracking PII practice data and conducting regular analysis to identify opportunities for interventions and improved outcomes.

8.2.1.1 Screening for Social Determinants of Health

The PII practice will screen PII patients for social determinants utilizing the CMS 10 as well as implementing screenings for substance use disorder, depression and suicide.

The PII practice will develop and implement policies and procedures for screenings. One Key Question or age-appropriate questions regarding pregnancy intention and contraceptive and STI care. Screenings should be conducted at least at the initial visit, annually, and post-partum.

8.2.1.2 Develop Referral Networks

PII PCMH practices will develop referral pathways with at least three (3) community-based organizations sharing information and goals of the PII program. The goal is to accept patients within one (1) week of being referred for family planning services.

PII specialty practices will develop referral pathways sharing the goals of the PII program with (1) patient-centered medical home (PCMH) primary care practice with the goal of accepting patients identified as not having a primary care provider.

8.2.1.3 *Stock LARC*

Within one (1) month of receiving the Per Member payment, the PII practice will stock the full spectrum of LARC devices at a level adequate for the practice size to ensure the availability of same-day availability for people who choose LARC as their preferred birth control method. The minimum number of stocked LARC devices shall be proportional to the number of patients served by the practice, as outlined in the table below:

Number of PII Patients	Minimum Number of Devices
up to 300	at least 5 devices, including 2 of hormonal IUD, 2 non-hormonal IUD, and 1 implant
300-499	at least 6 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
500-699	at least 9 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
700-799	at least 12 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
800-999	at least 15 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1000-1199	at least 18 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1200-1299	at least 21 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1300 or greater	at least 24 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant

PII practices that receive payment for more than two IUDs of each type and the one implant have the flexibility to choose among the available options to fulfill the needs of their patients after stocking the minimum requirement.

8.2.1.4 *Offer Same Day LARC Insertion*

The PII practice will develop and implement policy and procedures to provide same-day insertion for those who choose LARC as their preferred birth control method. PII

Training

The Blueprint will offer, at minimum twice per year, LARC Skills Based Training by a trained provider. Participating PII providers are offered a free accredited LARC insertion training. A typical training agenda includes:

- IUD Clinical Recommendations, Contraindications, Insertions, and Removals (didactic) (IUDs: Mirena, Kyleena, Liletta, Skyla, Paragard) by a qualified gynecologist;
- IUD Insertion and Removal Practice with VirtaMed GynoS™ Simulation Model 8; and
- Organon FDA – Approved Nexplanon Training. Certificate will be provided.

8.2.1.5 Reporting

PII practices are expected to connect the practice's electronic medical record to the Vermont Health Information Exchange and the clinical data warehouse at Vermont Information Technology Leaders (VITL) to allow clinical data to be collected, analyzed, and utilized for reporting and quality improvement purposes.

The PII practice will implement continuous quality improvement into the practice, including tracking PII practice data and conducting regular analysis to identify opportunities for interventions and improved outcomes.

The PII practice will submit Staffing and other specified reports each quarter, prior to the fifteenth (15th) day of the first month of each calendar quarter (January, April, July, and October). The BP Project Manager or designee shall enter and update PII staffing and practice demographics information in the Blueprint Portal.

At any time, the practice may be audited by the State.

8.3 PII PAYMENTS

PII practices shall receive up to three (3) Blueprint-specific forms of payment from Medicaid. These payments are to support the provision of high-quality primary health care and well-coordinated preventive health services for persons who can become pregnant ages 15 – 44.

Payments include:

- Recurring per member per month (PMPM) payments to PII practices;
- Recurring payments to support PII Community Health Team (CHT) staff to the CHT administrative entities for specialty practices. PCMH practices rely on existing CHT staff; and
- A one-time per member payment (PMP) to support stocking of Long-Acting Reversible Contraceptive (LARC) devices to all new PII practices.

8.3.1 PII Insurers or Payers

PII-participating insurers or payers include Vermont Medicaid and payers that voluntarily elect to participate in the PII.

8.3.2 Pregnancy Intention Initiative (PII) Attribution

PII payments are based on the total number of PII patients between the ages of 15 and 44 (inclusive) who receive services from each PII practice and who are beneficiaries of participating insurers. PII-participating insurers will calculate the total number of current active PII patients who are attributed to each PII practice. The same attribution methodology will be used for all three forms of PII payments and

includes a process for assigning providers to practices through a practice roster and attributing patients to each provider through health care claims as outlined below.

Practice Rosters: When a practice joins the PII and on-going as changes occur, PII practices will provide the Blueprint with a roster of the PII eligible providers within their practices. Eligible providers include physicians (MDs and DOs), advanced practice registered nurses (nurse-practitioners and certified nurse midwives), and physician assistants, who either:

- Work in a gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practice that provides OB/GYN preventive services as defined by ACOG; OR
- Work in a mixed-specialty practice as a board-certified obstetric or gynecology provider whose primary scope of practice is OB/GYN preventive services as defined by ACOG.

Quarterly, the Blueprint will provide the PII-participating insurers or payers a combined roster of PII providers and practices. The PII-participating insurers or payers will use the PII provider and practice roster information to calculate claims-based patient attributions of current active PII patients for each PII practice using the specifications outlined in Appendix 7.

Definition of a Current Active PII Patient: The patient must be female between the ages of 15 and 44 (inclusive). The patient must have had a majority of their OB/GYN preventive health visits in the PII practice within the 24 months prior to the date that the attribution process is being conducted, in accordance with the algorithms presented in Appendix 7 (for practice self-reports) and Appendix 8 (for PII-participating insurers). If a patient has an equal number of qualifying OB/GYN preventive health visits at more than one PII practice, then that patient will be attributed to the PII practice with the most recent visit. Patient attributions for members of Blueprint PII-participating self-insured plans will be included. Attribution will be refreshed at least quarterly.

Insurers Reporting of Attribution: Each PII-participating insurer, or payer, will send a list of the number of attributed patients to each PII practice (or parent organization) when the attribution is first conducted and subsequently when it is recalculated. Upon request of the practices, clinics, or their parent organizations, the PII-participating insurers, or payers, will provide the list of attributed patients for review and reconciliation. This process provides the opportunity for a PII practice to reconcile differences with each of the PII-participating insurers or payers. To support an efficient and uninterrupted payment process, the PII-participating insurer or payer and practice should agree on the number of attributed patients within 30 days of the delivery of the list.

Each PII-participating insurer or payer will also report attribution to the Blueprint. At the beginning of each calendar quarter (generally within 15 days of the start of each calendar quarter), each PII-participating insurer or payer will send the Blueprint a list of the counts of PII-attributed patients and PII practice PMPM payments made for the prior calendar quarter broken out by practice (including Blueprint Practice ID) and payment month. This reporting will enable payment verification and rollups across PII-participating payers at the practice and Health Service Area (HSA) levels.

The attribution methodology found in Appendix 7 (for practice self-reports) and Appendix 8 (for PII-participating insurers) are the current models generated in collaboration with the Women's Health Initiative Payment Implementation Work Group and approved by consensus of the Blueprint Executive Committee. The attribution methodology can be revised after seeking input from the Blueprint's

Payment Implementation Work Group and Executive Committee. The PII practice PMPM amounts can be revised by the Blueprint Director after seeking input from the Blueprint's Payment Implementation Work Group and Executive Committee.

8.3.3 PII Practice PMPM Payment

The PII practice PMPM payment provides operational support to a PII practice, including enhancing their scope of practice by implementing the PII Strategies. The total capitated payment to the practice is based on successful implementation of the PII Strategies in the first year. The PII-participating insurer or payer will provide the enhanced PII practice PMPM payment for all PII-attributed patients in the PII practice.

To calculate the total amount of the PII practice PMPM payment for each practice, the PII-participating insurer or payer will multiply the number of PII-attributed patients in the practice by the PII practice PMPM amount. Each participating practice will receive $1.25 PMPM upon successful completion of the self-attestation eligibility document and the successful implementation of the PII strategies, outlined in section 6.2 of this document.

PII practice PMPM payments will be sent directly to the practice, clinic, or parent organization. Payment for new practices or practices rejoining PII will be effective on the first day of the month following the date when the Blueprint confirms receipt of the self-attestation document to all PII-participating insurers or payers.

8.3.4 Supplemental PII Community Health Team (CHT) Payments

Supplemental CHT payments allow the CHT to hire licensed mental health professionals to work in PII practices. The PII-participating insurers or payers will share the costs associated with the supplemental CHT staffing and will send their share of CHT costs to the Administrative Entity in each HSA that are responsible for hiring CHT members.

Supplemental CHT payments are based on the population of attributed PII patients per month with the inclusion of a floor of 0.5 full-time equivalent CHT member per practice for smaller practices.[2] To calculate the total amount of the PII CHT PMPM payment for each CHT Administrative Entity, the PII-participating insurer or payer will multiply the number of PII-attributed patients in the practice by the PII CHT PMPM amount. PII-participating insurers or payers will pay $5.42 per payer claims-attributed member per month (PMPM).

CHT Floor: For practices with at least one (1) full-time equivalent OB/GYN provider and less than 600 attributed current active PII patients, a CHT floor or minimum CHT payment of $3,250 monthly (or $39,000 annually) was established with the intent of funding at least 0.5 full-time equivalent community

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[2] Supplemental CHT payments, and by extension the number of full time equivalent (FTE) supplemental CHT staff members, are intended to be equal to 1 FTE per $78,000 CHT payments based on an average licensed mental health professional yearly salary or 1 FTE per every 1,200 patients.

health team member per practice. For practices who are receiving payments based on the CHT floor, PII-participating insurers or payers will share in the cost of the monthly payment of $3,250, proportional to their share of the PII attributed patient population (claims-attributed total unique PII patients). PII-participating insurer or payer proportions will be derived retrospectively from the prior quarter PII practices' attribution. Practices that have less than one (1) full-time equivalent provider and less than 600 attributed PII patients will be pro-rated on a case-by-case basis. This CHT floor will not apply to Blueprint Patient-Centered Medical Homes (PCMH) with participating PII providers.

The PII-participating insurers or payers will make PII CHT payments on the same schedule as the PII practice payments. CHT payments will be made to the Blueprint Administrative Entity in the Health Service Area where the PII practice is located.

8.3.5 One-time Capacity Payment Per-Member Payment (PMP)

The purpose of the one-time capacity payment is to assist PII practices in initiating PII strategies and provide support to the practices as they design and implement processes to provide evidence-based family planning counseling on the full spectrum of birth control options, stock LARC devices, and offer same-day LARC insertion. The PII-participating insurers or payers will share the costs of the capacity payment and will send their share of the costs directly to the PII practices.

The capacity payment is a one-time per member payment (PMP) based on patient attribution. It includes a capacity payment floor or minimum payment for smaller practices and ceiling or maximum payment for larger practices depending on the total number of attributed lives. The payment amount for the one-time capacity payment is also dependent on whether a practice participates in the 340B pharmacy program.

Capacity Payment Floor: The capacity payment floor was established based on the cost of stocking at least two hormonal and two non-hormonal IUDs, and one implant. These 4 IUDs (two hormonal and two non-hormonal), and one implant comprise the minimum stocking requirement for PII practices (see section 8.2 PII Strategies). The capacity payment floor is pegged to the Medicaid reimbursement rates for the devices.

Capacity Payment Ceiling: The capacity payment ceiling was established based on covering the costs of stocking at least 8 non-hormonal IUDs, 8 hormonal IUDs, and 8 implants, yielding a total of 24 devices for each PII practice. The ceiling or maximum payment value is pegged to the Medicaid reimbursement rates for the devices.[3]

To practices whose PII patient attribution falls between the capacity payment floor and ceiling, PII-participating insurers or payers will pay a one-time capacity payment based on a per member rate. The rate will be calculated using the floor and ceiling LARC stocking guideline, and the rate amount will depend upon whether the PII practice is Medicaid 340B eligible. The PII-participating insurer or payer

[3] Medicaid reimbursement rates may differ for 340B Eligible and non-340B Eligible practices, yielding different capacity payment floors and ceilings.

will make the capacity payment one time, as determined by the PII initiation date set by the Blueprint for Health based upon the preferences of the PII practice.

If a new insurer joins the PII, a new PMP will be calculated for all practices based on the combined attribution for all insurers. The newly participating insurer will pay the difference between the initial PMP and new PMP. The payment made by the newly participating insurer will not exceed the per member payment based on that insurer's patient attribution.

8.4 Procedure for sustaining PII payments if practice lapses in implementing the PII strategies

It is incumbent upon the PII practices to implement and maintain the PII strategies in their practice. Annually, practices will attest to meeting the PII strategies and may be audited by the State or its designee. If a PII practice does not implement the strategies within one year after their PII initiation date or the timeline as designed in section 8.2, the PII practice and the Blueprint Assistant Director or designee will develop an action plan with a clear timeline for achieving compliance, if CHT payments are to continue.

The action plan must have the following 3 components:

1. Identification of the reason(s) for the practice not achieving compliance with their PII practice attestation,
2. A clear plan for targeted improvement with identification of parties responsible for the steps to take, and
3. A clear timeline for targeted improvement.

The action plan will be developed within 30 days after one year of participation in the PII.

Regardless of whether an action plan is developed, PII-participating insurers or payers will terminate PII Practice PMPM payments on the last day of the month following the practice's lapse. Payments will start again the first day of the month following a practice's implementing the PII strategies.

If an action plan is not developed as stated above, the additional PII CHT payments related to that practice's patients will end on the last day of the quarter during which the practice's year-long participation date falls. If an action plan is developed, the additional PII CHT payments related to that practice's patients will remain in place for the quarter following the date which the practice's year-long participation date falls and will then decline by 25% for each quarter thereafter, until the above criteria are met, (at which time full PII CHT payments will be restored).

8.5 Participation in the PII for Patient-Centered Medical Homes

Blueprint Patient-Centered Medical Home practices are encouraged to participate in the PII and are eligible for the PII PMPM and one-time capacity payment for their attributed Blueprint PCMH patients who are women between the ages of 15 and 44 years (inclusive). Attribution methodology for PCMHs can be found in sections 5.1 and Appendix 3. Practices that receive the CHT PMPM payments for their

Blueprint PCMH rostered providers are not eligible for the supplemental PII CHT payments for these providers.

Blueprint PCMHs who participate in the PII and receive the PII PMPM and PII PMP will attest to implementing and maintaining the PII strategies. As with other PII practices, the purpose of the PII PMPM payment and the PII one-time capacity payment is to assist PCMH/PII practices in initiating PII strategies.

The **PII PMPM payment** provides operational support to the practices, including enhancing their scope of practice by implementing the PII Strategies. The total capitated payment to providers is based on successful implementation of the PII Strategies in the first year with the addition of performance-based quality components of the payment in subsequent years. The PII-participating insurer or payer will provide the enhanced PII practice PMPM payment for all PII-attributed patients in the practice.

To calculate the total amount of the PII PMPM payment for each practice, the PII-participating insurer or payer will multiply the number of PII-attributed patients in the practice by the PII PMPM amount. Each participating practice will receive $1.25 PMPM upon successful completion of the self-attestation eligibility document and the successful implementation of the PII strategies, outlined in section 6.2 of this document.

The **PII one-time capacity payment** specifically provides support to the practices as they design and implement processes to provide evidence-based family planning counseling on the full spectrum of birth control options, stock LARC devices, and offer patients who choose LARC same-day insertion. The PII-participating insurers or payers will share the costs of the capacity payment and will send their share of the costs directly to the PCMH/PII practices.

The capacity payment is a one-time per member payment (PMP) based on patient attribution to the PCMH who are women between the ages of 15 and 44 (inclusive). It includes a capacity payment floor or minimum payment for smaller practices and ceiling or maximum payment for larger practices depending on the total number of attributed. The payment amount for the one-time capacity payment is also dependent on whether a practice participates in the 340B pharmacy program.

Capacity Payment Floor: The capacity payment floor was established based on the cost of stocking at least two hormonal and two non-hormonal IUDs, and one implant. These 4 IUDs (two hormonal and two non-hormonal), and one implant comprise the minimum stocking requirement for PII practices (see section 8.2 PII Strategies). The capacity payment floor is pegged to the Medicaid reimbursement rates for the devices and is reviewed quarterly.

Ceiling: The capacity payment ceiling was established based on covering the costs of stocking at least 8 non-hormonal IUDs, 8 hormonal IUDs, and 8 implants, yielding a total of 24 devices for each PII PCMH practice. The ceiling or maximum payment value is pegged to the Medicaid reimbursement rates for the devices.[4] Ceiling payments will be reviewed quarterly.

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[4] Medicaid reimbursement rates may differ for 340B Eligible and non-340B Eligible practices, yielding different capacity payment floors and ceilings. Both types of rates will be reviewed quarterly.

To practices whose PII patient attribution falls between the capacity payment floor and ceiling, PII-participating insurers or payers will pay a one-time capacity payment based on a per member rate. The rate will be calculated using the floor and ceiling LARC stocking guideline, and the rate amount will depend upon whether the PII PCMH practice is Medicaid 340B eligible. The PII-participating insurer or payer will make the capacity payment one time, as determined by the PII initiation date set by the Blueprint for Health based upon the preferences of the PII PCMH practice.

APPENDIX 1

PRIMARY CARE ATTRIBUTION CODES

Newly added codes on this list are effective January 1, 2023. Not every CPT, HCPCS, or revenue code on the above list is covered by every payer for claims reimbursement. If you have questions about specific codes, please contact the payer directly.

Primary-Care Patient Attribution Codes (CPT, HCPCS, and Revenue)
Administration of Health Risk Assessment • 96160-96161
Evaluation and Management - Office or Other Outpatient Services • 99201-99215[5]
Consultations - Office or Other Outpatient Consultations • 99241-99245
Nursing Facility Services: • 99304-99318
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • 99319-99340
Home Services • 99341-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354-99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358-99359

[5] Note: CPT Code 99201 was deleted effective January 1, 2021, and can no longer be billed. However, it remains as part of the list of attribution codes to ensure that any paid claims are captured in the 24-month look-back process.

Primary-Care Patient Attribution Codes (CPT, HCPCS, and Revenue)
Preventive Medicine Services • 99381–99387 • 99391–99397
Counseling Risk-Factor Reduction and Behavior-Change Intervention • 99401–99404 • 99406-99409 • 99411–99412
Online Digital Evaluation and Management • 99421-99423
Principal Care Management Services • 99424-99427
Other Preventive Medicine Services – Unlisted preventive: • 99429
Chronic Care Management • 99437, 99487, 99489-99491
Non-Complex Chronic Care Management • 99439
Telephone Evaluation and Management • 99441-99443
Newborn Care Services • 99460-99465
Assessment and Care Planning for Patients with Cognitive Impairment • 99483
Behavioral Health Integration Services • 99484, 99492-99494
Transitional Care Management Services • 99495-99496

Primary-Care Patient Attribution Codes (CPT, HCPCS, and Revenue)
Advanced Care Planning (services identified by these codes furnished in an inpatient setting are excluded) • 99497-99498
HCPCS Codes: • G0071 (RHC/FQHC virtual communication services) • G0402 (welcome to Medicare visit) • G0406-G0408 (inpatient/tele follow-up) • G0425-G0427 (inpatient/ED teleconsult) • G0438-G0439 (annual wellness visits) • G0442 (alcohol misuse screening service) • G0443 (alcohol misuse counseling service) • G0444 (annual depression screening service) • G0463 (services furnished in ETA hospitals) • G0506 (chronic care management) • G0511 (FQHC chronic care management services, monthly bundle) • G2010 remote evaluation of patient video/images • G2012, G2252 (virtual check-in) • G2025 (RHC/FQHC telehealth) • G2058 (non-complex care management) • G2061-G2063 (online assessment) • G2064-G2065 (principal care management services) • G2212 (prolonged office or other outpatient visit for the evaluation and management of a patient) • G2214 (psychiatric collaborative care model)
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

APPENDIX 2

VERMONT BLUEPRINT PRACTICE
TOTAL UNIQUE VERMONT PATIENTS ALGORITHM
FOR USE BY PRACTICES

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all patients who are Vermont residents.

3. Identify the number of Vermont patients who had at least one visit to a primary care provider in the practice with one or more of the qualifying primary-care patient attribution codes listed in Appendix 1, during the look-back period (most recent 24 months).

APPENDIX 3

VERMONT BLUEPRINT PMPM COMMON ATTRIBUTION ALGORITHM
FOR COMMERCIAL INSURERS, MEDICAID, AND MEDICARE

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members/beneficiaries who meet the following criteria as of the last day in the look back period:
   - Reside in Vermont for Medicaid (and Medicare);
   - Employer sitused in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members/beneficiaries to select a primary care provider, attribute those members/beneficiaries to that provider if the provider is in a Blueprint-recognized practice.

3. For other members/beneficiaries, select all claims for beneficiaries identified in step 2 with the qualifying primary-care patient attribution codes listed in Appendix 1, in the look-back period (most recent 24 months), for primary care providers included on Blueprint payment rosters, where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine, nurse practitioner, or physician assistant; or where the provider is a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC).

4. Assign a member/beneficiary to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the National Provider Identifiers (NPIs) of the individual providers associated with it.

5. If a member/beneficiary has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

6. Insurers can choose to apply elements in addition to 5. and 6. above when conducting their attribution. However, at a minimum use the greatest number of claims (5. above), followed by the most recent claim if there is a tie (6. above).

7. Insurers will run their attributions at least quarterly.

8. Insurers will make PMPM payments at least quarterly, by the 15th of the second month of the quarter. Base PMPM payments on the most current PMPM rate that insurers have received from the Blueprint prior to check production.

9. For insurers paying quarterly: if a new practice goes live in the third month of a quarter, add that practice to the attribution and payment schedule for the subsequent quarter. Payment would be made for the first month of participation, but it would be based on the attribution for the subsequent quarter and would be included in the subsequent quarter's payment. For example, if a practice becomes recognized on March 1, payment for March 1 through June 30 would occur by May 15.

APPENDIX 4

EXAMPLES OF PAYMENT IMPACTS ON:

1. **CURRENT PRACTICE FOR WHICH NCQA RECOGNITION LAPSES**
2. **BLUEPRINT PRACTICE THAT DOES NOT ACHIEVE RECOGNITION**

The following table outlines relevant time frames for a hypothetical current practice which would have, for example, an anticipated submission date of August 28, 2022 and an NCQA recognition lapse date of September 28, 2022:

Event	Date
Date on which practice decides to postpone scoring date / next anticipated submission date.	August 28, 2022
NCQA recognition lapse date.	September 28, 2022
Action Plan due date, indicating revised next anticipated submission date. Score date must be before by December 31, 2016 if payments are to continue in full.	September 30, 2022
Payment termination date if no action plan developed.	December 31, 2022
Practice attests to making quarter 1 progress toward NCQA recognition as defined in section 5.3.1.	January-March 2023
Date CHT and PCMH PMPM end if practice has not demonstrated progress toward NCQA PCMH recognition.	March 31, 2023
3rd-quarter practice attests to quarter 3 progress as defined in section 5.3.1.	July-September 2023
Date CHT and PCMH PMPM end if practice has not demonstrated progress toward NCQA PCMH recognition.	September 30, 2023
Date CHT and PCMH PMPM end if NCQA PCMH recognition is not achieved.	December 31, 2023

The following table outlines relevant time frames for a *hypothetical* Blueprint practice with an original next anticipated score date of, for example, December 1, 2022 (assume that practice postpones scoring):

Event	Date
Engagement date: CHT and PCMH PMPM payments begin	December 1, 2021
Original score date; practice decides on November 30, 2022 to postpone scoring	December 1, 2022
Action Plan due date if advance CHT payments are to continue (15 days after decision to postpone scoring date)	December 15, 2022
PCMH PMPM payment termination date regardless of whether an action plan is developed	December 31, 2022
Practice-related CHT payment termination date if no action plan developed (last day of quarter during which action plan is due)	December 31, 2022
Quarter in which practice-related CHT payment is reduced by 25% if recognition not achieved and action plan is developed (first quarter after action plan is due)	January-March 2023
Quarter in which practice-related CHT payment is reduced by 50% if recognition not achieved and action plan is developed (second quarter after action plan is due)	April-June 2023
Quarter in which practice-related CHT payment is reduced by 75% if recognition not achieved and action plan is developed (third quarter after action plan is due)	July-September 2023
Quarter in which practice-related CHT payment is reduced by 100% if recognition not achieved and action plan is developed (fourth quarter after action plan is due)	October-December 2023

APPENDIX 5

VERMONT BLUEPRINT PREGNANCY INTENTION INITIATIVE (PII)
PMPM COMMON ATTRIBUTION ALGORITHM
PII-PARTICIPATING COMMERCIAL INSURERS AND MEDICAID

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members/beneficiaries who meet the following criteria as of the last day in the look back period:
   - Female, aged 15 – 44 years;
   - Reside in Vermont for Medicaid (and Medicare);
   - Employer sitused in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer, or (for Medicaid) the beneficiary is a dual Medicaid/Medicare beneficiary without a commercial insurer as the primary payer.

3. For products that require members/beneficiaries to select a primary care provider, attribute those members/beneficiaries to that provider if the provider is in a PII-recognized practice.

4. For other members/beneficiaries, select all claims for beneficiaries identified in step 2 with the qualifying primary-care patient attribution codes listed in Appendix 1 and/or PII-unique codes in the look back period (most recent 24 months) for OB/GYN providers included on PII-participating practice payment rosters, where the practice has signed the self-attestation document for participation in the Blueprint PII and the provider's credential is as a doctor of medicine, doctor of osteopathic medicine, nurse practitioner, certified nurse midwife, or physician assistant.

PII Attribution Codes (CPT, HCPCS, and Revenue)
PII Unique Codes
Asymptomatic Bacteriuria Screening in Pregnant Female • 87081, 87084, 87086, and 87088
Breast and Ovarian Cancer Susceptibility, Genetic Counseling and Evaluation for BRCA Testing • 96040
Breast Cancer Screening • 77052, 77055-77057, and 77063 • G0202

PII Attribution Codes (CPT, HCPCS, and Revenue)
Breast Feeding Support, Supplies and Counseling • A4281-A4286 • E0602-E0604 • S9443
Cervical Cancer Screening • 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, and 88175 • G0101, G0123, G0141, G0143-G0145, G0147, and G0148 • Q0091
Chlamydia Screening • 86631, 86632, 87110, 87270, 87490, 87491, and 87800
Contraceptive Methods • A4261, A4264, A4266, and A4268 • J7297, J7298, J1050, J7300, J7301, J7303, J7304, J7306, and J7307 • S4981, S4989, and S4993 • 11976, 11980-11983, 57170, 58300, 58301, 58565, 58600, 58605, 58611, 58615, 58661, 58671, and 96372
Diabetes Screening • 82947 and 83036
DXA Scan • 77080
Global OB-Covered Well-Woman Visits • 59400, 59425, 59426, 59430, 59510, 59610, 59614, 59618, and 59622
Glucose Screening • 82950 and 82951
Gonorrhea Screening • 87850, 87590, and 87591
Hepatitis B Virus Infection Screening for Pregnant Female

PII Attribution Codes (CPT, HCPCS, and Revenue)
• 87340
Hepatitis C Screening • 86803
HIV Screening and Counseling • 86689, 86701-86703, 87390, and 87534-87536 • G0432-G0435
HPV DNA Testing • 87620-87625
Iron Deficiency Anemia Screening • 80055, 85013, 85014, 85018, 85025, and 85027
Rh(D) Incompatibility Screening in Pregnant Female • 86901
STI Counseling • 86593, 86695, and 86696 • G0445
Syphilis Infection Screening • 86592 and 86780
Well-Woman Visits • S0610, S0612, and S0613

5. Assign a member/beneficiary to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.
6. If a member/beneficiary has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.
7. Insurers can choose to apply elements in addition to 5. and 6. above when conducting their attribution. However, at a minimum use the greatest number of claims (5. above), followed by the most recent claim if there is a tie (6. above).
8. Insurers will run their attributions at least quarterly. Medicaid plans to continue to run their attribution monthly.
9. Insurers will make PMPM payments at least quarterly, by the 15th of the second month of the quarter. Base PMPM payments on the most current PMPM rate that insurers have received from the Blueprint prior to check production.

10. For insurers paying quarterly: if a new practice goes live in the third month of a quarter, add that practice to the attribution and payment schedule for the subsequent quarter. Payment would be made for the first month of participation, but it would be based on the attribution for the subsequent quarter and would be included in the subsequent quarter's payment. For example, if a practice becomes recognized on March 1, payment for March 1 through June 30 would occur by May 15.

APPENDIX 6

HEALTH SERVICE AREAS BY TOWN NAMES

Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport
BARRE CITY	ARLINGTON	BRATTLEBORO	BUELS GORE	ADDISON	CAMBRIDGE	ALBANY
BARRE TOWN	BENNINGTON	BROOKLINE	BURLINGTON	BRIDPORT	BELVIDERE	AVERILL
BERLIN	DORSET	DUMMERSTON	CHARLOTTE	BRISTOL	CRAFTSBURY	AVERYS GORE
BOLTON	DOVER	GUILFORD	COLCHESTER	CORNWALL	EDEN	BARTON
CABOT	GLASTENBURY	HALIFAX	ESSEX	LINCOLN	ELMORE	BLOOMFIELD
CALAIS	MANCHESTER	JAMAICA	FERRISBURGH	MIDDLEBURY	GREENSBORO	BRIGHTON
DUXBURY	POWNAL	MARLBORO	FLETCHER	NEW HAVEN	HARDWICK	BROWNINGTON
EAST MONTPELIER	READSBORO	NEWFANE	GRAND ISLE	ORWELL	HYDE PARK	BRUNSWICK
FAYSTON	RUPERT	PUTNEY	HINESBURG	PANTON	JOHNSON	CANAAN
MARSHFIELD	SANDGATE	STRATTON	HUNTINGTON	RIPTON	MORRISTOWN	CHARLESTON
MIDDLESEX	SEARSBURG	TOWNSHEND	JERICHO	SALISBURY	STANNARD	COVENTRY
MONTPELIER	SHAFTSBURY	VERNON	MILTON	SHOREHAM	STOWE	DERBY
MORETOWN	SOMERSET	WARDSBORO	MONKTON	VERGENNES	WATERVILLE	FERDINAND
NORTHFIELD	STAMFORD	WESTMINSTER	NORTH HERO	WALTHAM	WOLCOTT	GLOVER
PLAINFIELD	SUNDERLAND	WINDHAM	RICHMOND	WEYBRIDGE		HOLLAND
ROXBURY	WHITINGHAM	WINHALL	SHELBURNE	WHITING		IRASBURG
WAITSFIELD	WILMINGTON		SOUTH BURLINGTON			JAY
WARREN	WOODFORD		SOUTH HERO			LEMINGTON
WASHINGTON			ST. GEORGE			LEWIS
WATERBURY			STARKSBORO			LOWELL
WILLIAMSTOWN			UNDERHILL			MORGAN
WOODBURY			WESTFORD			NEWPORT CITY
WORCESTER			WILLISTON			NEWPORT TOWN
			WINOOSKI			NORTON
						TROY
						WARNERS GRANT
						WARREN GORE
						WESTFIELD
						WESTMORE

HEALTH SERVICE AREAS BY TOWN NAMES, CONT.

Randolph	Rutland	St. Albans	St. Johnsbury	Springfield	Windsor
BARNARD	BENSON	FAIRFAX	BARNET	ANDOVER	ORANGE
BETHEL	BRANDON	ALBURGH	BURKE	ATHENS	TOPSHAM
BRAINTREE	CASTLETON	BAKERSFIELD	CONCORD	BALTIMORE	BRADFORD
BROOKFIELD	CHITTENDEN	BERKSHIRE	DANVILLE	CAVENDISH	CORINTH
CHELSEA	CLARENDON	ENOSBURG	EAST HAVEN	CHESTER	FAIRLEE
GRANVILLE	DANBY	FAIRFIELD	GRANBY	GRAFTON	GROTON
HANCOCK	FAIR HAVEN	FRANKLIN	GUILDHALL	LANDGROVE	NEWBURY
PITTSFIELD	GOSHEN	GEORGIA	KIRBY	LONDONDERRY	PEACHAM
RANDOLPH	HUBBARDTON	HIGHGATE	LUNENBURG	LUDLOW	RYEGATE
ROCHESTER	IRA	ISLE LA MOTTE	LYNDON	PERU	THETFORD
STOCKBRIDGE	KILLINGTON	MONTGOMERY	MAIDSTONE	ROCKINGHAM	VERSHIRE
HARTFORD	LEICESTER	RICHFORD	NEWARK	SPRINGFIELD	WEST FAIRLEE
NORWICH	MENDON	SHELDON	SHEFFIELD	WEATHERSFIELD	BRIDGEWATER
POMFRET	MIDDLETOWN	ST. ALBANS CITY	ST. JOHNSBURY	WESTON	HARTLAND
ROYALTON	SPRINGS	ST. ALBANS	SUTTON		PLYMOUTH
SHARON	MOUNT HOLLY	TOWN	VICTORY		READING
STRAFFORD	MOUNT TABOR	SWANTON	WALDEN		WEST WINDSOR
TUNBRIDGE	PAWLET		WATERFORD		WINDSOR
	PITTSFORD		WHEELOCK		WOODSTOCK
	POULTNEY				
	PROCTOR				
	RUTLAND				
	RUTLAND CITY				
	SHREWSBURY				
	SUDBURY				
	TINMOUTH				
	WALLINGFORD				
	WELLS				
	WEST HAVEN				
	WEST RUTLAND				

APPENDIX 7

QUALITY IMPROVEMENT FACILITATION SERVICES

PRACTICE/ORGANIZATION QUALITY IMPROVEMENT FACILITATION

Topic	**Activities**
Creating infrastructure for continuous improvement	- Form and manage an external facilitation team with expertise tailored to practice needs - Form or optimize a central QI team for the organization or practice - Ensure diverse membership on the QI team or specific project teams - Help teams create or update QI plans - Help teams develop performance monitoring systems - Help teams use performance data to set improvement goals and monitor progress
Building skills in leadership and QI teams that support continuous improvement	- Provide executive coaching to leadership in change management and quality improvement - Build priority for change in practice and leadership using data, academic detailing and social learning, introduction to new ideas, and best-evidence - Train staff on QI approaches and methods (e.g., Model for Improvement, small tests of change, workflow mapping, benchmarking, chart reviews, audit and feedback) - Train team on concept of data-driven improvement and data collection and management - Teach skills for running effective QI meetings - Teach skills for encouraging culture of continuous QI in organization
Quality meeting facilitation	- Facilitate root cause analysis - Lead practice through the Model for Improvement, or other mutually agreed upon tool or framework for identifying goals and performance indicators - Employ QI interventions, such as workflow mapping, audit and feedback, benchmarking, academic detailing, and best practices research. - Monitor progress towards goals
Managing quality improvement/change projects	- Provide project and change management support, and build capacity for the same in practice

	- Set up and use collaboration software for change process management - Support accountability for action items and follow-through on improvement plans - Help practice coordinate, integrate, and realize synergies in all improvement work occurring across the organization
Organizational assessment	- Assess structure and resources in place to support QI and their internal and external QI requirements (such as Blueprint attestations, ACO participation, Federally Qualified Health Center requirements, Commercial Insurer QI Program Participation, or Medicare/Medicaid Quality Requirements) - Assess organizational/practice readiness for capacity building and improvement work - Conduct initial assessment of practice's core systems (administrative, clinical, health IT, data, and human resources) using an assets-based approach (i.e., identify both strengths and weaknesses) - Collect data from multiple sources, including surveys, paper records, registries, and electronic health records - Implement report generators and other systems that create capacity for routine performance reporting and train staff to maintain and expand these processes
Optimizing health IT for performance monitoring and population management	- Help practice interact with health IT vendors - Help practice engage expert consultants in health IT as needed - Share best practices in use of particular electronic health record (EHR) products from other practices as appropriate - Help practice structure EHR to maximize population management capacity - Set up registry tracks and create workflows for maintaining registries - Identify and correct data errors in EHR and registry - Set up connections between labs and EHRs, standalone registries and EHRs, and other relevant IT platforms and products - Help staff set up and manage templates and point-of-care decision support

	- Train staff to optimize EHR functions to enhance care team communication (e.g., tasking) - Train staff to create and generate performance reports for QI
Supporting implementation of targeted changes and improvements: - PCMH - Pregnancy Intention - Hub and Spoke - Other	- Train practice in service models such as PCMH, Systematic screening for Mental Health/Substance Use/Social Determinants of Health, Behavioral Health Integration, and Stepped Care (e.g. Hub and Spoke) and associated processes, interventions, and best practices and their benefits. - Engage external experts as needed to provide peer-to-peer and expert training to practice on new models of care, interventions, and other targeted improvements
Identifying and spreading exemplar practices	- Document exemplars and best practices and share with program and facilitation community
Identifying and communicating system-level barriers to improvement	- Document system-level barriers to improvement and communicate to program, funders, policymakers, and health care community
Supporting PCMH recognition with NCQA	- Guide each practice through NCQA recognition process - Ensure that practice implements standards/prepares and submits high quality evidence required by NCQA within the timeframes specified by NCQA and the Blueprint for Health. - Assist practice with QPASS entries - Assist practice with NCQA reviewer check-ins
Supporting patient and family involvement in the quality improvement process	- Assist practice with creating a role for patients/families/caregivers in the practice's governance structure or on its Board of Directors, or - Assists practice with organizing a Patient and Family Advisory Council (stakeholder committee)
Supporting participation in statewide patient experience survey	- Assist with practice submission of necessary information to survey contractor - Assistance with analysis, review, and presentation of survey results - Support for identifying patient/experience quality improvement opportunities and interventions

Program evaluation and reporting	- Assist practice with completing/submitting evaluation and reporting requirements for participation in Blueprint for Health or other quality programs. - Assist practice with selection, monitoring, and reporting of key quality measures.

APPENDIX 8

BLUEPRINT FOR HEALTH COMMUNITY HEALTH TEAM (CHT) EXPANSION PILOT: YEAR 1

Vermont is experiencing increased deaths from drug overdose and suicide and concerning levels and acuity of mental health and substance use disorders. In addition, there is a need to broaden screening for social determinants of health and address mental and physical health-related social needs of Vermonters of all ages. The objective of this project is to ensure that screening, brief intervention, and navigation to services occurs across the entire population served by primary care practices in Vermont that participate in the Blueprint for Health (most primary care practices in the state).

Eligible Practices

Blueprint Patient-Centered Medical Homes (PCMH) with at least 50 attributed Medicaid members are eligible to receive additional support. Blueprint PCMHs with between 50 and 250 attributed Medicaid members will receive this support through a centralized resource in the Health Service Area (HSA). Practices with at least 250 attributed Medicaid members are eligible to receive support in the form of embedded staff at levels commensurate with their Medicaid member attribution; these staffers may be hired by the practices utilizing pass-through funding or employed by the Blueprint Administrative Entities in their health service areas.

Practice Requirements

Blueprint Program Managers will meet with each practice to review eligibility for participation in the CHT Expansion Pilot. Practices will review an attestation document containing information regarding the requirements of participation. Each practice that decides to participate in the Expansion Pilot will sign the attestation and return it to their Blueprint Program Manager for signature. Blueprint Program Managers will send all signed attestations to the Blueprint central office for approval.

Provider Requirements

Delivering effective integrated care across all ages may require practices to make shifts in their culture, workflows, and/or clinical operations. Providers are asked to engage in team-based care that includes increasing mental health and substance use screenings and support for patients and families within the practice. Providers will also engage with quality improvement teams and training offered as part of the Pilot. Practices will be expected to make any necessary shifts in culture, workflows, and/or clinical operations with support from Quality Improvement Facilitators, state-level Blueprint staff, and training offered by Blueprint.

Organized and streamlined procedures that place primary care providers, CHT providers, outside referral specialist organization (e.g., designated agencies, parent child centers, support group leaders), patients, and their supporters in frequent communication enhance whole-person, team-based, integrated care. The focus of the CHT Pilot Expansion is on enhancing access to this level of integrated care for patients in all life stages.

Screenings to Identify Mental Health, Substance Use, and Health-Related Social Needs

This information is included in the practice attestation document and available on the Blueprint website. BPCHT_Expansion_Attestation_Year2 FINAL31924_2.pdf (vermont.gov)

Payment Disbursement

Administrative Entities received their first payments from Medicaid in August 2023, and will receive payments monthly for the duration of the Pilot. It is the responsibility of the Administrative Entities, in consultation with participating practices, to determine whether to hire staff directly or pass through dollars to practices for the hiring of staff.

Payment Amount Determinations

Payment amounts for each HSA are determined by the number of Medicaid members attributed to each practice within the HSA based on the Blueprint attribution methodology. Attribution levels will be held constant for the first year of the Pilot and reassessed at the end of the first year.

Allowable Uses of Funding

The CHT Expansion Pilot funding shall be used to embed a Community Health Worker, Family Specialist, master's prepared licensed or unlicensed Mental Health Counselor, Social Worker, or Psychologist as a member of the primary care team. The Administrative Entity may hire directly, pass through dollars to a practice to hire or contract with an outside referral specialist organization. Funding may also be used to support the development of the same types of centralized staffing to serve smaller practices. Requests for alterations in staffing type must be addressed to the Blueprint Executive Director by the Blueprint Program Manager and accompanied by justification. Such requests are subject to approval by the Blueprint Executive Director.

The Administrative Entity may use up to 1 month of funding from the first year of support (8.3% of funding from the first year) for administrative costs related to the CHT Expansion Pilot. Such costs may include the cost of posting positions, interviewing, electronic health record enhancements, and creating memoranda of understanding (MOUs) or contracts.

Embedded vs. Centralized Staff

Embedded CHT staff support an integrated model of mental health and substance use disorder care when primary care and mental health, substance use, or social services specialists are co-located within the same clinic space and share the overall care and treatment plan of the patient.

Centralized CHT staff support a coordinated model of integrated care, where primary care and mental health, substance use, or social need specialists are housed in separate locations and identification of patient needs and communication is primarily provider driven. Patients and providers must be able to reach centralized CHT staff through telehealth and centralized CHT staff shall have regular availability to support practitioners and patients.

Staffing at Multi-site Practice Organizations

Staff models to determine payment and FTE counts occur at the practice site (rather than multi-site practice organization) level, with the intent of supporting as many practice sites to employ an

embedded resource as possible. The CHT staff member ideally is always available to the practice site's providers and patients during the workday, whether that involves a warm hand off to transition care or quick consultations. Every Health Service Area and multi-site practice organization can discuss resource needs and creative solutions to staffing positions in each practice site.

Expected Interventions

Community Health Teams will provide evidence-based mental health and substance use treatments appropriate to the primary care setting. They will also support screenings for mental health, substance use, family, and social needs, provide education, and offer self-management support and strategies.

For individuals with complex needs, CHT staff may play a greater role as a care coordinator and assist with managing transitions of care, co-management of care, care consultations, team-based care, and care conferences.

Reporting Data to Blueprint

Reporting requirement information is located on the attestation document. The evaluation of the first year of the Pilot will focus primarily on understanding Pilot adoption and implementation. Clinical processes and outcomes will primarily be analyzed via Quality Improvement Facilitator-led chart reviews at this stage.

Medicaid Attribution Discrepancies

If Blueprint Program Managers are concerned about any discrepancies between the CHT Expansion Pilot payment methodology and other methods used to calculate practice/organization Medicaid caseload, they may contact the Blueprint Payment Administrator, Jennifer Herwood at Jennifer.Herwood@vermont.gov.

Program Manger Flexibility in Resource Allocation

If anticipated staffing needs vary from recommended staffing levels for the practice provided by the Blueprint for Health central office, Program Managers should contact the Executive Director to discuss potential solutions.

Current Positions and Expansion Funding

The intent of this Pilot is to expand CHT resources; as a result, funding shall be used to increase CHT staffing resources available to practices to address mental health, substance use, social determinants, and family specialist needs for all patients. If a practice has existing mental health and substance use disorder treatment services, practices and program managers should assess what unmet mental health, substance use, and social or family needs exist in the practice population to determine if other resources may be appropriate for the practice. It may be that the addition of another resource, such as a Community Health Worker, would allow existing mental health and substance use providers to work to the top of their license and address unmet needs. As a reminder, services provided by CHTs are not billable.

Practices should contact their local Program Manager with any questions or considerations specific to the practice. Program Managers may discuss individual practice questions or considerations with the Executive Director.

Time-bounded Funding

The Blueprint for Health has advocated strongly with the Vermont Legislature for two years of funding to evaluate the efficacy of embedding CHT staff to address these needs in primary care practices, and the Legislature was responsive to that request. If the CHT Expansion Pilot is successful, it will serve as the foundation for making these funds permanently available as part of the larger CHT.

Funding Source

This Pilot is being funded using Global Commitment to Health (Global Commitment) funds. Global Commitment is the name of the agreement between the State of Vermont and the Centers for Medicare and Medicaid Services (CMS) that is used to administer the majority of Vermont's Medicaid program. It is what is known as a Section 1115 Demonstration (often referred to as a "waiver") that waives certain provisions of Medicaid law to give states flexibility and encourage state innovation in designing and improving state Medicaid programs, while remaining budget neutral to the Federal Government. These funds are not considered a grant.

Working with Existing Blueprint Staff

Added CHT staff will work closely with the existing teams in the practices. The Blueprint Quality Improvement Facilitators can engage in the development of new and revised workflows to incorporate additional staff.

Each practice may consider creating a new position, adding to an existing position, or discussing other opportunities for staffing with their Blueprint Program Manager.

Vacant Positions

Vermont is currently contending with health care workforce shortages. There are long-standing vacancies that various communities have struggled to fill. The Agency of Human Services Health Care Reform team has responsibility related to the Health Care Workforce Development Strategic Plan to address some of the system and long-term changes required.

The Blueprint for Health recommends tapping into known effective strategies and lessons learned across the nation for recruiting and retaining this workforce, which may include:

- Partnering with the local Designated Agency, Parent Child Center or neighboring Health Service Area(s),
- Exploring opportunities associated with telehealth,
- Investing in training programs and career pathways, and
- Exploring licensing support and recruitment strategies.
- Program Managers should remain in close communication with the Executive Director about any ongoing staffing vacancies.

Integration with and Support for Developmental Understanding and Legal Collaboration for Everyone (DULCE) Program

This Pilot provides two years of support for the DULCE program and Family Specialist role embedded in 6 Dulce sites. These sites are also eligible for additional expanded CHT staff based on practice attribution. Administrative Entities for six DULCE sites will receive funding for their Family Specialist for two years; this funding is in addition to the amount of CHT staffing resource funding the HSA receives for the Expansion Pilot.

Vermont Department of Health and Blueprint central office staff will work directly with all HSAs to support continued development and implementation of a pediatric model that reflects Vermont's learning from the DULCE program. Pediatric practices without DULCE will engage in a pediatric model that includes elements modeled after DULCE's nine domains: Employment Security, Food Security, Intimate Partner Violence (IPV), Financial Supports, Transportation, Mental Health/Caregiver Depression, Housing Stability, Health & Safety, and Utilities. These elements are expected to be incorporated into Family Specialist positions with CHT Expansion staff. This pediatric model will not use the DULCE name due to specific requirements associated with the program; however, DULCE-like universal screening and support across all pediatric practices is an important goal of the CHT Expansion Pilot, as well as connection to existing systems of care outside of the health care system. DULCE required screenings do not currently require a specific screener to be used for any domain. Quality improvement specialists will collaborate with providers to incorporate screenings, implement interventions, create referral pathways, and support this model in pediatric and family practices throughout Vermont.

Tracking CHT Expansion Pilot Funding

CHT Expansion Pilot funding should be tracked separately from other funding sources. Additional funding questions should be addressed to the Executive Director.

Non-participation in Blueprint Expansion Pilot

If a practice does not attest, the Blueprint strongly encourages Program Managers to propose alternative means of utilizing the funds to meet the mental health and substance use needs of the community in alignment with the goals of the Expansion Pilot. Proposals shall be presented to the Blueprint Executive Director for approval. If a proposal is not made and approved for use of unspent funds, the Administrative Entity will remit the unspent FTE funds to the State and future payments will be adjusted accordingly.