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Combined Meeting of The Blueprint Executive Committee and Blueprint Planning and Evaluation Committee

November 16, 2016

Attendees: M. Beach; C. Elmquist; P. Farnham; K. Fitzgerald; J. Franz; C. Fulton; L. Hendry; M. Hutt; P. Jackson; J. Krulewitz; M. McAdoo; E. McKenna; M. Mohlman; J. Peterson; J. Plavin; J. Samuelson; B. Tanzman; T. Tremblay; J. Williams

By phone: B. Bick; P. Biron; S. Bruce; S. Claire; P. Clark; W. Cornwell; T. Dougherty; E. Emard; J. Fels; S. Fine; M. Gilbert; K. Hein; J. Hester; J. Olson; T. Reinertson; J. Riffon; L. Ruggles; T. Voci; J. Zirena

Next Meeting: B. Tanzman asked the committee for an extra meeting on December 14, 2016 in Williston at 312 Hurricane Lane in the DVHA Large Conference room. The purpose will be our obligation to check in with the Executive Committee regarding any payment changes proposed. We will also bring forward the proposal around Medicare payment operations for payments previously made through the MAPCP demonstration, which is ending on December 31, 2016.

The meeting opened at 8:30 a.m.

I. Opening Remarks and Announcements: Beth Tanzman

- Today's agenda, PowerPoint slide decks, and draft proposal for Blueprint payment changes related to the Women's Health Initiative (WHI) were distributed prior to this meeting.
- B. Tanzman introduced Penrose Jackson and Jason Williams from the University of Vermont Medical Center (UVMMC) who are up first in the agenda to give a "Housing is Health Care" presentation on the 100,000 homes project. B. Tanzman underscored that housing is a health care service for people who have medically complex and psychosocial needs. Addressing the social determinants of health frames and deepens our work around not only health systems, but healthy communities.
- B. Tanzman indicated that we want to check in with the committee on work to date on the Women's Health Initiative (WHI) and provide an update on planned implementation. This initiative concretely addresses the social determinants of health.
- B. Tanzman described the director's responsibility to consult with the executive committee concerning any changes to Blueprint payments. Today and at a special

meeting on December 14, 8:30 - 10:00 am, we are soliciting the committee's feedback on proposed WHI payment changes. Additionally, any payment changes needed to maintain the status quo of all Blueprint programs currently in place for calendar year 2017 of the All-Payer Model (APM) agreement will need to be brought forward to the committee. Blueprint central office staff are meeting with the current Administration later today, and more information will be forthcoming at the December meeting of this committee.

- B. Tanzman presented the opportunity to process as a group the changes coming because of the national and state election results. In terms of the APM agreement itself, there is no indication that the incoming Governor will withdraw from the signed agreement with the federal government. In the APM, there are two agreements linked at the hip – one with Medicare and the global commitment waiver for Medicaid. To undo or unravel these agreements would be a setback for Vermont. We are working towards full implementation of the APM and expect to be able to move forward successfully with it.
- E. McKenna stated that she thought the agreement included a provision for either party to pull back within the first 180 days. B. Tanzman confirmed that is correct. Either the state or the federal government can opt out of the APM within that timeframe, but they would have to want to do so.
- J. Plavin is concerned about mental health and substance abuse not being included until Year 3 as a theme within the APM agreement. It didn't get left behind, but the negotiation left it until very late in the process. BlueCross/BlueShield does not want consideration of these services left behind. B. Tanzman thanked J. Plavin for bringing this issue to the attention of the committee and reflected the importance of looking for opportunities to accelerate reforms in a meaningful way related to mental health and substance abuse.
- P. Jackson brought up Accountable Communities for Health (ACHs) and Community Collaboratives/Regional Clinical Planning Committees, which have different palettes. We need to pull it all together and be more intentional. Guidance from the Blueprint, the State, and the Accountable Care Organizations (ACOs) would be welcome, as it will eventually affect how money flows. We need to be thoughtful about that. B. Tanzman agreed with the importance of aligning initiatives in communities in ways that are coherent for community partners asked to do work on the ground for better population health.
- T. Mable asked about the goals of the new Governor's administration. Will this work align with those goals? B. Tanzman said we do not know yet, as the transition team is focused on more operational needs first, like the budget. The working position is that the Medicare and Global Commitment Medicaid waivers are intact and what we are all moving towards.

II. Housing is Health Care Presentation: Penrose Jackson and Jason Williams

- Refer to slide deck *Housing Presentation for Fall 2016.ppt*
- P. Jackson indicated that the Community Health Needs Assessment (CHNA) identified housing as a community need. The link to health care costs became apparent, so UVMMC is now in the business of housing.

- J. Williams emphasized that the work presented is only one part of the work on ending homelessness in Chittenden County or across the state. Also, this is just one partnership and example – one piece of the story. More work needs to be done. The legislature identified an unacceptable growth rate in motel housing voucher spending with abuse of the system and no corresponding good outcomes for those served. The Department of Children and Families (DCF) came up with new rules and eligibility criteria. J. Williams received a call from case manager/social worker that the hospital was going to have people to discharge who no longer qualified for vouchers. UVMMC needed to come up with a better way by getting into the business of housing, even though they don't want to be. Housing as health care is at the forefront of their population health approach.
- J. Williams talked about the system for coordinated entry into housing. They keep a list of the most vulnerable people who are homeless and most likely to die on the street without intervention. The system that calculates the vulnerability scores and prioritizes the list.
- J. Williams reviewed the data on Harbor Place (*slides 7, 8, and 9*), one of the housing units the hospital paid to discharge 100 patients to. The patients were not necessarily universally homeless, but most are. They get access to case management and domestic violence treatment, as appropriate. The average length of stay is creeping north of 10 nights with a cost of $30,000 and an additional capital contribution. What is the impact of discharge to Harbor Place on health care costs when you aggregate data? Pre-admission data includes the "sentinel event", whatever led to the person's admission to the hospital and resulting discharge to Harbor Place, compared to the post-discharge data. Costs dropped $1.3 million for the 60 days up to and include the hospital admission to $200,000 for the 60 days after discharge to Harbor Place. J. Williams emphasized that this is only one dimension of the patient's health care system and only one health care setting.
- P. Jackson and J. Williams showed video: https://vimeo.com/177739962
- B. Tanzman gave appreciation to P. Jackson and J. Williams for sharing this amazing work and recognizing it as the beginning. She remarked that it is encouraging that the experience is so positive. The 100,000 homes approach is organized and systematic, taking a seemingly unsolvable problem and breaking it down into manageable pieces.

III. Women's Health Initiative (WHI) – Jenney Samuelson

- B. Tanzman recognized and appreciated the leadership of J. Samuelson on organizing work groups to address how we help build provider and community linkages between specialty health providers and community partners who touch reproductive-age women. B. Tanzman also recognized the work on WHI payments of T. Tremblay and C. Elmquist and the work of M. Mohlman on the beginnings of an evaluation strategy.
- J. Samuelson acknowledged the work of the partners and providers serving on the work groups and their ability to quickly recruit 12 practices in 8 HSAs for a January 1, 2017 start date in the initiative.
- J. Samuelson reviewed slide deck *BPExec2016.11.15.pptx*
- J. Peterson asked if community organizations will conduct screenings. J. Samuelson responded that goal is for family planning counseling to occur in those agencies and for them to have a path for referral based on the outcome of the screenings. We hope to

strengthen the referral network of agencies for when screening results come up positive.

- T. Tremblay said research has shown that same-day access to long-acting reversible contraceptive (LARC) devices makes a big difference in uptake. J. Samuelson stated when women know LARC is available and that it is most effective form of birth control they actually choose it more often. Access has been a barrier in the past. J. Samuelson cited the example of the Bennington Parent Child Center, which serves many young women who were already pregnant in the past. The Parent Child Center realized they were doing birth control options counseling in their curriculum and tweaked the curriculum to include efficacy-based counseling and a referral pathway with local women's health providers. This approach significantly impacted the number of second unintended pregnancies and reduced the incidence of abortions, allowing them to get back to their curriculum. Their referral pathway allows the young women they serve to see a provider within one week to obtain their chosen birth control option. The Parent Child Center staff will also accompany these women to appointments, if desired.
- J. Samuelson presented the proposed payments for WHI. A woman can be attributed to both a WHI practice and a PCMH practice for those different purposes. J. Peterson asked why the CHT PMPM is so much higher ($5.42) than the PMPM for WHI practice participation ($1.25). J. Samuelson responded on how the CHT payment was calculated (refer to the *BlueprintManual_WHI_DRAFT_11.15.16.docx* Word document). The same salary range was used as for a MAT counselor.
- P. Farnham asked if providers who already stock LARC will be eligible for the one-time capacity payment. J. Samuelson responded "yes" because we are not providing the devices, just a one-time per-member capacity payment. Additionally, many of the practices who stock it may not have a sufficient amount. The Blueprint is recommending that the PMP be provided to all eligible women's health clinics. For many of the practices, they may need to make changes to their electronic health records (EHRs) to implement changes for input of screening answers, so the practice PMPM can cover costs of this nature.
- J. Samuelson indicated that the WHI payment recommendations, outlined in the *BlueprintManual_WHI_DRAFT_11.15.16.docx* Word document, are currently draft recommendations. We are looking for confirmation and feedback from the committee.
- K. Fitzgerald asked for clarification that WHI only applies to females aged 15 to 44. J. Samuelson confirmed this assumption.
- T. Mable confirmed that the program has not started yet and asked how practices enroll – via a competitive bid? J. Samuelson acknowledged the work of the Blueprint project managers (PMs) in local Health Service Areas (HSAs) going out to women's health practices, speaking to them about this initiative, and giving them the option to participate. The 12 practices enrolled for January 1, 2017 understand that some operational details are still being worked out and that they are participating in a kind of pilot. As practices have enrolled, we have asked them to join the work groups to help design the initiative.
- E. McKenna asked what is the enrollment deadline for practices who want to start on April 1. J. Samuelson stated that for the first phases we are enrolling practices by quarters to work the kinks out during 3-month periods. For practices that want to enroll in April, we need the information in December to get the practice's payment data.

- P. Farnham said she has gotten a positive response from women's health providers in the Burlington HSA. They are thrilled to be included in the Blueprint.
- J. Peterson stated it's great that the initiative is voluntary, and genius to do up-front stocking of devices, since those are the kinds of things that make it tough for practices or community partners to be able to participate. Aligning with measures for the APM is also great. Is there any funding to support Parent Child Centers that may participate in a positive way? They are poorly funded and contribute to so many initiatives in so many ways. B. Tanzman echoed that this was the first comment from Mental Health and Substance Abuse advisory committee as well. At this point, there is no direct funding mechanism for partners. B. Tanzman circled back to J. Plavin's comment at the beginning of the meeting as needing to accelerate payment reforms by designing a better and more targeted support for community organizations through the APM.
- M. Hutt asked if WHI could have a positive impact on providers being able to accept more Medicaid patients. M. Hutt would be interested in tracking that as a data measure for the evaluation, such as the number of women actively seen by practices in Medicaid or a growth in caseload. M. Mohlman stated we are also tracking whether we see a change in pregnant women becoming eligible for Medicaid.
- J. Krulewitz asked if WHI practices will screen only Medicaid women or all women. J. Samuelson said we expect practices to screen all women of reproductive age universally.
- E. McKenna asked if any additional practice facilitators are included with WHI funding. J. Samuelson responded that two additional facilitators were put forward in the budget to assist these practices.
- L. Ruggles asked why PCMH practices are not included. J. Samuelson responded that we will encourage PCMHs to implement same strategies and invite them to participate in educational initiatives that are ongoing. Currently, PCMHs already receive CHT and PMPM funds to the practice. If we can extend upfront LARC capacity payment to practices within budgetary constraints, we are exploring that option, but it's to be determined.
- K. Fitzgerald asked what is the total budget for WHI. J. Samuelson will send a response to the committee via email. B. Tanzman indicated that the budget covers a two-year cycle and is built on a classic return on investment (ROI) model for Medicaid based on current pregnancy, delivery, miscarriage, and abortion expenditures. We looked at the health care savings to Medicaid related to a reduction in unintended pregnancies only. We then evaluated the interventions most effective at helping to realize those savings. J. Samuelson stated that there is no new investment, no budgetary ask, since the ROI offsets the costs. We reviewed similar programs nationwide that took a similar approach to reducing unintended pregnancies and their resulting cost reductions.
- E. McKenna asked what it would take for commercial insurers to participate in this initiative, since, from an administrative perspective for MAT, Blueprint Administrative Entities always need to consider populations outside of Medicaid in cost calculations. Is there anything we can do to get commercial insurers to participate? J. Plavin from BlueCross/BlueShield comments that commercial insurers are an amalgam of things, including different populations and clients served. A lot of their clients are administrative service only and bear the risk (ERISA). They can opt out of Blueprint payments, so it's not just BlueCross/BlueShield as a commercial insurer. They also must convince clients. What is needed is data transparency to identify how many members,

not just of BlueCross/BlueShield, but also at the individual client level. They can then see the granularity to them because it is a bit of an uphill battle. To date, they have been unable to identify who is benefiting from the service. Insurers also must define rates one year ahead of time, so BlueCross/BlueShield had filed and got approval before becoming aware of this initiative. They are currently building a story to include WHI in a future rate proposal. J. Samuelson acknowledged the time and effort invested by BlueCross/BlueShield on the WHI work groups.

- E. McKenna asked if she and other local leaders can do anything to convince employers to participate. J. Plavin responded that it would be helpful when speaking to HR departments to have the data and local Blueprint leadership present.
- J. Samuelson stated that we will send a DRAFT of the payment manual updates via email with notes from this meeting. Please review the document and provide your feedback and comments. T. Tremblay emphasized that this document is a draft and will undergo some minor changes prior to the December meeting, but the current version gives a good overall view of where we are going and the WHI payment structure.

With no further time, the meeting adjourned at 10:05 am.

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UVMHealth.org/MedCenter

Housing is Health Care: Collaborative Approaches to Combat Homelessness

2016

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Burlington homeless demographics

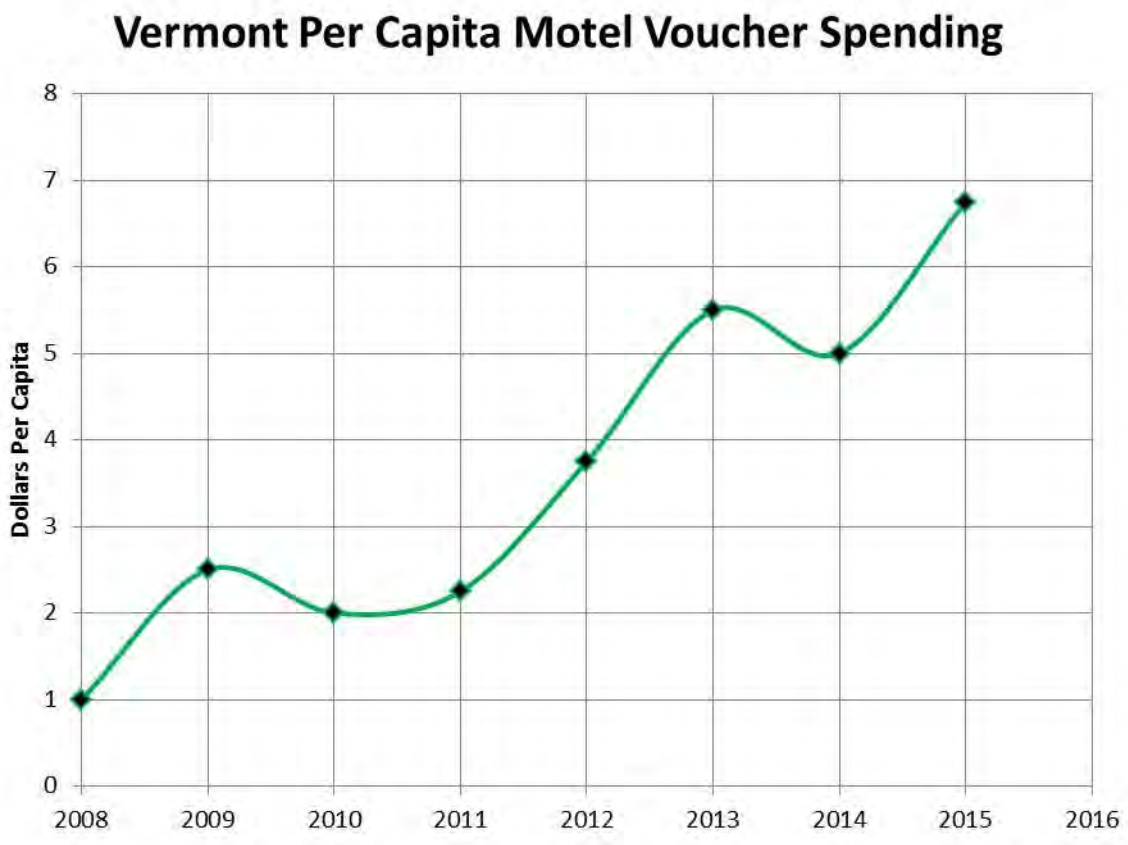
General Assistance (Motel) FY15

- Unduplicated # single households = 858
- Unduplicated # family households = 191

2016 Point in Time Count (Compared to 2015)

- Single individuals = 205 (-39%)
- Family individuals = 124 (-7%)

Vermont per capita motel voucher spending



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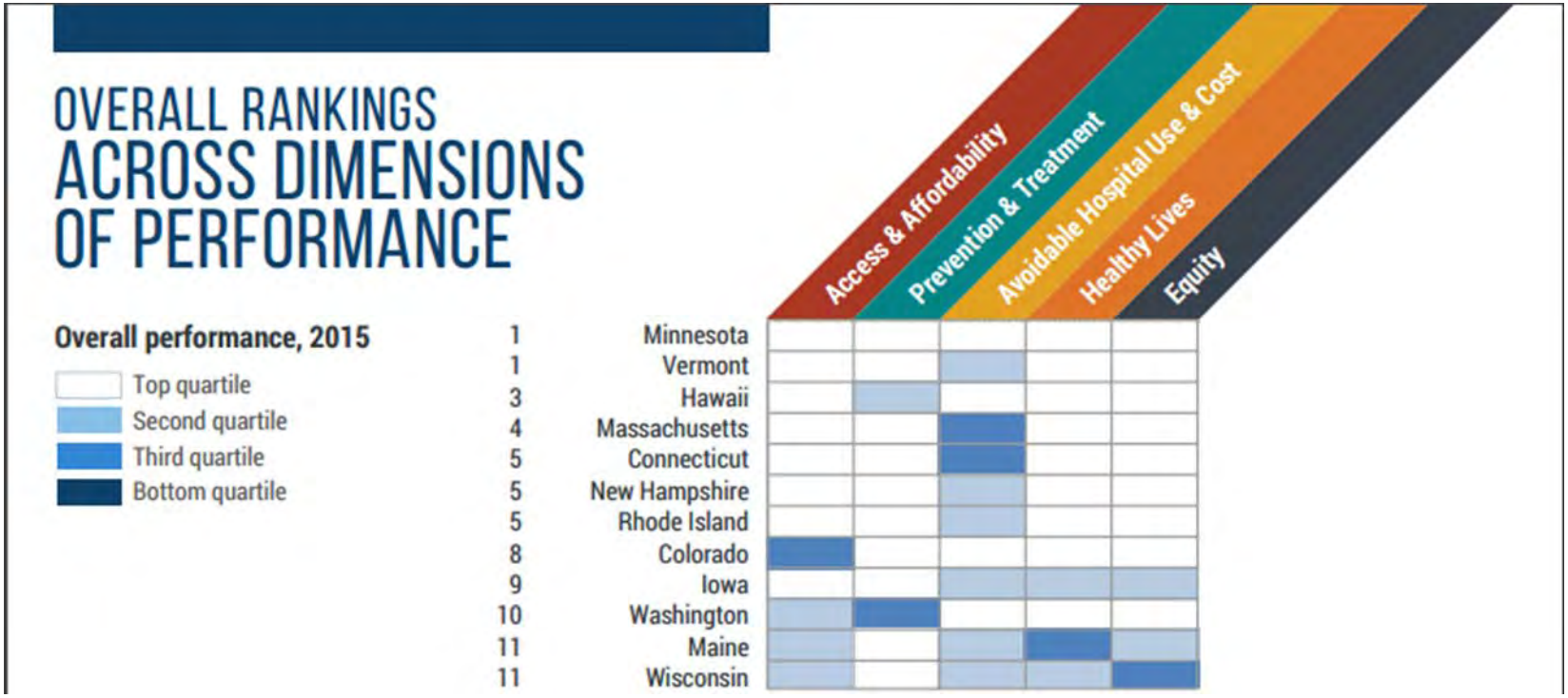
Fitting into the bigger picture



From: Commonwealth Fund's "Aiming Higher: Results from a Scorecard on State Health System Performance" 2015 Edition

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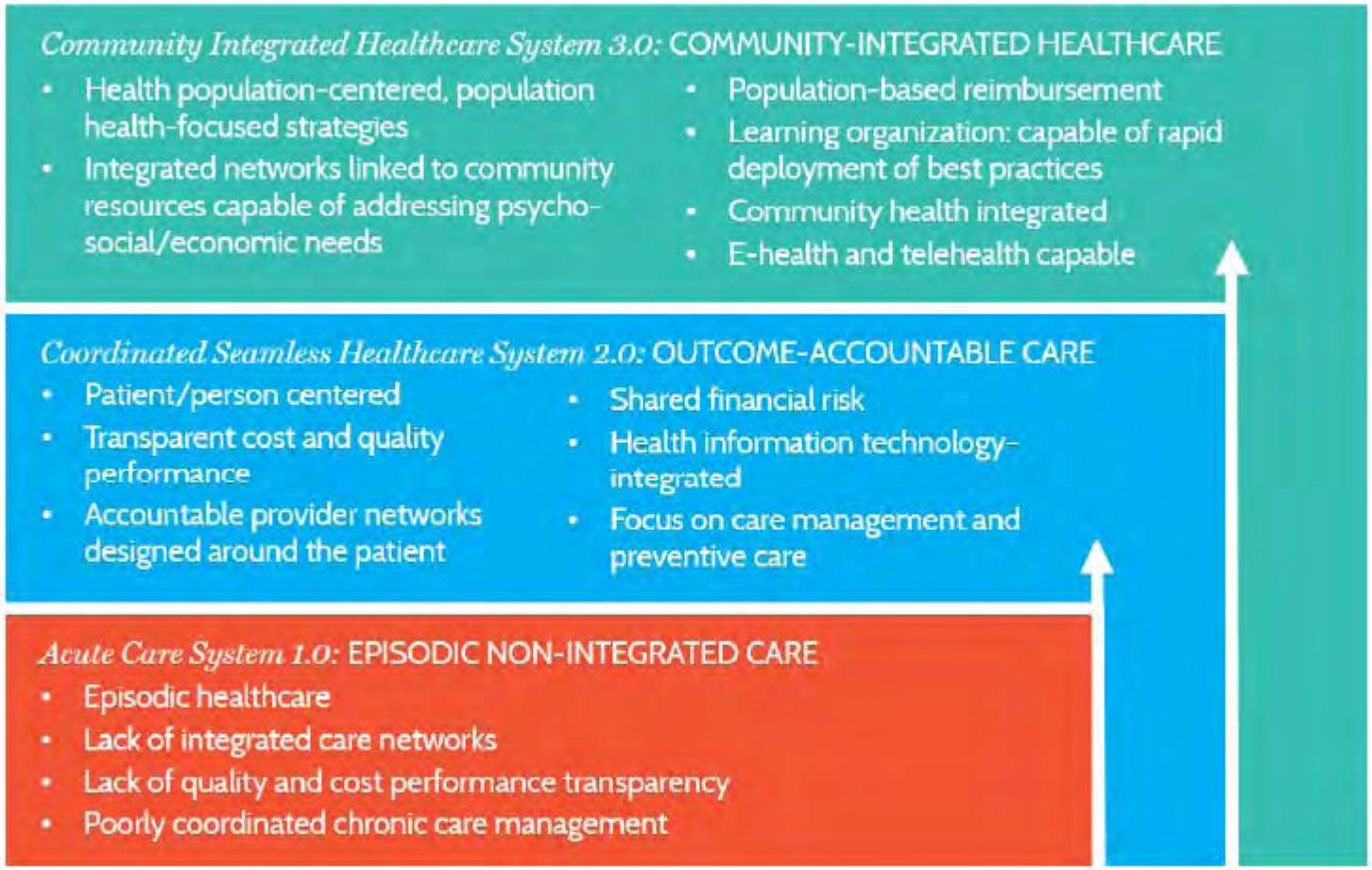
Fitting into the bigger picture



Adapted from Hester et al., 2015

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Opportunities

- 100,000 Homes
- Harbor Place
- Warming Shelter
- Beacon Apartments
- Partnerships!

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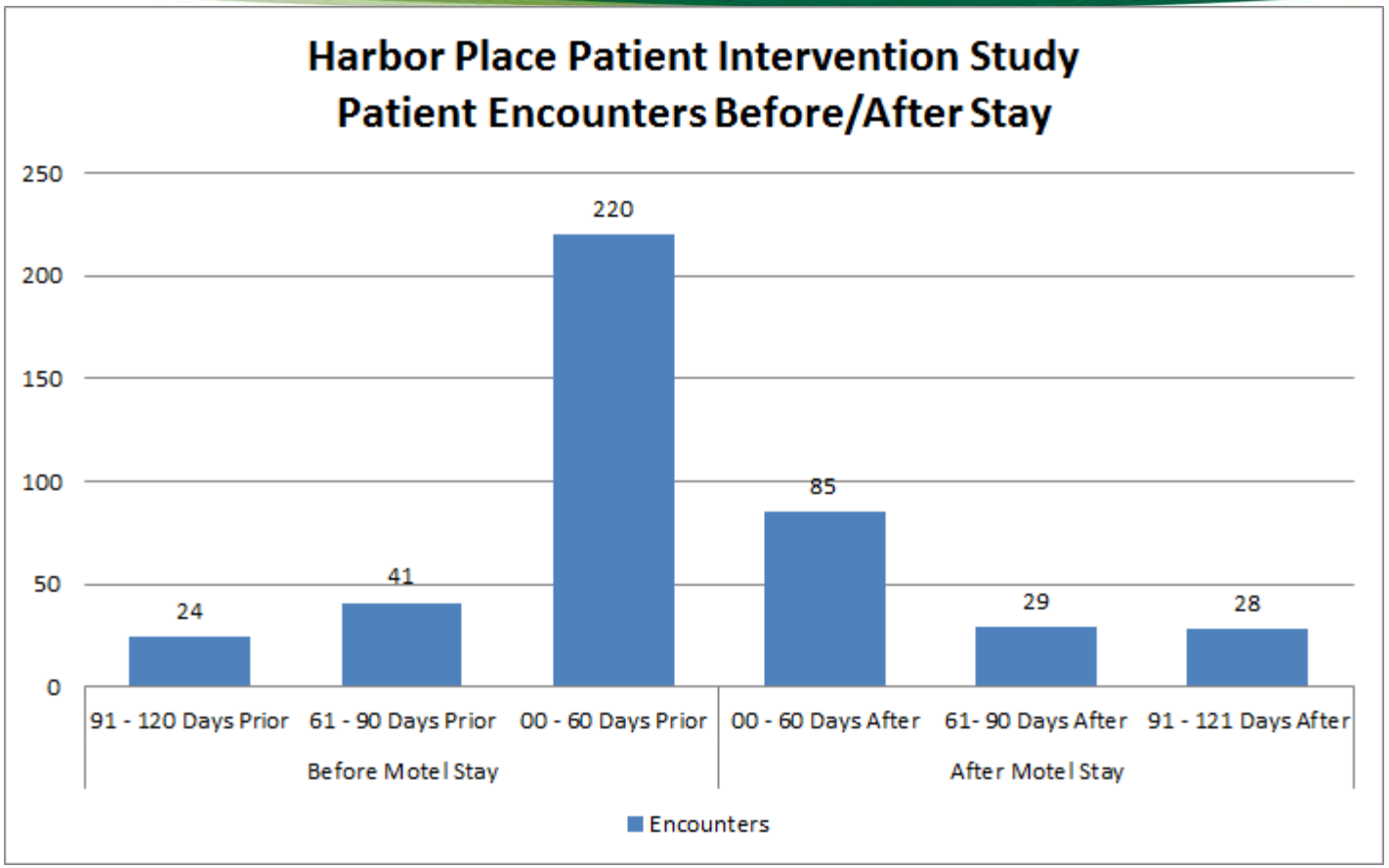

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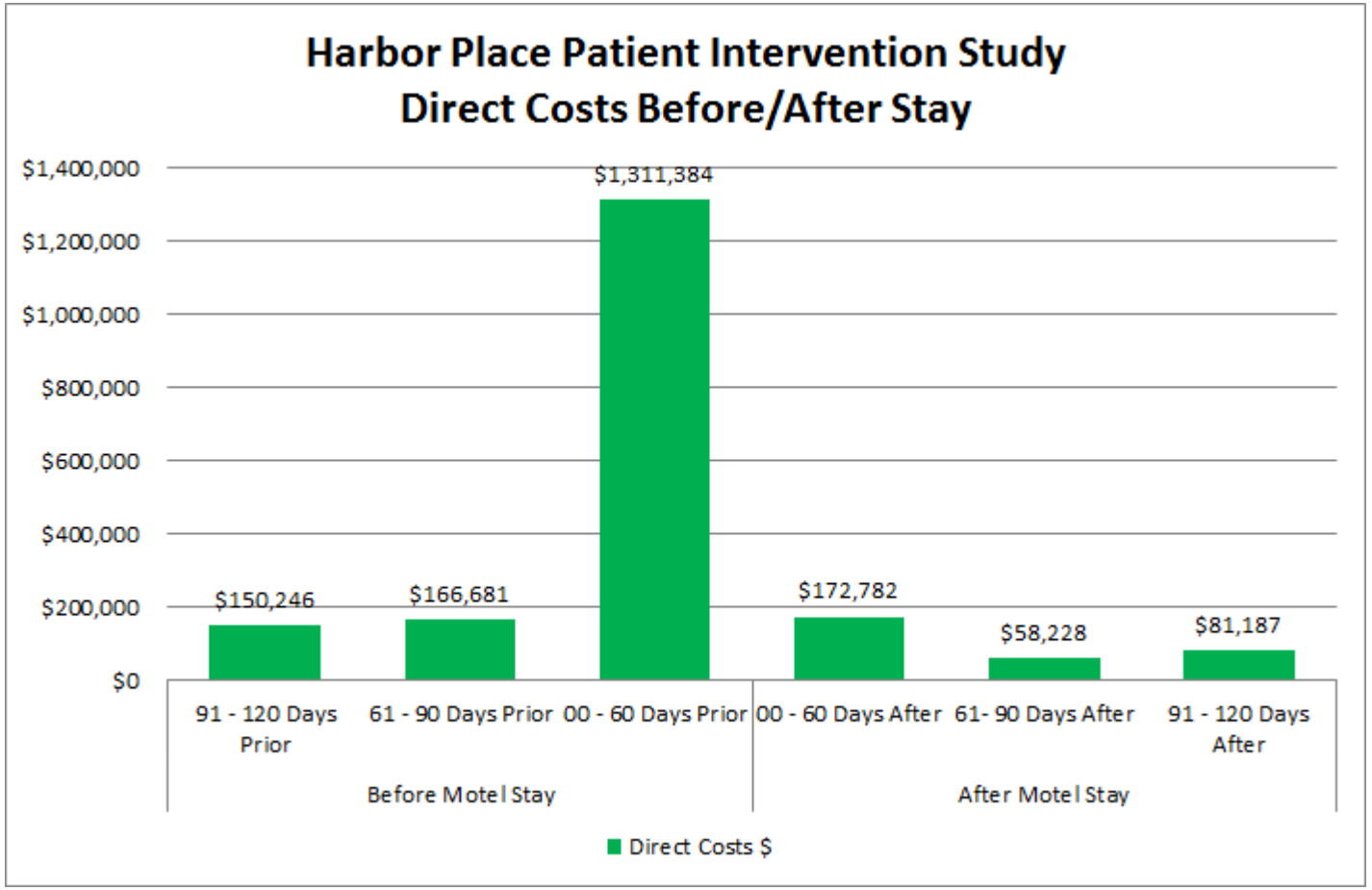

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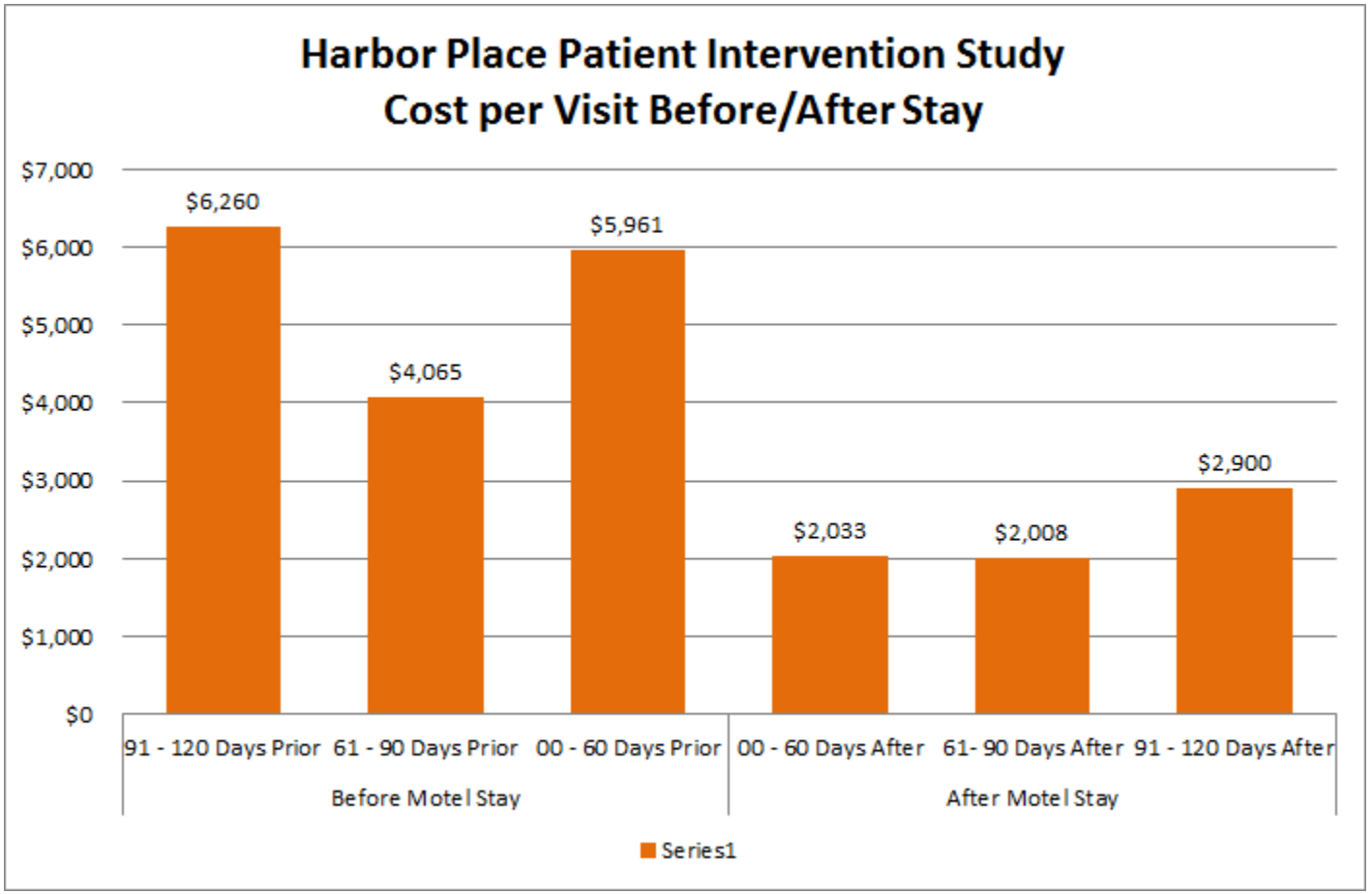

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Moving forward

- Medical Respite
- Increase in the number of permanent supportive housing units
- $3M in affordable housing investments through UVM Health Network FY15 budget adjustment
- Working with Legislature and State Government on State investments
- Measurement and evaluation mirroring the three dimensions of health care: quality, access, and cost

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- https://vimeo.com/177739962

Questions?

VERMONT

Department of Vermont
Health Access

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Women's Health Initiative

Blueprint Executive Committee
November 16, 2016

Healthier Women, Children, and Families

- In Vermont, 50% of all pregnancies are unintended
- Unintended pregnancies = increased risk, including:
  - Poor health outcomes for mothers and babies
  - Long-term negative consequences for health and well-being of children, including adverse childhood experiences (ACEs)
- Counseling and health interventions for women who intend to become pregnant can help lower risks, such as through smoking cessation counseling and treatment for alcohol and substance abuse/use
- Healthy Vermonters 2020 goal for pregnancy intention is 65%

Women's Health Initiative Program Overview

- Many women receive majority of their health care at OB-GYN and women's health clinics
- In these settings, this initiative will allow for:
  - Enhanced health and psychosocial screening
  - Comprehensive family planning counseling
  - Timely access to long-acting reversible contraception (LARC)
- By offering:
  - New staff (supplemental CHT social workers)
  - Practice support (learning collaboratives & practice facilitators)
  - Payments (for practices participating in the initiative)

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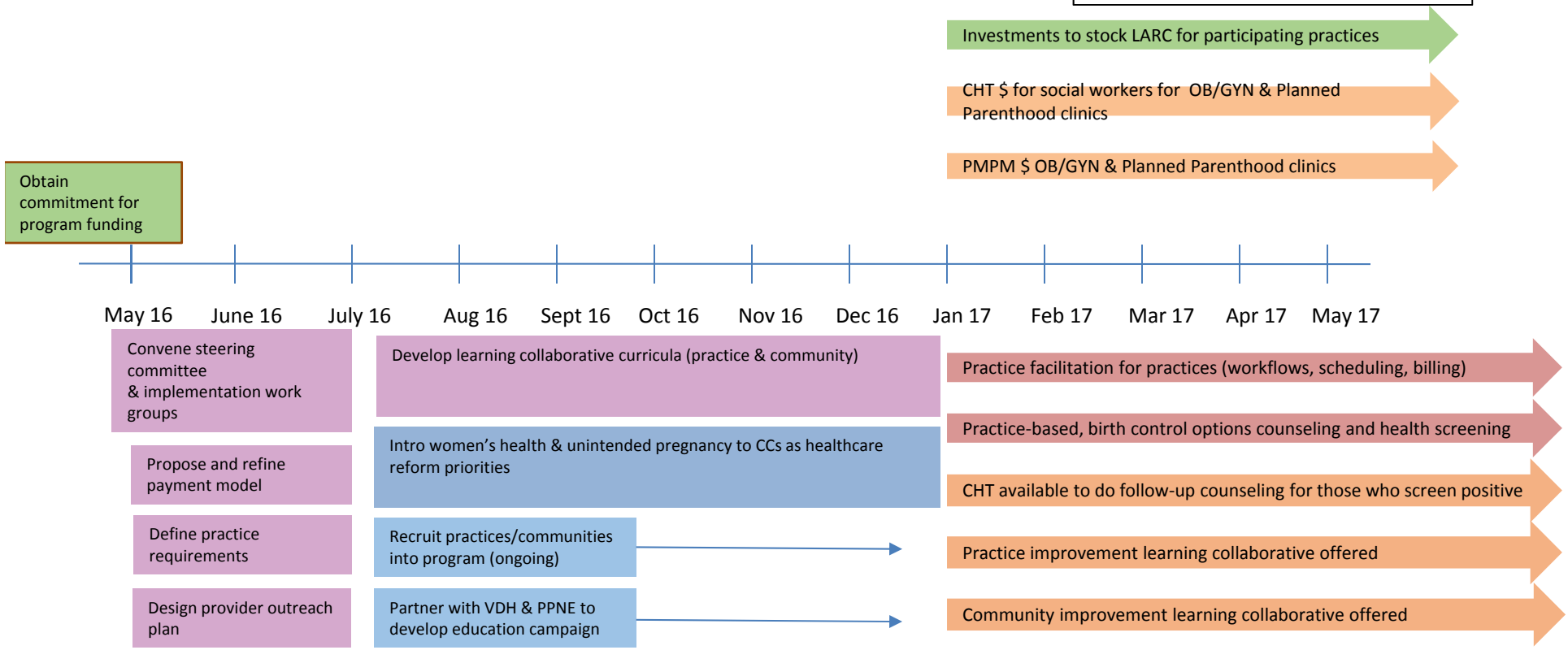
Key
CC=Blueprint / ACO community collaboratives
PPNE =Planned Parenthood Northern New England
VDH=Vermont Department of Health
LARC=Long acting, reversible, contraception
CHT= Blueprint Community Health Teams
PMPM= Per Member Per Month

Women's Health Initiative



Practice Recruitment to start on January 1

- 12 practices including hospital owned, independent and Planned Parenthood of Northern New England
- Representing 8 HSAs
  - Barre
  - Bennington
  - Burlington
  - Middlebury
  - Newport
  - Rutland
  - St. Albans
  - St. Johnsbury

Eligibility

- Practices:
  - Gynecology, maternal fetal medicine, obstetric, reproductive health, or family planning medical practice, specializing in providing women's preventive services as defined by the American Congress of Obstetricians and Gynecologists.
  - Mixed specialty medical practice with board certified obstetric or gynecology providers whose primary scope of services is women's preventive services as defined by the American Congress of Obstetricians and Gynecologists.
- Providers:
  - Physicians (MD, DO)
  - Advance Practice Registered Nurses (NP, CNM, APRN)
  - Physician Assistants

Screening and Referrals

- Workflow for psychosocial screening

  Within the first 3 months:
  - Depression
  - Current intimate partner violence and adverse childhood experience
  - Substance abuse

  Within the first 18 months
  - Access to primary care/patient centered medical home (PCMH)
  - Food insecurity
  - Housing stability
- Onsite availability of the full spectrum of LARC within 1 month
- Workflow for efficacy-based, comprehensive family planning counseling within the first 3 months
- Workflow for same-day insertion within 6 months
- Referral protocols and agreements with community based organizations to see patients within 1 week at which time they will provide same-day availability for full spectrum of birth control options within first year at least 3 agreements
- Referral protocol and agreement with PCMHs to accept patients who are identified without a primary care provider within first year at least 3 agreements

Payment

- Payments to women's health providers (PCMH not eligible)
- Payment tied to implementing screening and referrals
- Medicaid payments only to start, but other insurers/payers invited to join
- Use a 24-month lookback period for the claims-based attribution
- De-duplicated by WHI practices with patients attributed to the practice that has provided the majority of services during the 24 month look back, with attribution going toward the most recent provider if there is the same number of visits to two or more providers

Practice PMPM & CHT Payments

Practices

- Year 1 - $1.25 PMPM payment for the population of Medicaid-enrolled reproductive-age women (age 15 to 44)
- Year 2 – Up to $1.50
  $1 base and $0.50 performance component)

CHT

- CHT mental health clinicians will be available in practices for brief intervention and follow-up
- $5.42 PMPM

Capacity Payments

Provide an initial one-time capacity payment scaled based on attribution

- Graduated rates based on whether a practice is 340B eligible
- Includes a floor based minimum expectation of LARCs stocked
- Creates a ceiling of 8 of each device for larger practices

340B Eligible Practices

PMP - $4.42
Floor – $927
Ceiling – $5,163

Non-340B Eligible Practices

PMP - $11.87
Floor – $3,387
Ceiling – $16,184

Program Evaluation Work Group

- Align measures with current initiatives with a specific emphasis on selecting measures, for example, from:
  - All Payer Model
  - ACO measures
  - Act 186 measures
- Include measures at the State, HSA and organization level
- Consider measures that will change in both the long and short-term
- Enhance the HSA profiles to include WHI measures
- Provide practice profiles to WHI practices

Questions and Comments?

Alternative proposals?

6. Women's Health Initiative Practice

6.1 Definition

An eligible Women's Health practice is a medical practice or clinic that is:

- a gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practice, specializing in providing women's health preventive services as defined by the American Congress of Obstetricians and Gynecologists (ACOG); OR
- a mixed practice or clinic employs at least one board-certified obstetric or gynecology provider whose primary scope of practice is women's preventive services as defined by ACOG.

An eligible Women's Health Initiative (WHI) practice is an eligible Women's Health practice that has attested to meeting the criteria as a WHI eligible practice and is implementing the participation program requirements listed in section 6.2 below.

6.2 Patient Attribution & Enhanced Payments for the Women's Health Initiative

Eligible, participating WHI practices shall receive three (3) Blueprint-specific forms of payment from the Blueprint's WHI-participating insurers, or payers, to support the provision of high-quality women's health primary care and well-coordinated health services:

1. Recurring per person per month (PPPM) payments to WHI practices
2. Recurring payments to support WHI resources on Community Health Teams (CHTs)
3. A one-time per member payment (PMP) to support stocking of Long Acting Reversible Contraceptive (LARC) devices.

The PPPM payments are made directly to WHI practices or clinics, contingent on their attestation of 1) meeting program eligibility requirements outlined in the self-attestation document and 2) meeting program participation requirements. In effect, the PPPM payments support the quality of services provided by the practice as assessed by the program participation requirements, which are:

- Within one (1) month of receiving the PMP, the WHI practice will stock the full spectrum of LARC devices at a level adequate for the practice size, ensuring the availability of same-day insertions for women 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 WHI Patients	Minimum Number of Devices
up to 300	at least 5 devices, including 2 of hormonal IUD, 2 non-hormonal IUD, and 1 implant

Number of WHI Patients	Minimum Number of Devices
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

- Within the first three (3) months of CHT and PPPM payments starting, the WHI practice will develop and implement a policy and procedure for screening, brief intervention, and referral for depression, current intimate partner violence, adverse childhood experience, and substance abuse.
- Within the first three (3) months of CHT and PPPM payments starting, the WHI practice will update and/or implement a policy and procedure for evidence-based, comprehensive family planning counseling.
- Within the first six (6) months of CHT and PPPM payments starting, the WHI practice will develop and implement a policy and procedure to provide same-day insertion for those women who choose LARC as their preferred birth control method.
- Within the first twelve (12) months of CHT and PPPM payments starting, the WHI practice will develop referral protocols and written agreements with at least three (3) community based organizations to see patients within one (1) week of being referred for family planning services. At that visit, the WHI practice will provide same-day availability for the full spectrum of birth control options, including LARC devices.
- Within the first twelve (12) months of CHT and PPPM payments starting, the WHI practice will develop a referral protocol and written agreement with at least one (1) patient-centered medical home (PCMH) primary care practice to accept patients identified as not having a primary care provider.
- Within the first eighteen (18) months of CHT and PPPM payments starting, the WHI practice will develop and implement a policy and procedure to screen for access to a primary care provider/PCMH, food insecurity, and housing insecurity and to refer to services in the event of a positive screen.

6.2.1 Women's Health Initiative (WHI) Practice Payments

The enhanced PPPM payment for WHI practices in conjunction with additional CHT funding aims to assist practices in providing well-coordinated preventive women's health services for all female patients aged 15 – 44 years.

The Blueprint will provide payers with practice roster information received from all WHI practices. Payers will use the practice roster information to calculate claims-based Blueprint patient attributions for each WHI practice, as specified in Appendix 7, for validated WHI providers.

Validated WHI providers are eligible providers, including physicians (MDs and DOs), advanced practice registered nurses (NPs and CNMs), and physician assistants, who either:

- Work in a gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practice that provides women's health 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 women's health preventive services as defined by ACOG.

The enhanced WHI practice PPPM payment is based on the number of total unique patients attributed to the practice and to validated WHI providers by each insurer. The attribution method used by all insurers determines the practice's active caseload. Insurers will attribute all patients having a majority of their women's health visits (Appendices 7 & 8) to the practice in the last 24 months. The payers have elected to apply this lookback period based on their beneficiaries' demographics, recommended health maintenance, and health-related risks. Payment is contingent on the WHI practice's completion of the program participation requirements as outlined above.

The definition of a "current active patient" is as follows:

- Female
- Age 15 through 44 years
- Majority of women's health visits in WHI practice (Evaluation & Management Code) within the 24 months prior to the date of conducting the attribution process and in accordance with the algorithms presented in Appendix 6 and Appendix 7 of this document
- If a patient has an equal number of qualifying visits at more than one WHI practice, then that patient will be attributed to the practice with the most recent visit.
- Patient attributions for members of Blueprint-participating self-insured plans will be included.
- Attribution is recalculated at least quarterly.

The WHI practice PPPM payment helps support the operations of a women's health preventive care practice or clinic. The payer will provide the enhanced WHI practice PPPM payment for all patients attributed to the payer in the practice. The algorithm to identify

attributed patients for Commercial and Medicaid payers is presented in Appendix 7. Upon request of the practices or their parent organizations, the payer will provide the list of attributed patients for review and reconciliation. To calculate the total amount of the WHI practice PPPM payment for each practice, the payer will multiply the number of attributed patients in the practice by the WHI practice PPPM amount.

For the first twelve (12) months of participation in the program (pilot year), WHI practices will be paid a $1.25 PPPM maximum capitated payment. Starting the second year of participation in the program, WHI practices will be paid a base payment of $1.00 PPPM, based on their self-attestation. Additionally, a WHI practice could earn a quality payment of up to $0.50 PPPM based on performance measures and utilization measures. This WHI practice PPPM will be sent directly to the practice, clinic, or parent organization.

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

Each insurer 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 insurer will send to the Blueprint a list of the counts of attributed patients and WHI practice PPPM payments made for the prior calendar quarter for WHI practices broken out by practice (including Blueprint Practice ID) and payment month. This reporting will enable payment verification and rollups across payers at the practice and Health Service Area (HSA) levels.

The attribution methodology found in Appendix 7 and Appendix 8 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, Expansion Design and Evaluation Committee, and Executive Committee. The WHI practice PPPM amounts can be revised 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 new practices or practices rejoining the Blueprint will be effective on the first day of the month following the date when the Blueprint transmits confirmation of receipt of the self-attestation document to all payers. Changes in payment resulting from subsequent changes in scores from the quality-of-care measures and/or the utilization measure will be implemented by all payers on the first day of the month after scores are received by all payers from the Blueprint.

6.2.1.1 WHI Practice PPPM Payment Model

The WHI practice PPPM payment model offers a means for more adequately funding women's health preventive services. For Medicaid and commercial insurers, the total capitated payment to women's health providers is based on completion of the program participation requirements in the pilot year with the addition of performance-based quality and utilization components of the payment in subsequent years.

The outcome measures driving the performance component in year 2 include a Quality Index and a Total Utilization Index, the measures of which are yet to be determined. The new women's health preventive services model for Medicaid and commercial insurers includes the following elements:

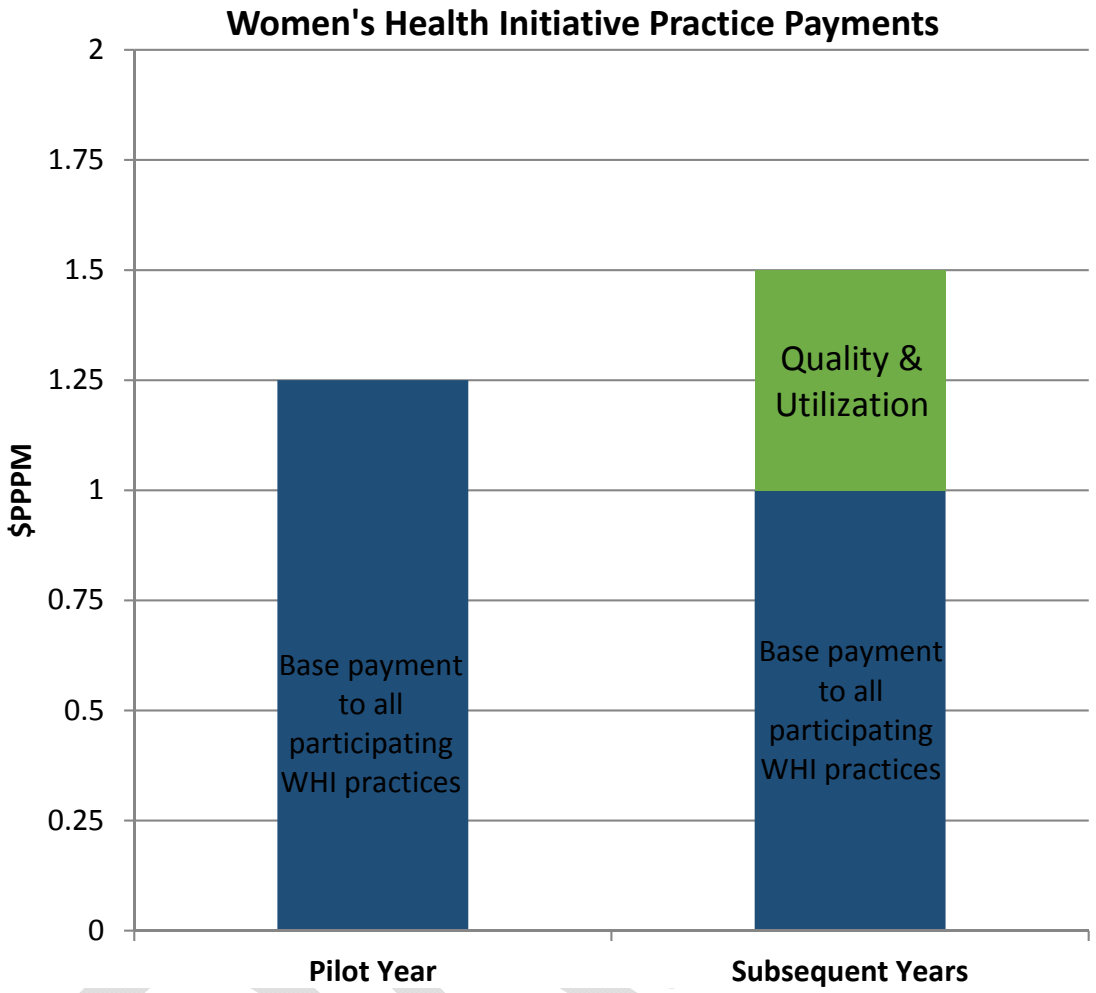
- Base Component: First year of participation (Pilot Year) = $1.25; Subsequent Years = $1.00
    - Requires successful completion of the self-attestation eligibility documents
    - Requires successful completion of the program participation requirements, outlined in section 6.2 of this document

- Quality Performance Component (Year 2 and subsequent years):
    - Up to $ 0.25 PPPM

- Utilization Performance Component (Year 2 and subsequent years):
    - Up $ 0.25 PPPM

- Total Payment in Pilot Year = $1.25
- Total Payment in Subsequent Years = $1.00 + Quality Index + Utilization Index
- Total Payment in Subsequent Years ranges from $1.00 to $1.50 PPPM

Figure 3. Women's Health Initiative (WHI) Practice Payments



6.2.2 Supplemental Community Health Team (CHT) Payments

Supplemental CHT payments help augment existing CHT staff with licensed mental health professionals. The insurers will share the costs associated with the supplemental CHT 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 served by the supplemental CHT staff workers, WHI practices and participating payers will calculate and report the number of active patients attributed to WHI practices in the previous two years. The 24-month lookback period attempts to estimate the number of active patients in a WHI practice that can potentially be engaged in preventive women's health care with effective outreach from WHI practices.

All participating payers will share in the cost of the supplemental CHT payment, proportional to their share of the payer-reported, claims-attributed WHI patient population (claims-attributed total unique patients). Patient volume and payer contribution proportions will be derived from the attribution and WHI payment reports

submitted quarterly by payers to the Blueprint. Payment calculation updates will lag by at least one quarter to allow for the receipt of complete attribution reports.

For purposes of the Blueprint payment specifications, "number of patients" means the number of total unique Vermont female patients aged 15 to 44 years in WHI-participating practices with a majority of their primary care (Evaluation and Management) claims coded to visits in the WHI practices during the previous 24 months. Appendix 7 contains the algorithm to be used by WHI practices to calculate and report total unique Vermont WHI patients. Appendix 8 contains the algorithm to be used by payers to calculate and report total unique Vermont WHI patients. Patient attributions for members of WHI-participating self-insured plans will be included.

Supplemental CHT payments are scaled based on the population of payer claims-attributed WHI patients per month.[1] Commercial and Medicaid payers will pay $5.42 per payer claims-attributed patient per month (PPPM).

The payer will make supplemental 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 the payer requires an invoice) by the 15th calendar day of the month or the 15th calendar day of each quarter. Invoices will reflect the Administrative Entity's supplemental CHT payments as determined by the Blueprint based on the total unique Vermont female patients aged 15 to 44 years in WHI-participating practices. Changes in the amount of financial support due to scaling up or down of CHT capacity will be made quarterly by the Blueprint 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 5th 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[2], and validated proportionally by data provided by

[1] Supplemental CHT payments, and by extension the number of full time equivalent (FTE) supplemental CHT staff members, have been based on an average of 3,000 payer claims-attributed WHI patients for each unit population, with unit populations being females aged 11 to 14, 15 to 19, 20 to 24, 25 to 29, 30 to 34, and 35 to 44. With the proportion of payer claims-attributed WHI patients needing brief treatment from supplemental CHT staff being estimated at one-third, the average treatment being 3 1-hour sessions, the average hours worked by a supplemental CHT staff licensed mental health professional being 1200 hours, and the average salary of a supplemental CHT staff licensed mental health professional being $78,000, the supplemental CHT payment is $5.42 per-patient-per-month.
((((((3,000 payer-claims-attributed WHI patients*1/3 need intervention)*3 average intervention hours)/1,200 average social worker hours per year)*$78,000 average social worker yearly salary)/3,000 payer-claims-attributed WHI patients)/12 months)

[2] 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 supplemental CHT payments by HSA.

CHT Administrative Entities to the Blueprint. The Blueprint will also provide payers with a monthly practice and provider roster of WHI 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 Administrative Entity in the HSA, the CHTs for each administrative entity will be treated as individual CHTs for payment purposes. If more than one Administrative Entity exists in an HSA, 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.

6.2.3 LARC Per-Member Payment (PMP)

The purpose of the LARC PMP is to assist WHI practices in designing and implementing a process to stock LARC devices to facilitate offering patients same-day availability for LARC insertion. The insurers will share the costs associated with the LARC PMP and will send their share of LARC PMP costs directly to the WHI practices.

To estimate the size of the patient population served by the upfront LARC capacity payment for each WHI practice, participating practices and participating payers will calculate and report the number of active WHI-attributed patients seen in WHI practices in the previous two years. The 24-month lookback period offers an estimate of the number of active patients in a WHI practice who can potentially choose same-day LARC insertion with effective outreach from WHI practices.

All participating payers will share in the cost of LARC PMP, proportional to their share of the payer-reported, claims-attributed, WHI patient population (claims-attributed total unique patients). Patient volume and payer contribution proportions will be derived from the attribution, and WHI payment reports submitted preceding a Women's Health Initiative initiation date for a WHI practice.

For purposes of the Blueprint payment specifications, "number of patients" means the number of total unique Vermont female patients aged 15 to 44 years in WHI-participating practices with a majority of their primary care (Evaluation and Management) claims coded to visits in the WHI practices during the previous 24 months. Appendix 7 contains the algorithm to be used by WHI practices to calculate and report total unique Vermont WHI patients. Appendix 8 contains the algorithm to be used by payers to calculate and report total unique Vermont WHI patients. Patient attributions for members of WHI-participating self-insured plans will be included.

The LARC PMP is based upon a floor of stocking at least two hormonal and two non-hormonal IUDs, and 1 implant. These 4 IUDs, two hormonal and two non-hormonal, in addition to 1 implant comprise the minimum stocking requirement for WHI practices. There is a ceiling of stocking 8 of each device, yielding a total of 24 devices for each WHI practice. WHI practices that receive payment for more than 2 IUDs of each type and the 1

implant have the flexibility to choose among the available options to fulfill the needs of their patients after stocking the minimum requirement.

The LARC PMP is a graduated rate based on whether a practice is 340B eligible. The LARC PMP is scaled based on the population of payer claims-attributed WHI patients in the 24-month lookback period preceding a WHI practice initiation date.[3] Commercial and Medicaid payers will pay a $4.42 per member payment for 340B eligible WHI practices or a $11.87 per member payment for non-340B eligible WHI practices. The payer will make the LARC PMP one time, as determined by the WHI initiation date set by the WHI practice.

[3] The LARC PMP is based upon an average number of 43,090 Medicaid women annually eligible for LARC insertion. Knowing that 30% of these women are attributed to a 304B eligible WHI practice and knowing the total upfront LARC cost for the minimum stocking requirement for 340B eligible WHI practices is $268, the floor for 340B eligible WHI practices is set at $927 and the ceiling is set at $3,387. Knowing that 70% of Medicaid women eligible for LARC insertion are attributed to a non-340B eligible WHI practice and knowing the total upfront LARC cost for the minimum stocking requirement for non-340B eligible WHI practices is $720, the floor for non-340 eligible WHI practices is set at $5,163 and the ceiling is set at $16,184.

APPENDIX 7
VERMONT BLUEPRINT PRACTICE
TOTAL UNIQUE VERMONT PATIENTS ALGORITHM

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

2. Identify all female patients aged 15 to 44 years 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 following qualifying CPT Codes during the look back period (most recent 24 months).

CPT-4 Code Description Summary
PCMH & WHI Codes
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409

CPT-4 Code Description Summary
• New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
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
WHI 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
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, and J7300-J7307 • S4981, S4989, and S4993

CPT-4 Code Description Summary
• 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 • 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

APPENDIX 8
VERMONT BLUEPRINT PPPM COMMON ATTRIBUTION ALGORITHM
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.

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 WHI-recognized practice.

4. For other members/beneficiaries, select all claims for beneficiaries identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 24 months) for women's health providers included on WHIP payment rosters, <u>where the provider's credential is as a doctor of medicine, doctor of osteopathic medicine, nurse practitioner, certified nurse midwife, or physician assistant.</u>

CPT-4 Code Description Summary
PCMH & WHI Codes
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact

CPT-4 Code Description Summary
• 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
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WHI 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
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

CPT-4 Code Description Summary
• 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, and J7300-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 • 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 PPPM payments at least quarterly, by the 15th of the second month of the quarter. Base PPPM payments on the most current PPPM 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 3/1/2013, payment for 3/1/2013 through 6/30/2013 would occur by 5/15/13.