

Vermont Blueprint for Health Manual

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1. Introduction to Blueprint for Health Manual

1.1. Intent

The Blueprint is a state-led program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness, for all Vermonters. Acting as an agent of change, the Blueprint is working with a broad range of stakeholders to implement a novel 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 to Reduce, or at least control, the per capita cost of care. A growing national consensus suggests that this Triple Aim, as promoted by the Institute for Healthcare Improvement (IHI), can be achieved through health services that are safe, effective, efficient, patient centered, timely, and equitable (*Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academy Press, Institute of Medicine; 2001).

The foundation of the Blueprint model is Advanced Primary Care that meets patients and families' needs by coordinating seamlessly with a broad range of health and human services. This Manual is a guide for primary care practices, health centers, hospitals, and providers of health services (medical and non-medical), to implement the Blueprint's Multi-payer Advanced Primary Care Practice (MAPCP) model in their community, and to become part of a statewide Learning Health System. The Blueprint model includes the following components: multi-insurer payment reforms that support advanced primary care practices and community health teams; a statewide health information architecture that will support coordination across a wide range of providers of health and human services; and an evaluation and quality improvement infrastructure to support a Learning Health System which continuously refines and improves itself.

For Blueprint policy sources, please see Title 18 V.S.A. Chapter 13, Sections 702-709 (available at <http://legislature.vermont.gov/statutes/>), DVHA Rules 8100-8105.2 (available at <http://dvha.vermont.gov/budget-legislative>), and this Blueprint Manual (available at <http://blueprintforhealth.vermont.gov/implementation-materials>).

1.2. Process for Updating Blueprint for Health Manual

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

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 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 consist of no fewer than 10 individuals including but not limited to:

- Commissioner of Health
- Commissioner of Mental Health
- Representative from the Department of Banking, Insurance, Securities, and Health Care Administration
- Representative from the Department of Vermont Health Access
- Representative from the Vermont Medical Society
- Representative from the Vermont Nurse Practitioners Association
- Representative from a Statewide Quality Assurance Organization
- Representative from the Vermont Association of Hospitals and Health Systems
- Two Representatives of Private Health Insurers
- Representative of the Vermont Assembly of Home Health Agencies who has clinical experience
- Representative from a Self-insured Employer who offers a Health Benefit Plan to its Employees
- Representative of the state employee's health plan, who shall be designated by the director of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan
- Representative of the complementary and alternative medicine professions
- A primary care professional serving low income or uninsured Vermonters
- A consumer

In addition, the Director of the Commission on Health Care Reform shall be a nonvoting member of the Executive Committee.

Meeting Frequency: Regular meetings shall be held monthly, convening no fewer than 6 times annually. Meeting schedules, committee membership, minutes and updates can be found by going to http://blueprintforhealth.vermont.gov/workgroups_and_committees.

Members Responsibilities: Members will be expected to attend all meetings except as they are prevented by a valid reason.

2.2. Blueprint Expansion Design and Evaluation Committee

Purpose: The Blueprint Expansion Design and Evaluation Committee shall advise the Blueprint Director in more detailed planning related to program design, including modifications over time, for statewide implementation of the Blueprint model and to recommend appropriate methods to evaluate the Blueprint.

Committee Make-up: The Blueprint Expansion Design and Evaluation Committee is composed of but not limited to the following individuals:

- Members of the Executive Committee (or designee)
- Representatives of participating health insurers
- Representatives of participating medical homes and community health teams
- Deputy Director of Health Care Reform
- Representative of the Bi-State Primary Care Association
- Representative of the University of Vermont College of Medicine's Office of Primary Care
- Representative of Vermont Information Technology Leaders, Inc.
- Consumer representatives

Meeting Frequency: Regular meetings will be held every other month with no fewer than six meetings annually. Meeting schedules, committee membership, minutes and updates can be found by going to

http://blueprintforhealth.vermont.gov/workgroups_and_committees.

Members Responsibilities: Members shall be expected to attend all meetings except as they are prevented by a valid reason.

2.3. Blueprint Payment Implementation Work Group

Purpose: The purpose of the Blueprint Payment Implementation Work Group is to implement the payment reforms that support advanced primary care practices and community health teams, design the payment mechanisms and patient attribution strategies, modifications over time, and to make recommendations to the Blueprint Expansion Design and Evaluation Committee.

Work Group Make-Up: The Blueprint Payer Implementation Work Group is composed of but not limited to the following individuals:

- Representatives of the participating health insurers (public and commercial)
- Representatives of participating advanced primary care practices 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 complies with open meeting and public record requirements. Meeting schedules, work group membership, minutes and updates

can be found by going to [http://blueprintforhealth.vermont.gov/workgroups and committees](http://blueprintforhealth.vermont.gov/workgroups_and_committees).

Members Responsibilities: Members shall be expected to attend all meetings except as they are prevented by a valid reason.

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 All-Payer Model (APM) and the Blueprint program in their HSA. Lead administrative entities within each HSA will also receive multi-insurer payments to support hiring of Community Health Teams, and therefore must be Centers for Medicare and Medicaid Services (CMS) eligible providers.

4. Design & Implementation

4.1. Statewide Health Reform

The Vermont Blueprint for Health is a State of Vermont program created to work with the health and human service providers to design, test, and implement innovative ways of delivering and paying for health services and prevention projects targeted at improving the health of all Vermonters and reducing the growth in health care costs. To achieve these goals, the Blueprint works with other partners to advance health care reform statewide.

4.1.1 Accountable Care Organization

Accountable Care Organizations (ACOs) are member organizations composed of health care providers (hospitals, specialty medical practices, and primary care practices) and affiliated organizations (home health agencies, mental health agencies, area agencies on aging, etc.). ACOs, on behalf of their members, enter into agreements with insurers to take on financial risk for the total cost of healthcare services and accountability for the health outcomes of attributed beneficiaries. ACOs may receive payments for delivering the health care services in lieu of fee-for-service payments. In Vermont, the ACO serving this function is OneCare Vermont.

4.1.2 All-Payer Model

The Vermont All-Payer Accountable Care Organization (ACO) Model is the Centers for Medicare & Medicaid Services' (CMS) new test of an alternative payment model through an ACO in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care

delivery system and transform health care for the entire state and its population. (See <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>.)

4.1.3 Population Health and Clinical Priorities

Through the All-Payer Model (APM) 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, the Accountable Care Organizations in the state have established clinical priorities with their members, and the Blueprint supports these efforts.

4.1.4 Health Service Areas

To achieve the All-Payer Model population health outcomes and ACO clinical priorities, the Blueprint and ACOs have focused on supporting and making joint investments into communities to innovate and organize their health services. Thirteen communities or geographic regions, known as health service areas, 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 8.

4.2. Community Collaboratives

To help coordinate efforts in each Health Service Area, a governance body and associated work group structure known jointly as a Community Collaborative is in place. The Community Collaborative is accountable for achieving the state population health and ACO's goals within their local health service area.

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 will use the Accountable Community for Health (ACH) framework, by addressing the medical and non-medical needs that affect measurement results and 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 span from focusing on the integration of high-quality medical care, mental health services, substance use treatment, long-term services and supports, and incorporates social services to community-wide primary prevention efforts.

4.2.1 Community Collaboratives—Governance

Based on this breadth of focus, a local governance body has been created in each health service area that 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 to be 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
- Blueprint Project Manager

Additional members may be added if necessary to achieve the goals established by the community. AHS local leaders (AHS Field Directors, Public Health District Directors) and Blueprint Project Managers may serve and/or support these activities.

The governing body works across organizational boundaries to assess the outcomes in the Health Service Area, compares outcomes to state population health and ACO goals in a community health needs assessment, establishes local goals, monitors progress towards those goals, establishes a plan and workgroups to achieve the goals, allocates financial and human resources from individual organizations to achieve collective outcomes, and jointly seeks funding and support for local projects. The Blueprint Project Manager shall facilitate Community Collaborative meetings and workgroups unless a mutually agreed upon alternative is submitted to and approved by the State.

4.2.2 Community Collaboratives—Workgroups

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

The Community Collaborative also provides local oversight and coordination for the current healthcare reform initiatives and investments being made into the local health services areas.

The following workgroups are required in each Community Collaborative unless a mutually agreed upon alternative is approved: a care coordination team, a primary prevention (such as RiseVT/3-4-50) team, a community-based self-management program team, and a group focusing on clinical quality improvement.

4.3. Community Health Team

The Administrative Entity shall have primary oversight for the CHT including acting as the fiscal agent for CHT funding received by the insurers, maintaining a community health team plan under the direction of the Community Collaborative, and ensuring the CHT is fully staffed.

4.3.1 Community Health Team Plan

In consultation with the Community Collaborative advisors, community partners, and participating practices, the Project Manager shall update the CHT staffing design and submit the plan to the State annually and, after that, upon request by the State and prior to changes in the design. The CHT design plan shall include:

- CHT staff, including roles, credentials, and FTEs;
- Function of the CHT; and
- Detailed budget comprised of any and all administrative, operational, and personnel costs, as well as investments in kind.

The CHT design plan shall be made available and presented to the Community Collaborative governing body and committees at least annually. Alternately, the Community Collaborative governing body may elect to appoint a CHT design subcommittee.

4.3.2 Community Health Team Budget

The Project 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 forums 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 and shall be available to the Community Collaborative, allowing for appropriate measures to protect employee privacy.

4.3.3 Community Health Team Evaluation.

The Administrative Entity 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 Administrative Entity 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 shall provide CHT staff based on the CHT staffing plan.

The Administrative Entity shall provide organizational support for the operations of the CHTs, including ongoing mentoring and supervision of team members and the CHT Leader. The CHT Leader shall be responsible for the day-to-day supervision of CHT staff members.

The Administrative Entity, under the direction of the Community Collaborative, shall direct CHT staff to work on activities outlined in all levels of care in the population health model.

The Administrative Entity shall work collaboratively with the State and the ACOs, to prepare and launch new initiatives and service layers as they arise. The Project Manager shall 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, shall be filled within 60 days.

4.3.5 Community Health Team Integration

The Administrative Entity shall 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 Assisted Treatment (MAT) licensed, registered nurses and licensed, Master's prepared substance use disorder or mental health counselors for office-based treatment of opioid use disorder;
- Women's Health Initiative (WHI) licensed, Master's prepared mental health professionals to work in WHI practices;
- Support and Services at Home (SASH) nurses and care coordinators for Medicare beneficiaries living in congregate housing or in the community for assistance with 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; and
- Designated Agencies.

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; and

- Mechanisms for risk stratification and algorithms for determining which care managers will provide care for different patient populations and at what level of acuity.

The Project Manager shall document and report to the State:

- Respective roles of the Core CHT and other care management providers, including ACO resources such as Clinical Consultants;
- CHT model evaluation results and specific plans to address gaps;
- Alignment with the care coordination model;
- 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-Assisted Treatment

Vermont’s Hub and Spoke program for treating opioid use disorder has garnered national attention for its comprehensive approach to providing Medication Assisted Treatment (MAT). Hub and Spoke integrates programs providing higher levels of care (opioid treatment programs, called “Hubs”) with programs offering treatment in general medical settings (office-based opioid treatment programs, called “Spokes”).

The Blueprint, in collaboration with the Vermont Department of Health, offers training and support for practices to implement MAT 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 MAT, set up program protocols, and begin the process of providing team-based, patient-centered care for Vermonters with opioid use disorder.

4.3.7 Women’s Health Initiative

The Women’s Health Initiative (WHI) extends the Vermont Blueprint for Health to obstetrics, gynecology, family planning and nurse midwifery practices. Because many women receive substantial preventive care services in these practices, there is an opportunity to increase access to additional services to improve health outcomes for women and children, as well the potential to reduce unintended pregnancies. The WHI promotes psychosocial screening, supports brief in-office intervention, connects patients with community supports, and offers enhanced payments to participating practices to achieve these goals. (See Section 6)

4.4. Blueprint Program Management

Each Administrative Entity hires a Blueprint Project Manager to oversee the Blueprint activities in an HSA. The Project Manager will be the primary local contact responsible for

management of all programmatic and administrative components of the agreement. If more than one individual is sharing this role, a single point of contact will be named.

4.4.1 Program Management—Program Monitoring

The Project Manager will meet regularly with a Blueprint Assistant Director, or a designee of the Blueprint Executive Director, either in-person or via telephone call, according to a schedule established by the State. The Project Manager will prepare and submit to the State regular reports describing program progress, successes, and challenges. The State reserves the right to request updates on specific activities within the Health Service Area either in advance of, or during, the regularly scheduled meetings.

4.4.2 Program Management—State Meetings

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

- All Field Team meetings (in person);
- Blueprint Expansion Design and Evaluation Committee meetings (often combined with Executive Committee meetings);
- Blueprint Payment Implementation Work Group meetings;
- Project Manager meetings;
- ACO Clinical Committees;
- Care Coordination Core Team meetings;
- Information Technology meetings;
- The Blueprint Annual Conference (in person); and
- Self-Management Regional Coordinator meetings (when needed).

4.4.3 Program Management—Community Collaboratives

The Project Manager role includes the facilitation of the Community Collaborative/ACH. Community Collaborative meetings include both the governance body and required health service area specific workgroups. Facilitation includes recruiting relevant committee members, working with committee chairs, if applicable, and members to set agendas, recording decisions made during meetings, monitoring progress on work that will be completed by members between meetings, including what will be completed, by whom and by when, following-up with members between meetings to ensure progress is being attained, identifying and preparing presenters prior to the meetings, ensuring effective communication between members during the meetings, and reporting the progress of the Community Collaborative to the committee and workgroup members.

4.4.4 Program Management—Practice Outreach and Participation in Health Reform

The Project Manager shall maintain ongoing relationships with all primary care (internal medicine, general medicine, geriatric medicine, family medicine), women’s health, and substance use disorder treatment practices within the health service area, as evidenced by 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, MAT, WHI, self-management, and ACO) and Community Collaborative activities. Annual outreach shall include an in-person meeting with each practice, or if the practice refuses to meet, then documentation of an electronic or paper memo.

The Project 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, 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 Project Manager will monitor the status of each practice's participation as a patient centered medical home, integration of the community health team, participation in ACO and Community Collaborative quality improvement projects, implementation of the care model, medication assisted treatment and the women's health initiative. The Project Manager shall report on the status of each practice during monitoring meetings with the State and ongoing any issues encountered by practices to the State and ACOs as they arise. The Project Manager will ensure alignment with ACO care coordination activities and requirements, serving as the local point person for communications between local care coordination teams and the ACO care coordination team, and providing project management support as needed for ACO care coordination efforts in the HSA.

4.4.5 Program Management—Recruit Participation in Quality Improvement

In collaboration with the QI facilitators, the Project Manager will also support primary care practices in implementing quality improvement initiatives by:

- Providing access to relevant data reports and interpretation of these reports, such as Blueprint practice and Health Service Area profiles, Emergency Department (ED) use, inpatient admissions, data on trends in hospital readmission rates, population outreach reports, access to lists of patients for each practice, and other relevant patient data.
- Evaluating practices' effective use of ACO analytic resources, such as ACO reports, Workbench One, Care Navigator, other ACO self-serve analytics tools;
- Reporting at check-in meetings on progress of quality improvement projects between practices, specialists, hospitals, and community organizations based on core clinical measures and State healthcare reform initiatives, including APM measures, ACO clinical priorities, and population health measures;
- Developing referral processes to Blueprint-sponsored self-management programs into

primary care and women’s health practice workflows, including a feedback loop back to primary care providers;

- Providing education on, and CHT staff support for, empanelment and panel management, such as 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 primary care practices and creating innovative opportunities for learning and communication between primary care practices; and
- Developing and coordinating co-management and referral agreements with practices in the health home neighborhood (integrated community).

4.4.6 Program Management—MAT and WHI Practice Contacts

The Project Manager shall be in contact with all practices and programs providing medication assisted treatment for opioid use disorder within the Health Service Area on an at least quarterly basis to encourage their participation in the statewide “Hub & Spoke” and Women’s Health Initiative, to coordinate hiring and deployment of MAT and WHI staff, and to support quality improvement projects to improve care and patient outcomes. The Project Manager will also collaborate with local leadership to encourage the recruitment of additional providers to offer MAT.

4.4.7 Program Management—Health Reform Communication

The Project Manager shall be responsible for communicating directly with practices as frequently as necessary on changes in statewide healthcare reform policies and procedures, especially as they affect practice processes, participation requirements, involvement in other State or national reform or billing efforts, ACO activities, and Blueprint program payment levels and practice eligibility criteria. The Project 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 Project Manager shall coordinate, support, and partner with others in activities that strengthen data passed into, and available for reporting from, Vermont’s Health Information Exchange and health information technology and data infrastructure, including Care Navigator and Workbench One as available.

4.4.8.1 Care Management and Analytic Tools

The Project Manager shall work with the State and ACOs to implement and utilize innovative technologies supporting health reform efforts through their work with practices, affiliated community organizations, and CHT staff. For example, in the Health Service Areas with access to Care Navigator and Workbench One, the Project Manager shall develop a local work plan to implement analytic tools such as Care Navigator and Workbench One, identify the care team that needs to be trained, recruit care team members and practices to participate in trainings, and monitor the implementation and utilization of the tools using data provided by the ACOs.

4.4.8.2 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. The Project 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 Project 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 (<https://blueprintforhealthportal.vermont.gov/>) to Project Managers as the data collection tool for required information according to the following schedule:

- a. Total Unique Patients Reports: Each quarter, the Project Manager or designee shall accurately enter and update practice-level patient counts (PCMH and WHI), to determine CHT staffing ratios, prior to the fifteenth (15th) day of the last month of the calendar quarter (March, June, September, and December).
- b. Practice Rosters (Practice Summary Reports): Each quarter, on or about the fifteenth (15th) day of the first month of the quarter, the State shall notify and identify to the Project Manager or designee a cohort of those practices which are scheduled to undergo NCQA PCMH scoring approximately 6 months in the future. For those identified practices, the Project Manager or designee shall enter and update all practice and provider information within a month, prior to the 15th day of the month following the notification date and identification of the list of practices to the Administrative Entity from the State.
- c. CHT/MAT/WHI Staffing and Practice Demographics Reports: Each quarter, prior to the fifteenth (15th) day of the first month of each calendar quarter (January, April, July, and October), the Project Manager or designee shall enter and update CHT/MAT/WHI staffing and practice demographics information.

The Administrative Entity, via the Project Manager or designee, shall report practice changes (being changes to practice-specific information previously submitted to the Blueprint Provider Directory), 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 Provider Directory.

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 insurer funding for CHT and PCMH operations until the information is collected, updated, and submitted.

4.4.9.2 Payment Communication

The Project Manager shall be responsible for communicating updates on payment-related processes to practices as they occur based on updates received from the State and 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. Advanced Primary Care Practice

4.5.1 Definition

An Advanced Primary Care Practice 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.

Primary care practices receive per member per month payments in exchange for providing enhanced services as a Patient-Centered Medical Home (PCMH), integrating a CHT into their practice, connecting to the health information technology infrastructure and participating in the Community Collaborative efforts. The starting point for practices participating in the Blueprint is becoming recognized as patient centered medical homes by the National Committee for Quality Assurance (NCQA). Patient centered medical homes form the foundation of the ACO and are central to the care model. For low risk patients, they promote healthy behaviors and preventive health screenings, for moderate risk patients they assist with self-management support to prevent chronic diseases from progressing, with high-risk and very high-risk patients they are an integral part of the care teams, with a lead care coordinator for people who have complex medical conditions.

4.5.2 NCQA Scoring

Overview: The Blueprint uses the NCQA PCMH standards to evaluate and score practices (as well as the other requirements) to become and to maintain their status as Blueprint Advance Primary Care Practices. A copy of the standards can be found on the NCQA website at <http://www.ncqa.org>. The practice is responsible for paying the required fee to NCQA for their review, validation, and recognition.

The overarching goal, mandated in Act 128, is to extend the program to all willing primary care providers.

In order to be eligible for enhanced payments as an Advanced Primary Care Practice, Vermont practices must achieve and maintain NCQA PCMH recognition under the applicable standards and/or start the engaging process under the 2017 standards. 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.

4.6. Expansion and Quality Improvement Program (EQuIP)

The Blueprint for Health Expansion and Quality Improvement Program (EQuIP) program creates capacity, supports, and coaches our stakeholders – 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.

Specifically, EQuIP facilitates practices and communities to achieve improvement of clinical quality measures, patient experience measures, care coordination, practice transformation, and reducing variation in outcomes. EQuIP does this through building ongoing relationships with the stakeholders Quality Improvement Facilitators work with – primary care practices, specialty practices, and community collaboratives - that are flexible to individualized needs, and connected in 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 key 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 standards and continue improvement on population health quality and payment reform efforts, defined by Blueprint, Green Mountain Care Board or Accountable Care Organizations (ACOs)
3. Achieve and continue improvement on clinical, cost, or patient experience priorities identified by the practice

Practices engaging in EQuIP 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 practices 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.
- 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 also help practices/organizations prepare for and maintain National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) and 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 practice with submitting materials and support phone calls for recognition on an ongoing basis to NCQA or other applicable recognition body.

QI Facilitators will visit each site or organization at least once and shall offer to meet virtually with each site or organization at least bi-weekly and shall meet with each organization no less than 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 the ACOs 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 against 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.
- 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 All-Payer Model objectives and ACO clinical priorities. QI Facilitators work with Community Collaboratives to:

- Identify best practice clinical standards in the areas identified for improvement.
- Assess differences between how care is being delivered against 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 staffing and/or facilitation when a QI Facilitator, Blueprint representative, or ACO representative identify a need for staffing and/or facilitation.

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 to 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 within their geographic areas to allow support for vacancies, scheduled time off, and fluctuating demands for Facilitation support in quality improvement activities. QI Facilitators are assigned based on the following geographic areas:

1. South West – Middlebury, Rutland, Bennington
2. South East – Springfield, Windsor, Brattleboro
3. Central – Randolph, Upper Valley, Barre
4. North West – Chittenden & St. Albans
5. North East – Newport, St. Johnsbury, Morrisville.

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) and Patient-Centered Specialty Practice (PCSP) or 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, Accountable Care Organizations (ACOs) 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 other body on submission, providing shadowing opportunities, and hosting education sessions during facilitator and field staff meetings.

QI Facilitators shall be responsive to other Facilitators, ACO, and Blueprint staff questions; providing consultation through phone, email, and predominately a web-based communication and information-sharing tool (i.e., Basecamp). QI facilitators are expected to attend facilitator meetings, field staff meetings, regional check-in meetings, and project administrator calls.

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

Locally-based regional coordinators, hired by the administrative entities, and collaborating partners such as the area agencies on aging, SASH, designated mental health agencies, and peer organizations, offer opportunities to engage Vermonters in peer support self-management programs to support Vermonters in improving and maintaining their own health. The self-management programs are available throughout the State of Vermont, at no-charge to Vermont residents, and include six (6) evidence-based, workshops designed to facilitate peer support: the Self-Management Resource Center’s Chronic Disease Self-Management Program, Diabetes Self-Management Program, Chronic Pain Self-Management Program, Workplace Chronic Disease Self-Management, (known in Vermont as Healthier Living Workshops for Chronic Disease, Diabetes, and Chronic Pain, respectively); the Vermont Quit Partners FreshStart tobacco cessation in-person workshops, Not On Tobacco for Adolescents, the Copeland Center Wellness Recovery Action Planning (WRAP for Adults and Adolescents), and the CDC’s Diabetes

Prevention Program (Prevent T2 Curriculum delivered in-person or online). For information on program measures, expectations of master trainers and workshop leaders, program costs and stipends, regional coordinator expectations, and marketing materials, please refer to the Regional Coordinator Operations Manual.

<http://blueprintforhealth.vermont.gov/sites/bfh/files/documents/Regional%20Coordinator%20Operations%20Manual%20v2.0.pdf>

The Project Manager shall meet with the Regional Coordinator at least monthly, and more frequently upon the request of the State, to review progress towards performance goals.

The Regional Coordinator shall:

1. Oversee local planning, participant recruitment, implementation, and evaluation of the community-based self-management programs. With support from the Administrative Entity, the State, and the State's designee for statewide self-management program coordination, the Regional Coordinator shall recruit key representatives and referral sources from community organizations (including, but not limited to, CHT, MAT, WHI, SASH, VDH district offices, Area Agencies on Aging (AAAs), designated mental health and substance use disorder treatment agencies, health insurers, ACOs, and local employers) to partner in implementing the workshops and to participate in a statewide learning collaborative and local quality improvement work group for increasing the number of workshops hosted and workshop attendance at the local level. The Administrative Entity may elect to integrate the work group into an existing local meeting or committee, as long as the goals of collaboration on QI projects aimed at growing the self-management program within the Health Service Area are met.
2. Collaborate with primary community partners to develop a community-level self-management program implementation plan, including identification of areas and opportunities for improvement and novel delivery ideas to test. Implementation plans shall identify target goals, strategies, responsible parties, methods for measuring success, and data on the outcomes following a test of change (Plan Do Study Act (PDSA) cycle).
3. Review data on progress with key stakeholders (such as through local Community Collaborative leadership team and advisory committee meetings, local care management learning collaborative meetings, and extended and core CHT meetings) at least quarterly and include data that compares self-management program progress within the Health Service Area to other Health Service Areas, the statewide average, and national progress. Data from other Health Service Areas, the statewide average, and national progress must be made available by the State or its designee for this purpose.
4. Build relationships with community partners, and work with these partners to implement best practice strategies, such as:
 - Identifying a list of target participants served by partnering organizations and outreaching to them to enroll in workshops;
 - Providing workshops where target populations already convene, such as worksites and

- senior meal sites;
 - Coupling programs with worksite wellness programs and health risk assessments;
 - Using social media to market and promote workshops;
 - Providing incentives for workshop completion; and
 - Outreaching to currently hospitalized patients.
5. Collaborate with community partners to develop (or update) and document streamlined referral protocols (at least five (5) per grant year) into the self-management programs. Some examples of successful referral pathways include, but are not limited to:
- Certified Diabetes Educators (CDEs) on CHT staff referring patients into HLW – Diabetes workshops;
 - Blueprint primary care practices (PCPs) performing panel management on specific conditions for NCQA certification referring patients into appropriate workshops;
 - PCPs prescribing opioids to patients for chronic pain referring patients into HLW – Chronic Pain workshops, when applicable;
 - Vermont Chronic Care Initiative case managers referring patients to the appropriate self-management programs;
 - Local Vermont Department of Health (VDH) WIC program representatives referring pregnant women and new mothers into tobacco cessation workshops, when applicable; and
 - Local Integrated Care Management Learning Collaborative pilot referring enrolled patients to appropriate workshop(s) for their condition(s).
6. Honor requests from organizations or residents in the HSA to offer workshops in diverse locations within the HSA, including, but not limited to:
- Employer work sites;
 - Designated Agency offices;
 - Designated Regional Housing Office (DRHO) housing facilities;
 - Meal sites;
 - Substance use disorder treatment facilities; and
 - Corrections facilities or transitional housing sites.

The Regional Coordinator shall make every effort to fulfill requests for workshops, where the requesting party can provide the required number of registrants, in a timely manner. The Regional Coordinator shall respond to requests within 48 hours and ensure workshops are offered within 4 weeks of the request or within a mutually agreed upon time period between the requesting party and the Administrative Entity.

7. Attend all regular Regional Coordinator in-person and teleconference meetings scheduled by the State or the State’s designee.

The Administrative Entity shall:

1. Ensure all workshops are led by certified leaders as specified by the State. The Regional Coordinator shall recruit and coordinate local workshop leaders, ensuring sufficient capacity to facilitate planned workshops without interruption and to staff ad hoc workshops requested based on community need. The Administrative Entity shall ensure that the Regional Coordinator reviews workshop evaluations with every leader or leader pair following each workshop and documents a plan for improvement based on workshop fidelity standards, as needed.
2. Ensure interpreter services from appropriately credentialed interpreters are available to workshop participants upon request.

The Administrative Entity shall:

1. Provide registrant (individuals registered for a workshop), participant (individuals attending at least one session of a workshop), completer (individuals attending the designated number of sessions of a workshop to qualify for completion), and outcome data for each workshop to the State or its designee in the format specified. The Regional Coordinator shall fully and accurately complete and submit all data and paperwork for self-management programs as specified and required by the State prior to payments being issued.
2. Report progress on self-management program implementation plan to the State or its designee at least monthly and more frequently upon request or as needed, and in the format requested by the State or the State's designee.
3. Submit updated work plan annually, prior to October 15, to the State or the State's designee to include, at a minimum:
 - a. Target goals and objectives specified for meeting grant deliverables and outcomes;
 - b. Action plan;
 - c. PDSA cycles planned, in-progress, and completed, submitted quarterly; and
 - d. Identified barriers to achieving target goals with proposed mitigation plans.

5. Patient Attribution & 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 Advanced Primary Care Practices (APCPs), or Patient-Centered Medical Homes (PCMHs), and payments to support Community Health Teams (CHTs). The PCMH payment is made to primary care practices, contingent on their NCQA recognition, or qualifying NCQA score, 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 scoring data, 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 3 and 4. Based upon the NCQA PCMH recognition score, 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 Patient Per Month (PPPM) payment for each practice. This PCMH PPPM 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 (Evaluation & Management Code) within the 24 months prior to the date that the attribution process is being conducted, in accordance with the algorithms presented in Appendices 2, 3, and 4. 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 refreshed at least quarterly.

Each insurer will send a list of the number of attributed patients to each Advanced Primary Care Practice (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 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 PPPM 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 and rollups at the practice and Health Service Area levels, across payers.

The enhanced per person per month (PPPM) payment for Advanced Primary Care Practices 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 enhanced payment is in addition to any payment that the practice receives based on existing agreements (e.g. Fee for Service).

The enhanced PCMH PPPM 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 all patients that have had a majority of their primary-care visits (Evaluation & Management Code) to the practice in the last 24 months. Vermont's insurers have elected to apply these look back periods based on their beneficiaries' demographics, recommended health maintenance, and health related risks.

The PCMH per person per month (PPPM) 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 PPPM 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, and for Medicare in Appendix 4. 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 PPPM payment for each practice, the payer will multiply the number of attributed patients in the practice by the PCMH PPPM 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 3 and 4 are the current models 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 PPPM amounts can be revised if the applicable NCQA standards change; in addition, PCMH PPPM 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-scored practices or practices rejoining the Blueprint will be effective on the first of the month after the date that the Blueprint transmits the NCQA engaging date to payers. Changes in payment resulting from subsequent receipt of the PCMH NCQA recognition date will be implemented by the payer on the first of the month 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). Practices may request an interim add-on survey or upgrade, pending availability of reviewers, but not more frequently than once every six months. Payment will remain at the previous level until the NCQA review is received, at which time it will be adjusted according to the NCQA score.

Exception for Medicare PCMH payments. For Calendar Year 2017 payments, Medicare PCMH payments will be fixed and based on a 3-month average of the latest monthly Medicare patient attributions available from Medicare reports as of early December 2016 (i.e., ending with October 2016 attributions for most practices), and based on the single latest monthly PPSM value (following 2% Medicare sequestration) available from Medicare payment reports as of early December 2016 (i.e., as of October 2016 for most practices). For new Medicare PCMH practices in 2017 for whom no patient attributions are available from Medicare reports, PCMH payments will be based on their initial qualifying NCQA scores, per Appendix 6, and on the latest All-Payer Claims Dataset (VHCURES) Medicare patient attribution counts available as of early December 2016.

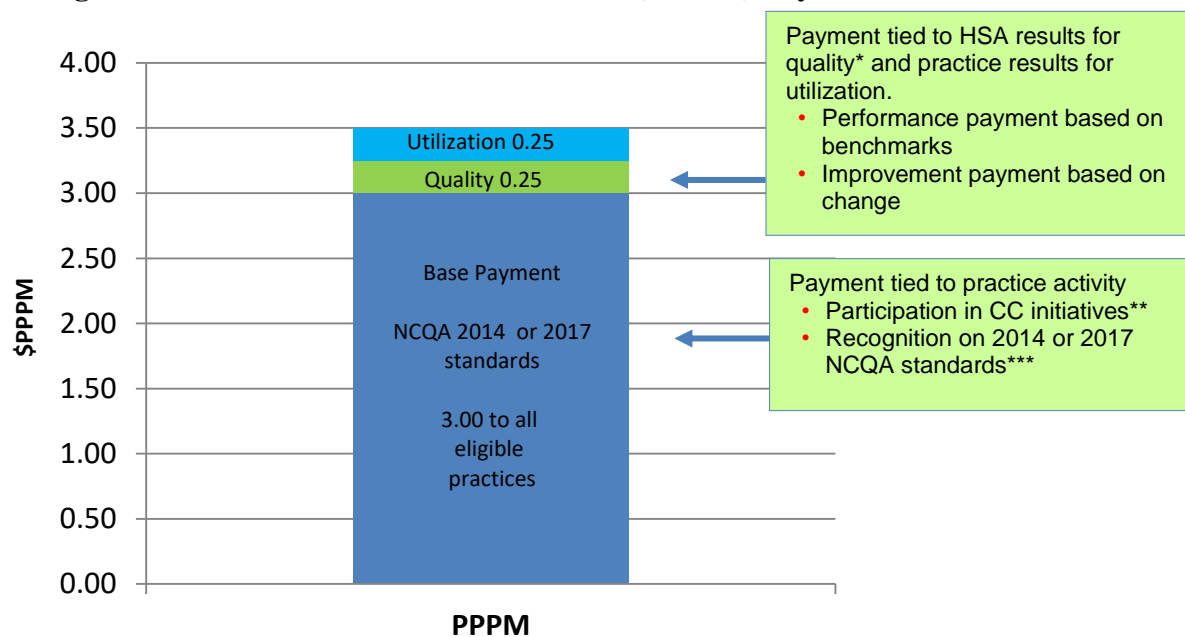
5.1.1 PCMH PPSM Payment Model (Medicaid and Commercial Insurers)

The PCMH PPSM 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 the ACO provider networks. For Medicaid and commercial insurers, the total capitated payment to medical homes is based on a composite of medical home recognition, collaborative participation, and performance. The outcome measures driving the performance component include a Quality Index comprised of core ACO 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 new medical home payment model for Medicaid and commercial insurers includes the following elements:

- Base Component: Based on NCQA recognition & CC Participation.
 - Requires successful recognition on 2014 NCQA standards or engagement and subsequent recognition on 2017 NCQA standards
 - Requires active participation in the local CC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local CCs. Minimum requirement is active participation with at least one CC priority initiative each calendar year.

- All qualifying practices receive \$3.00 PPM
- Quality Performance Component: Based on Hospital Service Area (HSA) results for Quality Index.
 - Three payment levels up to \$ 0.25 PPM 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. Scores are reassessed every six months
- Utilization Performance Component: Based on Practice results for Total Resource Utilization Index (TRUI).
 - Three payment levels up \$ 0.25 PPM for the top three quartiles with the lowest TRUI scores. Scores are reassessed every six months.
- Total Payment = Base + HSA Quality Performance + Practice TRUI Performance
- Total Payment ranges from \$3.00 to \$3.50 PPM

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 recognition on NCQA 2014 or engagement and subsequent recognition on 2017 standards

The new 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. In theory, the combination of the UCC structure and decision making process, with the interdependent nature of the payment model, will lead to better organization and coordination across provider groups. In contrast, a medical home payment linked solely to practice quality is less likely to stimulate better coordination across a service area. Although fee for service is still the predominate payment, this PCMH PPPM payment model is an important *step* towards a more complete capitated payment structure with a performance component that is anticipated for 2017. It will help to stimulate the culture and activity that is essential for a high value, community oriented health system.

The incentive structure that is woven into the payment model includes:

- Requires active and meaningful participation in UCCs 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, however shifts the emphasis to the most important Must Pass elements in the medical home standards and de-emphasizes the intensive documentation that is required to achieve the highest score.
- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization)
- Rewards coordination with UCC 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)
- Rewards coordination with UCC 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 participating practice and for each service area. The profiles include the results of core quality measures which have been selected thru 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 UCCs 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 core 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 Advanced Primary Care Practices 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 Advanced Primary Care Practices. 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 in Blueprint-participating practices with a majority of their primary-care (Evaluation and Management) claims-coded visits to the 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 Appendices 3 and 4 contain 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 (PPPM).^{1 2} Commercial and Medicaid payers will pay \$2.77 per payer-claims-attributed patient per month (PPPM), and Medicare will pay \$2.47 per payer-claims-attributed patient per month (PPPM).

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. 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 attributions³, and validated proportionally by data provided by CHT administrative entities to the Blueprint. (Total practice-reported patient counts have historically averaged approximately 1.85 times the level of total payer-reported, claims-attributed patient counts, based on data from Calendar Years 2013 and 2014.) The Blueprint will also provide payers with a monthly practice roster and NCQA scoring schedule.

Monthly payments related to the initiation of a new CHT will begin on the first day of the month after (or on which) the payer receives information from the Blueprint indicating that practices affiliated with the new CHT have received their initial qualifying NCQA scores from the Blueprint and/or achieved NCQA PCMH recognition and the CHT begins clinical operations. As is the case for already-existing CHTs, the amount of financial support for new CHTs will be based on the number of total unique Vermont patients in Blueprint-

¹ CHT payments, and by extension the number of full time equivalent (FTE) CHT staff members, have been based on \$350,000.00 annually for each population unit of 10,811 payer-claims-attributed Blueprint patients, or an average of \$2.70 per payer-claims-attributed patient per month (PPPM). For historical comparison, this is equivalent to a rate of 0.25 FTEs, or \$17,500.00 annually, for each population unit of 1,000 practice-reported Blueprint patients, or \$1.46 per practice-reported patient per month, given an observed average ratio of practice-reported to payer-claims-attributed patient counts of approximately 1.85 (1.90 for commercial and Medicaid; 1.69 for Medicare) for the period of Calendar Years 2013 through 2014: $\$17,500.00 / 12 \text{ months} / 1,000 \text{ patients} * 1.85 \text{ payment adjustment ratio} = \2.70 PPPM .

² Medicare pays \$6.71 PPPM, based on Medicare-claims-based patient attributions, to cover the combined costs of CHT and SASH services. Against that amount, Medicare's CHT contributions are charged at the rate of \$1.46 per practice-reported patient per month, or \$2.47 per payer-claims-attributed patient per month, and the remainder is available for SASH panels.

³ 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.

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 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.

Exception for Medicare CHT payments. Medicare Core CHT payments will be fixed at the levels paid prospectively for the 4th calendar quarter of 2016 (i.e., at the monthly levels paid prospectively for December 2016), with the exception (or adjustment) that \$2.47 PPPM will additionally be paid to relevant CHTs for new Medicare PCMHs in 2017. For Calendar Year 2017 payments, Medicare SASH payments will be fixed at the levels paid prospectively to SASH for the 4th calendar quarter of 2016 (i.e., at the monthly level paid prospectively for December 2016).

5.3. NCQA Recognition and PCMH PPM and CHT Payments

To be eligible for Blueprint PCMH PPM and CHT payments practices must achieve and maintain their NCQA Patient Centered Medical Home recognition under the 2014 standards and/or start the engaging process under the 2017 standards, and actively participate in a quality projects identified by their local Community Collaboratives.

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 PPM and CHT payments if current NCQA recognition lapses

If a practice that is scheduled to be rescored does not achieve 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 NCQA with a clear timeline for achieving subsequent recognition. The practice will share this action plan with the Blueprint Executive Director, 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 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.

For practices that have succeeded in obtaining a level 3 under the 2014 standards and are in the annual reporting phase of sustaining recognition with NCQA:

- The action plan will be developed within 30 days of failure to achieve recognition within the 1 month time period set by NCQA, or within 15 days of the decision to postpone the scoring date, such that NCQA recognition will lapse.

For practices transforming from a level 1 or level 2 under the 2014 standards:

- The action plan will be developed within 30 days of failure to achieve recognition within the 6 month time period set by NCQA, or within 15 days of the decision to postpone the scoring date, such that NCQA recognition will lapse.

Regardless of whether an action plan is developed, insurers will terminate PPPM 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 will be restored).

If the practice submits additional payment to NCQA for extended time for PCMH recognition, insurers will pay (or continue to pay) the practice at the previous PPPM rate based on the most recent successful NCQA score, starting on the date of the payment to NCQA for extended time for PCMH recognition.

For practices that have succeeded in obtaining a level 3 under the 2014 standards and are in the annual reporting phase of sustaining recognition with NCQA:

- 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 PPPM 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).

For practices transforming from a level 1 or level 2 under the 2014 standards:

- If the practice does not achieve recognition within an additional 3 month time period for extended recognition set by the Blueprint for Health, insurers will have the option of recouping the practice's PPPM 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).

5.3.2 Procedure for reducing PCMH PPPM and CHT payments for Blueprint practices if initial NCQA recognition is not attained

Regarding CHT funding for Blueprint practices in the engagement phase, if an engaging Blueprint practice does not achieve NCQA recognition as scheduled (due to either a postponement of the scoring date or failure to achieve recognition), the practice develop an action plan with NCQA as described above. The practice will share this action plan with the Blueprint Executive Director, if CHT payments are to continue.

The action plan will be developed within failure to achieve recognition within the 12 month time period set by NCQA, or within 15 days of the decision to postpone the scoring date. If

it is not developed within the applicable time frame, CHT payments for that practice's patients will end on the last day of the quarter in which the applicable time frame ends. If an action plan is developed, the additional CHT payments related to that practice's patients will decline by 25% for each quarter after the quarter in which the applicable time frame ends, until recognition is achieved.

Regardless of whether an action plan is developed, insurers will terminate PPPM payments on the last day of the month following the date on which the practice failed to achieve NCQA recognition within the 12 month time period for recognition set by NCQA.

If the practice submits additional payment to NCQA for extended time for PCMH recognition, insurers will pay (or continue to pay) the practice at the previous PPPM rate based on the most recent successful NCQA score, 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 3 month time period for extended recognition set by the Blueprint for Health, insurers will have the option of recouping the practice's PPPM payments back to the date on which those payments would have ended (i.e. – last day of the month following the date on which the practice failed to achieve NCQA recognition within the 12 month time period for recognition set by NCQA.

6. Women's Health Initiative

The Women's Health Initiative (WHI) extends the Vermont Blueprint for Health to obstetrics, gynecology, family planning and nurse midwifery practices. Because many women receive substantial preventive care services in these practices, there is an opportunity to increase access to additional services to improve health outcomes for women and children, as well the potential to reduce unintended pregnancies. The WHI promotes psychosocial screening, supports brief in-office intervention, connects patients with community supports, and offers enhanced payments to participating practices in an effort to achieve these goals. The WHI section of the Blueprint Implementation Manual outlines who is eligible to participate (section 6.1), the strategies that will be implemented (section 6.2), payment processes (6.3), how payments are sustained (section 6.4), and the level of participation of Blueprint participating patient centered medical homes (PCMHs) (6.5).

6.1. Women's Health Initiative Practices

Women's Health Initiative (WHI) practices attest to implementing and maintaining the WHI strategies (section 6.2) and receives WHI payments (section 6.3). Eligible medical practices or clinics include:

- gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practices, specializing in providing women's health preventive services as defined by the American Congress 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 women’s preventive services as defined by ACOG.

6.2. WHI Strategies

WHI strategies were identified to address the risks for unintended pregnancy and to improve the health of women and their children. The strategies focus on improving health and reducing health risk, enhancing family planning services, addressing barriers to accessing long acting reversible contraception (LARC), and further enhancing the integration of health services. Practices who choose to participate in the Women’s Health Initiative agree to implement and maintain the WHI strategies, which include:

- **Stock LARC:** 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 to ensure 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
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

WHI 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.

- **Screen for Mental Health, Substance Abuse, and Inter-Partner Violence:** Within the first three (3) months of WHI CHT and PMPM payments, the WHI practice will

develop and implement policies and procedures for screening, brief intervention, and referral for depression, intimate partner violence, and substance abuse.

- **Provide Family Planning Counseling:** Within the first three (3) months of WHI CHT and PMPM payments, the WHI practice will update and/or implement a policy and procedure for evidence-based, comprehensive family planning counseling including implementing “One Key Question.”
- **Offer Same Day LARC Insertion:** Within the first six (6) months of WHI CHT and PMPM payments, 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.
- **Develop Referral Networks for Women’s Health Services:** Within the first twelve (12) months of WHI CHT and PMPM payments, 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.
- **Develop Referral Networks for Primary Care:** Within the first twelve (12) months of WHI CHT and PMPM payments, 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.
- **Screening for Social Determinants of Health:** Within the first eighteen (18) months of WHI CHT and PMPM payments, the WHI practice will develop and implement policies and procedures 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.

6.3. Women’s Health Initiative Payments

WHI practices shall receive three (3) Blueprint-specific forms of payment from WHI-participating insurers or payers, to support the provision of high-quality women’s health primary care and well-coordinated preventive women’s health services for women ages 15 – 44.

Payments include:

1. Recurring per member per month (PMPM) payments to WHI practices
2. Recurring payments to support WHI Community Health Team (CHT) staff to the CHT administrative entities
3. A one-time per member payment (PMP) to support stocking of Long Acting Reversible Contraceptive (LARC) devices to WHI practices.

6.3.1 WHI Insurers or Payers

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

6.3.2 Women's Health Initiative (WHI) Attribution

WHI payments are based on the total number of women between the ages of 15 and 44 (including women who are 44) who receive services from each WHI practice and who are beneficiaries of participating insurers. WHI-participating insurers will calculate the total number of current active WHI patients who are attributed to each WHI practice. The same attribution methodology will be used for all three forms of WHI 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 WHI and on-going as changes occur, WHI practices will provide the Blueprint with a roster of the WHI 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 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.

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

Definition of a Current Active WHI Patient: The patient must be female between the ages of 15 and 44 (inclusive). The patient must have had a majority of their women's preventive health visits in the WHI 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 WHI-participating insurers). If a patient has an equal number of qualifying women's preventive health visits at more than one WHI practice, then that patient will be attributed to the WHI practice with the most recent visit. Patient attributions for members of Blueprint WHI-participating self-insured plans will be included. Attribution will be refreshed at least quarterly.

Insurers Reporting of Attribution: Upon request of the practices, clinics, or their parent organizations, the WHI-participating insurers, or payers, will provide the list of attributed patients for review and reconciliation. Each WHI-participating insurer, or payer, 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 WHI-participating insurers or payers. To support an efficient and uninterrupted payment process, the WHI-participating insurer or payer and practice should agree on the number of attributed patients within 30 days of the delivery of the list.

Each WHI-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 WHI-participating insurer or payer will send the Blueprint a list of the counts of WHI-attributed patients and WHI 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 WHI-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 WHI-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 WHI practice PMPM amounts can be revised by the Blueprint Director after seeking input from the Blueprint's Payment Implementation Work Group and Executive Committee.

6.3.3 WHI Practice PMPM Payment

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

To calculate the total amount of the WHI practice PMPM payment for each practice, the WHI-participating insurer or payer will multiply the number of WHI-attributed patients in the practice by the WHI practice PMPM amount.

For the first twelve (12) months of participation in the program, WHI practices will be paid a \$1.25 PMPM maximum capitated payment. Starting the second year of participation in the program, WHI practices will be paid a base payment of \$1.00 PMPM, based on their self-attestation of implementing the WHI Strategies. Additionally, a WHI practice could earn a quality payment of up to \$0.50 PMPM based on performance measures. The quality component of the WHI PMPM contains three payment levels up to \$ 0.50 PPPM based on total score of the three 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. Scores are reassessed every six months.

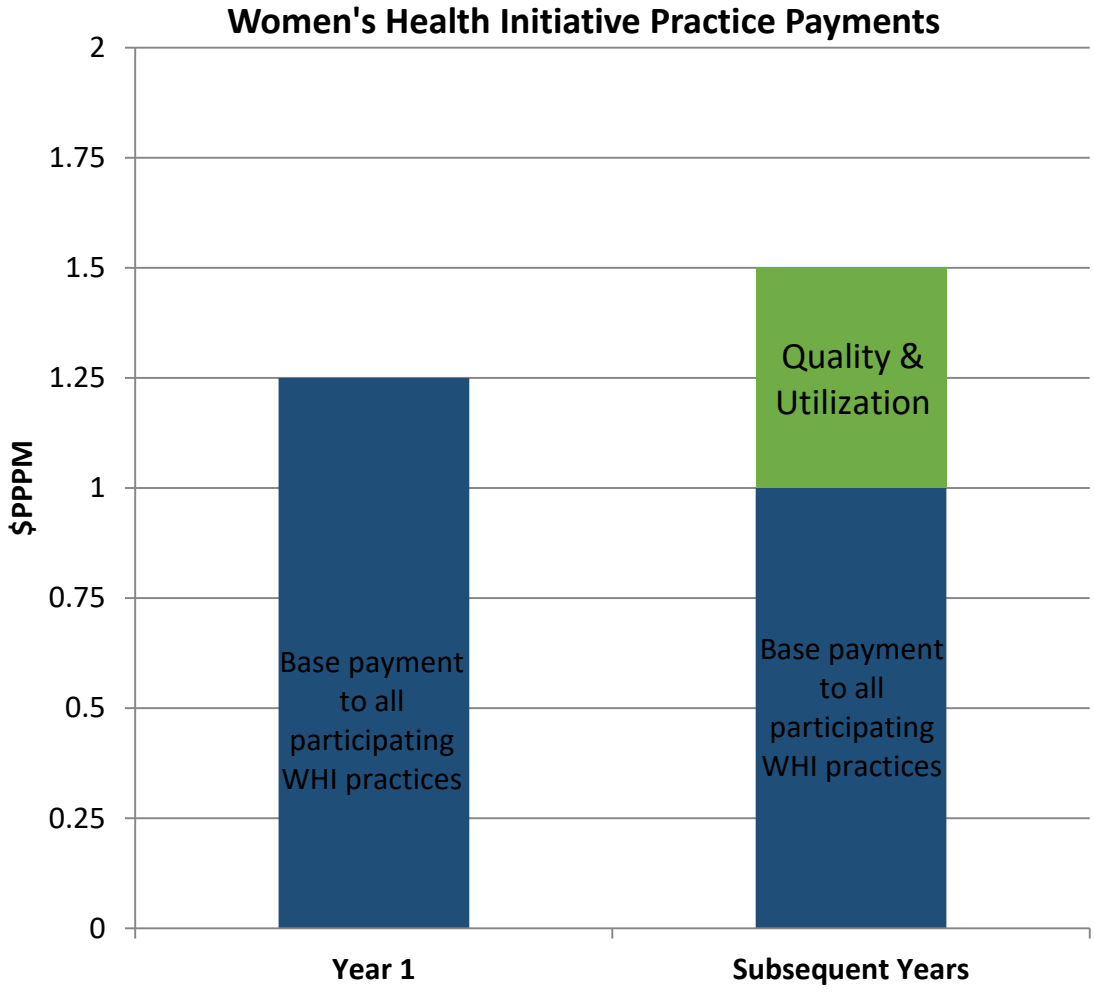
The women's health preventive services model for WHI-participating insurers includes the following elements:

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

- Quality Performance Component (Year 2 and subsequent years):
 - Up to \$ 0.50 PMPM
 - Three payment levels up to \$ 0.50 PPPM based on total score of the three 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. Scores are reassessed every six months.

- Total Payment in Year 1 = \$1.25
- Total Payment in Subsequent Years = \$1.00 + Quality Component
- Total Payment in Subsequent Years ranges from \$1.00 to \$1.50 PMPM

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



WHI practice PMPM payments will be sent directly to the practice, clinic, or parent organization. Payment for new practices or practices rejoining WHI 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 WHI-participating insurers or payers. Changes in payment resulting from subsequent changes in performance on the quality-of-care measures and/or the utilization measure will be implemented by all WHI-participating insurers or payers on the first day of the month after scores are received from the Blueprint.

6.3.4 Supplemental Community Health Team (CHT) Payments

Supplemental CHT payments allow the CHT to hire licensed mental health professionals to work in WHI practices. The WHI-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 WHI patients per month with the inclusion of a floor of 0.5 full-time equivalent CHT member per practice for

smaller practices.⁴ To calculate the total amount of the WHI CHT PMPM payment for each CHT Administrative Entity, the WHI-participating insurer or payer will multiply the number of WHI-attributed patients in the practice by the WHI CHT PMPM amount. WHI-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 women’s health provider and less than 600 attributed current active WHI 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 health team member per practice. For practices who are receiving payments based on the CHT floor, WHI-participating insurers or payers will share in the cost of the monthly payment of \$3,250, proportional to their share of the WHI attributed patient population (claims-attributed total unique WHI patients). WHI-participating insurer or payer proportions will be derived retrospectively from the prior quarter WHI practices’ attribution. Practices that have less than one (1) full-time equivalent provider and less than 600 attributed WHI 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 WHI providers.

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

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

The purpose of the one-time capacity payment is to assist WHI practices in initiating WHI strategies and 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 WHI-participating insurers or payers will share the costs of the capacity payment and will send their share of the costs directly to the WHI 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

⁴ 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.

requirement for WHI practices (see section 6.2 WHI Strategies). The capacity payment floor or minimum payment value of the PMP is \$927 for Medicaid 340B eligible practices and \$5,163 for non-Medicaid 340B eligible practices.

Capacity Payment Ceiling: There is a ceiling based on covering the costs of stocking at least 8 of each device, yielding a total of 24 devices for each WHI practice. The ceiling or maximum payment value of the PMP is \$3,387 for Medicaid 340B eligible practices and \$16,184 for non-Medicaid 340B eligible practices.

Between the capacity payment floor and ceiling, WHI-participating insurers or payers will pay \$4.42 per member for Medicaid 340B eligible WHI practices, or \$11.87 per member for non-Medicaid 340B eligible WHI practices. The WHI-participating insurer or payer will make the capacity payment one time, as determined by the WHI initiation date set by the Blueprint for Health based upon the preferences of the WHI practice.

For practices, whose payments are below the capacity payment floor or above the ceiling, WHI-participating insurers or payers will share in the cost, proportional to their share of the WHI patient population (claims-attributed total unique WHI patients). WHI-participating insurer or payer proportions will be derived from the WHI practices' attribution during the first month of the practices' participation.

If a new insurer joins the WHI, 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.

6.4. Procedure for sustaining WHI payments if practice lapses in implementing the WHI strategies

It is incumbent upon the WHI practices to implement and maintain the WHI strategies in their practice. Annually, practices will attest to meeting the WHI strategies and may be audited by the State or its designee. If a WHI practice does not implement the strategies within one year after their WHI initiation date or the timeline as designed in section 6.2, the WHI practice and the Blueprint Associate 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 Women's Health Initiative 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 Women's Health Initiative.

Regardless of whether an action plan is developed, WHI-participating insurers or payers will terminate WHI 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 Women's Health Initiative strategies.

If an action plan is not developed as stated above, the additional WHI 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 WHI 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 WHI CHT payments will be restored).

6.5. Participation in the WHI for Patient Centered Medical Homes

Blueprint Patient Centered Medical Home practices are encouraged to participate in the WHI and are eligible for the WHI 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 WHI CHT payments for these providers.

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

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

To calculate the total amount of the WHI PMPM payment for each practice, the WHI-participating insurer or payer will multiply the number of WHI-attributed patients in the practice by the WHI PMPM amount.

For the first twelve (12) months of participation in the program, practices will be paid a \$1.25 PMPM maximum capitated payment. Starting the second year of participation in the program, practices will be paid a base payment of \$1.00 PMPM, based on their self-attestation of implementing the WHI Strategies. Additionally, a practice could earn a quality payment of up to \$0.50 PMPM based on performance measures. The quality component of the WHI PMPM contains three payment levels up to \$ 0.50 PPPM based on total score of the

three 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. Scores are reassessed every six months.

The women's health preventive services model for WHI-participating 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 document
 - Requires successful implementation of the WHI Strategies, outlined in section 6.2 of this document
- Quality Performance Component (Year 2 and subsequent years):
 - Up to \$ 0.50 PMPM
 - Three payment levels up to \$ 0.50 PMPM based on total score of the three 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. Scores are reassessed every six months.
- Total Payment in Year 1 = \$1.25
- Total Payment in Subsequent Years = \$1.00 + Quality Component
- Total Payment in Subsequent Years ranges from \$1.00 to \$1.50 PMPM

The **WHI 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 WHI-participating insurers or payers will share the costs of the capacity payment and will send their share of the costs directly to the PCMH/WHI 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 WHI practices and PCMHs (see section 6.2 WHI Strategies). The capacity floor or minimum payment value of the PMP is \$927 for Medicaid 340B eligible practices and \$5,163 for non-Medicaid 340B eligible practices.

Ceiling: There is a ceiling based on covering the costs of stocking at least 8 of each device, yielding a total of 24 devices for each practice. The ceiling or maximum payment value of the PMP is \$3,387 for Medicaid 340B eligible practices and \$16,184 for non-Medicaid 340B eligible practices.

Between the capacity payment floor and ceiling, commercial and Medicaid WHI-participating insurers or payers will pay \$4.42 per member for Medicaid 340B eligible PCMHs, or \$11.87 per member for non-Medicaid 340B eligible PCMHs. The WHI-participating insurer or payer will make the capacity payment one time, when the PCMH joins the WHI.

For Blueprint PCMH practices whose payments are below the capacity payment floor or above the ceiling, WHI-participating insurers or payers will share in the cost, proportional to their share of the PCMH patients who are women between the ages of 15 and 44 (inclusive). WHI-participating insurer or payer proportions will be derived from the PCMH practices' attribution during the first month of the practices' participation.

If a new insurer joins the WHI, a new PMP will be calculated for the practice based on the combined attribution. 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.

Practices with Both WHI and PCMH Rostered Providers: Attributed patients for all participating providers in mixed practices that includes both Blueprint PCMH and WHI providers will be combined to determine whether a practice is below the floor or above the Capacity Payment ceiling for a single practice. If the PCMH providers and WHI providers join the women's health initiative at different times, a new PMP will be calculated for the practice based on the combined attribution. The WHI-participating insurers will share the cost of the difference between the initial PMP and new PMP, proportional to their share of the attributed patients who are women between the ages of 15 and 44 (inclusive).

APPENDIX 1
VHCIP Core Quality & Performance Measures as of 1/1/2016

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/Endorsed	Included in HSA Profile?	Measure Description
Core-1		Plan All-Cause Readmissions	NQF #1768, HEDIS measure	Adult	For members 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.
Core-2		Adolescent Well-Care Visit	HEDIS measure	Pediatric	The percentage of members 12-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)	NQF #0075, NCQA	Adult	The percentage of members 18-75 years who were discharged alive for acute myocardial infarction, coronary artery bypass grafting, or percutaneous coronary intervention in the year prior to the measurement year or who had a diagnosis of Ischemic Vascular Disease during the measurement year and one year prior, who had LDL-C screening.
Core-4		Follow-up after Hospitalization for Mental Illness, 7 Day	NQF #0576, HEDIS measure	Adult	The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Core-5		Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement	NQF #0004, HEDIS measure	Adult	(a) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment within 14 days. (b) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and had two additional services with a diagnosis of AOD within 30 days of the initiation visit.
Core-6		Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	NQF #0058, HEDIS measure	Adult	The percentage of adults 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic.
Core-7		Chlamydia Screening in Women	NQF #0033, HEDIS measure	Adult and Pediatric	The percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/Endorsed	Included in HSA Profile ?	Measure Description
Core-8		Developmental Screening in the First Three Years of Life	NQF #1448	Pediatric	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF, AHRQ (Prevention on Quality Indicator (PQI) #5)	Adult	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
Core-11	MSSP-20	Mammography / Breast Cancer Screening	NQF #0031, HEDIS measure	Adult	The percentage of women 50-74 years who had a mammogram to screen for breast cancer in the last two years.
Core-12		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite	NQF, AHRQ (Prevention on Quality Indicator (PQI) Chronic Composite)	Adult	Prevention Quality Indicators' (PQI) overall composite per 100,000 population, ages 18 years and older; includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.
Core-13		Appropriate Testing for Children with Pharyngitis	NQF #0002	Pediatric	Percentage of children 2-18 years who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.
Core-14		Childhood Immunization Status (Combo 10)	NQF #0038, HEDIS measure	No	The percentage of children 2 years of age who had each of nine key vaccinations (e.g., MMR, HiB, HepB, etc.).

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/Endorsed	Include d in HSA Profile?	Measure Description
Core-15		Pediatric Weight Assessment and Counseling	NQF #0024	No	The percentage of members 3-17 years who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
Core-16	MSSP-22,-23,-24,-25,-26	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	NQF #0729 (composite)	Adult	(a) MSSP-22: Percentage of patients 18-75 years with diabetes who had HbA1c <8% at most recent visit; (b) MSSP-23: Percentage of patients 18-75 years with diabetes who had LDL <100 mg/dL at most recent visit; (c) MSSP-24: Percentage of patients 18-75 years with diabetes who had blood pressure <140/90 at most recent visit; (d) MSSP-25: Percentage of patients 18-75 years with diabetes who were identified as a non-user of tobacco in measurement year; (e) MSSP-26: Percentage of patients 18-75 years with diabetes and IVF who used aspirin daily -- Aspirin use was not included as part of the profile composite.
Core-17	MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059, NCQA	Adult	Percentage of patients 18-75 years with diabetes whose HbA1c was in poor control >9%.
Core-18	MSSP-19	Colorectal Cancer Screening	NQF #0034, NCQA HEDIS measure	No	The percentage of members 50-75 years who had appropriate screening for colorectal cancer.
Core-19	MSSP-18	Depression Screening and Follow-Up	NQF #0418, CMS	No	Patients 12 years and older who had negative screening or positive screening for depression completed in the measurement year with an age-appropriate standardized tool. Follow-up for positive screening must be documented same day as screening.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized /Endorsed	Include d in HSA Profile?	Measure Description
Core-20	MSSP-16	Adult Weight Screening and Follow-Up	NQF #0421, CMS	No	Patients 18 years and older who had BMI calculated during the last visit in the measurement year or within the prior 6 months. In cases where the BMI is abnormal, a follow-up plan must be documented during the visit the BMI was calculated or within the prior 6 months.
Core-21		Access to Care Composite	NCQA	No	NCQA Survey - percentage of patients who could get appointments or answers to questions from providers when needed.
Core-22		Communication Composite	NCQA	No	NCQA Survey - percentage of patients who felt they received good communication from providers.
Core-23		Shared Decision-Making Composite	NCQA	No	NCQA Survey - percentage of patients whose provider helped them make decisions about prescription medications.
Core-24		Self-Management Support Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about specific health goals and barriers.
Core-25		Comprehensiveness Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about depression, stress, and other mental health issues.
Core-26		Office Staff Composite	NCQA	No	NCQA Survey - percentage of patients who found the clerks and receptionists at their provider's office to be helpful and courteous.
Core-27		Information Composite	NCQA	No	NCQA Survey - percentage of patients who received information from their provider about what to do if care was needed in the off hours and reminders between visits.
Core-28		Coordination of Care Composite	NCQA	No	NCQA Survey - percentage of patients whose providers followed-up about test results, seemed informed about specialty care, and talked at each visit about prescription medication.
Core-29		Specialist Composite	NCQA	No	NCQA Survey - percentage of patients who found it easy to get appointments with specialists and who found that their specialist seemed to know important information about their medical history.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized /Endorsed	Include d in HSA Profile?	Measure Description
Core-30		Cervical Cancer Screening	NQF #0032, HEDIS measure	Adult	The percentage of females 21-64 years who received one or more PAP tests to screen for cervical cancer in the measurement year or two years prior to the measurement year.
Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #0068, NCQA	No	Percentage of patients 18 years and older with IVD who had documentation of using aspirin or another antithrombotic during the measurement year.
Core-35	MSSP-14	Influenza Vaccination	NQF #0041, AMA-PCPI	Adult	Patients 6 months and older with an outpatient visit between October and March who received an influenza vaccine.
Core-36	MSSP-17	Tobacco Use Assessment and Cessation Intervention	NQF #0028, AMA-PCPI	No	Percentage of patients 18 years and older who had a negative tobacco screen or positive tobacco screen with cessation intervention in the two years prior to the measurement year.
Core-38	MSSP-32	Drug Therapy for Lowering LDL Cholesterol	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and an outpatient visit in the measurement year whose LDL-C <100 mg/dL or LDL-C >=100 mg/dL and who received a prescription of a statin in the measurement year.
Core-38	MSSP-33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and a LVEF < 40% or diagnosis of CAD and diabetes who received a prescription of ACE/ARB medication in the measurement year.
Core-39	MSSP-28	Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg	NQF #0018, NCQA HEDIS measure	Adult	Percentage of patients 18-85 years with hypertension whose BP was in control <140/90 mmHg.

Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	Not NQF-endorsed; MSSP	No	Percentage of patients 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
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VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized /Endorsed	Include d in HSA Profile?	Measure Description
Core-47	MSSP-13	Falls: Screening for Fall Risk	NQF #0101	No	Percentage of patients 65 years and older who had any type of falls screening in the measurement year.
Core-48	MSSP-15	Pneumonia Vaccination (Ever Received)	NQF #0043	Adult	Patients 65 years and older who had documentation of ever receiving a pneumonia vaccine.
	MSSP-1	CG CAHPS: Getting Timely Care, Appointments, and Information	NQF #0005, AHRQ	No	CMS Survey - Getting Timely Care, Appointments, and Information
	MSSP-2	CG CAHPS: How Well Your Doctors Communicate	NQF #0005, AHRQ	No	CMS Survey - How Well Your Doctors Communicate
	MSSP-3	CG CAHPS: Patients' Rating of Doctor	NQF #0005, AHRQ	No	CMS Survey - Patients' Rating of Doctor
	MSSP-4	CG CAHPS: Access to Specialists	NQF #0005, AHRQ	No	CMS Survey - Access to Specialists
	MSSP-5	CG CAHPS: Health Promotion and Education	NQF #0005, AHRQ	No	CMS Survey - Health Promotion and Education
	MSSP-6	CG CAHPS: Shared Decision Making	NQF #0005, AHRQ	No	CMS Survey - Shared Decision Making

	MSSP-7	CG CAHPS: Health Status / Functional Status	NQF #0006 , AHRQ	No	CMS Survey - Health Status/Functional Status
	MSSP-8	Risk- Standardized, All Condition Readmission	CMS, not submitted to NQF (adapted from NQF #1789)	No	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognize d/Endorse d	Include d in HSA Profile?	Measure Description
	MSSP-10	Ambulatory Sensitive Condition Admissions: Congestive Heart Failure	NQF #0277, AHRQ (Prevention Quality Indicator (PQI) #8)	Adult	All discharges with an ICD-9-CM principal diagnosis code for CHF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with CHF. This is an observed rate of discharges per 1,000 members.
	MSSP-11	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS EHR Incentive Program Reporting	No	Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.
	MSSP-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #0554	No	Percentage of patients 65 years and older who were discharged from any inpatient facility in the measurement year and had an outpatient visit within 30 days of the discharge who had documentation in the outpatient medical record of reconciliation of discharge medications with current outpatient medications during a visit within 30 days of discharge.
	MSSP-31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #0083	No	Percentage of patients 18 years and older with a diagnosis of heart failure who also had LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.

M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	NQF #0055, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received an eye exam for diabetic retinal disease during the measurement year.
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF #0062, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received a nephropathy screening test during the measurement year.

**APPENDIX 2
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 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 following qualifying CPT Codes during the look back period (most recent 24 months).

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services <ul style="list-style-type: none"> • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations <ul style="list-style-type: none"> • New or Established Patient: 99241-99245
Nursing Facility Services: <ul style="list-style-type: none"> • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: <ul style="list-style-type: none"> • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services <ul style="list-style-type: none"> • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact <ul style="list-style-type: none"> • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact <ul style="list-style-type: none"> • 99358 and 99359
Preventive Medicine Services <ul style="list-style-type: none"> • New Patient: 99381-99387 • Established Patient: 99391-99397
Counseling Risk Factor Reduction and Behavior Change Intervention <ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
<p>Other Preventive Medicine Services – Administration and interpretation:</p> <ul style="list-style-type: none"> • 99420
<p>Other Preventive Medicine Services – Unlisted preventive:</p> <ul style="list-style-type: none"> • 99429
<p>Newborn Care Services</p> <ul style="list-style-type: none"> • 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
<p>Federally Qualified Health Center (FQHC) – Global Visit <i>(billed as a revenue code on an institutional claim form)</i></p> <ul style="list-style-type: none"> • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner
<p>Medicare-Covered Wellness Visits: Codes G0404, G0438, and G0439</p>

**APPENDIX 3
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:
 - Reside in Vermont for Medicaid (and Medicare);
 - Employer situated 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.
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 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 an FQHC or Rural Health Clinic.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services <ul style="list-style-type: none"> • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations <ul style="list-style-type: none"> • New or Established Patient: 99241-99245
Nursing Facility Services: <ul style="list-style-type: none"> • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: <ul style="list-style-type: none"> • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services <ul style="list-style-type: none"> • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact <ul style="list-style-type: none"> • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact

CPT-4 Code Description Summary
<ul style="list-style-type: none"> • 99358 and 99359
<p>Preventive Medicine Services</p> <ul style="list-style-type: none"> • New Patient: 99381–99387 • Established Patient: 99391–99397
<p>Counseling Risk Factor Reduction and Behavior Change Intervention</p> <ul style="list-style-type: none"> • 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
<p>Other Preventive Medicine Services – Administration and interpretation:</p> <ul style="list-style-type: none"> • 99420
<p>Other Preventive Medicine Services – Unlisted preventive:</p> <ul style="list-style-type: none"> • 99429
<p>Newborn Care Services</p> <ul style="list-style-type: none"> • 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
<p>Federally Qualified Health Center (FQHC) – Global Visit <i>(billed as a revenue code on an institutional claim form)</i></p> <ul style="list-style-type: none"> • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

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, and CIGNA plans to move from semi-annual to quarterly attribution in April of 2013.

9. Insurers will make PPPM payments at least quarterly, by the 15th of the second month of the quarter. CIGNA plans to move from semi-annual to quarterly payment in April of 2013. 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.

**APPENDIX 4
 MEDICARE DEMONSTRATION PROJECT
 VERMONT BENEFICIARY ASSIGNMENT ALGORITHM**

1. The look back period is the most recent 24 months for which claims are available.
2. Identify all Medicare beneficiaries who meet the following criteria as of the last day in the look back period:
 - Reside in Vermont;
 - Have both Medicare Parts A & B;
 - Are covered under the traditional Medicare Fee-For-Service Program and are not enrolled in a Medicare Advantage or other Medicare health plan; and
 - Medicare is the primary payer.
3. Select all claims for beneficiaries identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 24 months) where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, nurse practitioner, or physician assistant; or where the provider is an FQHC.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services <ul style="list-style-type: none"> • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations <ul style="list-style-type: none"> • New or Established Patient: 99241-99245
Nursing Facility Services: <ul style="list-style-type: none"> • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: <ul style="list-style-type: none"> • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services <ul style="list-style-type: none"> • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact <ul style="list-style-type: none"> • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact <ul style="list-style-type: none"> • 99358 and 99359
Preventive Medicine Services <ul style="list-style-type: none"> • New Patient: 99381-99387 • Established Patient: 99391-99397

CPT-4 Code Description Summary
<p>Medicare Covered Wellness Visits</p> <ul style="list-style-type: none"> • G0402 - Initial Preventive Physical Exam ("Welcome to Medicare" visit) • G0438 - Annual wellness visit, first visit • G0439 - Annual wellness visit, subsequent visit
<p>Counseling Risk Factor Reduction and Behavior Change Intervention</p> <ul style="list-style-type: none"> • 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
<p>Other Preventive Medicine Services – Administration and interpretation:</p> <ul style="list-style-type: none"> • 99420
<p>Other Preventive Medicine Services – Unlisted preventive:</p> <ul style="list-style-type: none"> • 99429
<p>Federally Qualified Health Center (FQHC) – Global Visit <i>(billed as a revenue code on an institutional claim form)</i></p> <ul style="list-style-type: none"> • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner

4. Assign a 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.
5. If a beneficiary has an equal number of qualifying visits to more than one practice, assign the beneficiary to the one with the most recent visit.
6. This beneficiary assignment algorithm shall be run every 3 months with reports provided as designated in the CR to various entities within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.

APPENDIX 5

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 with a next anticipated submission date of August 28, 2015 and an NCQA recognition lapse date of September 28, 2015:

Event	Date
Date on which practice decides to postpone scoring date / next anticipated submission date.	August 28, 2015
NCQA recognition lapse date.	September 28, 2015
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, 2015
Payment termination date if no action plan developed.	December 31, 2015
Practice attests to making quarter 1 progress toward NCQA recognition as defined in section 5.3.1.	January-March 2016
Date CHT and PCMH PPPM end if practice has not demonstrated progress toward NCQA PCMH recognition.	March 31, 2016
3 rd -quarter practice attests to quarter 3 progress as defined in section 5.3.1.	July-September 2016
Date CHT and PCMH PPPM end if practice has not demonstrated progress toward NCQA PCMH recognition.	September 30, 2016
Date CHT and PCMH PPPM end if NCQA PCMH recognition is not achieved.	December 31, 2016

The following table outlines relevant time frames for a hypothetical Blueprint practice with an original next anticipated score date of December 1, 2015 (assume that practice postpones scoring):

Event	Date
Engagement date: CHT and PCMH PPPM payments begin	December 1, 2014
Original score date; practice decides on November 30, 2015 to postpone scoring	December 1, 2015
Action Plan due date if advance CHT payments are to continue (15 days after decision to postpone scoring date)	December 15, 2015
PCMH PPPM payment termination date regardless of whether an action plan is developed	December 31, 2015
Practice-related CHT payment termination date if no action plan developed (last day of quarter during which action plan is due)	December 31, 2015
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 2016
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 2016
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 2016
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 2016

APPENDIX 7
VERMONT BLUEPRINT WOMEN'S HEALTH INITIATIVE (WHI)
PPPM COMMON ATTRIBUTION ALGORITHM
WHI-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 situated 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 WHI-recognized practice.
11. 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 WHI-participating practice payment rosters, where the practice has signed the self-attestation document for participation in the Blueprint Women’s Health Initiative and the provider’s credential is as a doctor of medicine, doctor of osteopathic medicine, nurse practitioner, certified nurse midwife, or physician assistant.

CPT-4 Code Description Summary
PCMH & WHI Codes
Evaluation and Management - Office or Other Outpatient Services <ul style="list-style-type: none"> • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations <ul style="list-style-type: none"> • New or Established Patient: 99241-99245
Nursing Facility Services: <ul style="list-style-type: none"> • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: <ul style="list-style-type: none"> • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services <ul style="list-style-type: none"> • New Patient: 99341-99345 • Established Patient: 99347-99350

CPT-4 Code Description Summary
<p>Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact</p> <ul style="list-style-type: none"> • 99354 and 99355
<p>Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact</p> <ul style="list-style-type: none"> • 99358 and 99359
<p>Preventive Medicine Services</p> <ul style="list-style-type: none"> • New Patient: 99381–99387 • Established Patient: 99391–99397
<p>Counseling Risk Factor Reduction and Behavior Change Intervention</p> <ul style="list-style-type: none"> • 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
<p>Other Preventive Medicine Services – Administration and interpretation:</p> <ul style="list-style-type: none"> • 99420
<p>Other Preventive Medicine Services – Unlisted preventive:</p> <ul style="list-style-type: none"> • 99429
<p>Newborn Care Services</p> <ul style="list-style-type: none"> • 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
<p>Federally Qualified Health Center (FQHC) – Global Visit <i>(billed as a revenue code on an institutional claim form)</i></p> <ul style="list-style-type: none"> • 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
<p>Asymptomatic Bacteriuria Screening in Pregnant Female</p> <ul style="list-style-type: none"> • 87081, 87084, 87086, and 87088
<p>Breast and Ovarian Cancer Susceptibility, Genetic Counseling and Evaluation for BRCA Testing</p> <ul style="list-style-type: none"> • 96040
<p>Breast Cancer Screening</p> <ul style="list-style-type: none"> • 77052, 77055–77057, and 77063 • G0202
<p>Breast Feeding Support, Supplies and Counseling</p> <ul style="list-style-type: none"> • A4281–A4286

CPT-4 Code Description Summary
<ul style="list-style-type: none"> E0602-E0604 S9443
Cervical Cancer Screening <ul style="list-style-type: none"> 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, and 88175 G0101, G0123, G0141, G0143-G0145, G0147, and G0148 Q0091
Chlamydia Screening <ul style="list-style-type: none"> 86631, 86632, 87110, 87270, 87490, 87491, and 87800
Contraceptive Methods <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 82947 and 83036
DXA Scan <ul style="list-style-type: none"> 77080
Global OB-Covered Well-Woman Visits <ul style="list-style-type: none"> 59400, 59425, 59426, 59430, 59510, 59610, 59614, 59618, and 59622
Glucose Screening <ul style="list-style-type: none"> 82950 and 82951
Gonorrhea Screening <ul style="list-style-type: none"> 87850, 87590, and 87591
Hepatitis B Virus Infection Screening for Pregnant Female <ul style="list-style-type: none"> 87340
Hepatitis C Screening <ul style="list-style-type: none"> 86803
HIV Screening and Counseling <ul style="list-style-type: none"> 86689, 86701-86703, 87390, and 87534-87536 G0432-G0435
HPV DNA Testing <ul style="list-style-type: none"> 87620-87625
Iron Deficiency Anemia Screening <ul style="list-style-type: none"> 80055, 85013, 85014, 85018, 85025, and 85027
Rh(D) Incompatibility Screening in Pregnant Female <ul style="list-style-type: none"> 86901
STI Counseling <ul style="list-style-type: none"> 86593, 86695, and 86696 G0445
Syphilis Infection Screening <ul style="list-style-type: none"> 86592 and 86780

CPT-4 Code Description Summary

Well-Woman Visits

- S0610, S0612, and S0613

12. 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.
13. 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.
14. 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).
15. Insurers will run their attributions at least quarterly. Medicaid plans to continue to run their attribution monthly.
16. 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.
17. 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 3/1/2016, payment for 3/1/2016 through 6/30/2016 would occur by 5/15/16.

APPENDIX 8
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	POWNAI	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	JERICO	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			JAY
WARREN	WOODFORD		BURLINGTON			LEMINGTON
WASHINGTON			SOUTH HERO			LEWIS
WATERBURY			ST. GEORGE			LOWELL
WILLIAMSTOWN			STARKSBORO			MORGAN
WOODBURY			UNDERHILL			NEWPORT CITY
WORCESTER			WESTFORD			NEWPORT TOWN
			WILLISTON			NORTON
			WINOOSKI			TROY
						WARNERS GRANT
						WARREN GORE
						WESTFIELD
						WESTMORE

Health Service Areas by Town Names

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 SPRINGS	ST. ALBANS CITY	ST. JOHNSBURY	WESTON	HARTLAND
ROYALTON	MOUNT HOLLY	ST. ALBANS TOWN	SUTTON		PLYMOUTH
SHARON	MOUNT TABOR	SWANTON	VICTORY		READING
STRAFFORD	PAWLET		WALDEN		WEST WINDSOR
TUNBRIDGE	PITTSFORD		WATERFORD		WINDSOR
	POULTNEY		WHEELOCK		WOODSTOCK
	PROCTOR				
	RUTLAND				
	RUTLAND CITY				
	SHREWSBURY				
	SUDBURY				
	TINMOUTH				
	WALLINGFORD				
	WELLS				
	WEST HAVEN				
	WEST RUTLAND				