VERMONT Blueprint for Health

Smart choices. Powerful tools.

Vermont Blueprint for Health Manual

Effective July 1, 2015

Department of Vermont Health Access
Vermont Health Care Reform
312 Hurricane Lane, Suite 201
Williston, VT 05495
http://blueprintforhealth.vermont.gov/

Telephone: 802-654-8925
Fax: 802-654-8917

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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.

1.2. Process for Updating Blueprint for Health Manual

Consensus-building has been and remains essential to the planning, implementation and evaluation of the Blueprint. To this end, the committees described in Section 2 advise the Blueprint Director. The Blueprint Director will approve changes to the Blueprint for Health Manual that potentially modify the requirements of the insurers, hospitals, primary care practices or others, based on guidance and, when possible, consensus of the advisory groups and key stakeholders.

A stakeholder can appeal the decisions of the Blueprint Director to the Commissioner of the Department of Vermont Health Access (DVHA), who shall provide a hearing in accord with Chapter 25 Title 3.

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 shall 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.

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 Multi-payer Advanced Primary Care Practice (MAPCP) model in their HSA, and meeting requirements of the Blueprint program. 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 Process

4.1. Community Health Team Development

The Community Health Team (CHT) is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations. The goal is to provide citizens with the support they need for well coordinated preventive health services, and, coordinated linkages to available social and economic support services. The CHT is flexible in terms of staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHT services are available to all patients with no eligibility requirements, prior authorizations, referrals or co-pays. The CHT design should address regional health improvement priorities, fill gaps in care, and be developed through an inclusive process including leadership of both medical and community based service organizations. Vermont's major commercial and public insurers finance the CHT as a shared resource.

4.1.1 Community Health Team Scale

The costs of the core CHT units will be shared by Vermont's commercial and public insurers (Medicare and Medicaid).

The number of core CHT members hired in each geographic service area is scaled up or down, depending on the size of the population served by participating Advanced Primary Care Practices. An Advanced Primary Care Practice is a primary care practice that has completed all eligibility requirements including achieving National Committee for Quality Assurance – Patient Centered Medical Home (NCQA PCMH) recognition. The population

served is determined by the number of patients that have had a majority of their primary-care visits to any of the participating Advanced Primary Care Practices in the last 2 years.

4.2. Advanced Primary Care Practice

4.2.1 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.

4.2.2 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 Vermont Child Health Improvement Program (VCHIP) at the University of Vermont College of Medicine works with the aspirant advance primary care practices to complete a practice site assessment and scoring utilizing the NCQA PCMH framework. In order to be recognized for enhanced payment by insurers and to receive that payment, practices must be scored by VCHIP. The VCHIP assessment is then submitted to NCQA for validation at the national level. The Blueprint pays for the cost of VCHIP assisting with assessment. 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 NCQA PCMH recognition.

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 based on their score on NCQA 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 and Blueprint-advance (frontloaded)[1] 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.

For Medicaid, the PCMH payment will be $3.00 PPPM for all qualified Blueprint practices, contingent on the practice maintaining their NCQA PCMH recognition on 2011 or 2014 standards, in accordance with NCQA's policies and procedures (except as otherwise specified in Section 5.3), and contingent on the practice participating in the development and initiatives of a Unified Community Collaborative organized in collaboration with the Blueprint.

For commercial payers and Medicare, the PCMH PPPM payment varies based on the practice's NCQA PCMH score, starting at Level 1, and increases based on every 5-point increment the practice achieves on the NCQA PCMH scoring scale. For commercial payers and Medicare, the PCMH PPPM payment is based on each Blueprint-participating practice's NCQA PCMH score, as shown in Appendix 1 for practices scored according to 2011 or 2014 NCQA Standards. To calculate the total amount of the PCMH PPPM payment for each practice, commercial and Medicare payers will multiply the number of attributed patients in the practice by the PCMH PPPM amount associated with the practice's most recent

[1] To estimate the size of the population that will be served by CHTs, and the number of CHT staff 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 and Blueprint-advance, or frontloaded, practices in the previous two years. Blueprint-advance, or frontloaded, practices will have patient attributions calculated for the purpose of CHT payments, but will not be eligible for PCMH PPPM payments. (That is, the PCMH PPPM value for Blueprint frontloaded practices is $0.00.)

applicable NCQA PCMH score as shown in Appendix 1. The actual payments to specific practices will be based on their most recent NCQA PCMH scores.

Although all scores must be validated by NCQA, practices are first considered NCQA-scored for payment purposes once VCHIP has completed their initial assessment. The use of consistent and independent scoring methodologies is important for the credibility and integrity of the program, and for evaluation purposes.

The PCMH per person per month (PPPM) payment is designed to support the operations of a patient-centered medical home. 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.

The PCMH PPPM payment schedules shown in Appendix 1 for commercial payers and Medicare, the $3.00 PCMH PPPM for Medicaid, and 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 NCQA PCMH scores from VCHIP to payers, and will initially be based on VCHIP scores. Changes in payment resulting from subsequent receipt of NCQA scores, as well as changes for practices that are experiencing an add-on survey, an upgrade, or a re-score, will be implemented by the payer on the first of the month after the NCQA scores 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 VCHIP reviewers, but not more frequently than once every six months. Payments to practices for add-on surveys, upgrades, or re-scores will not change based on VCHIP's review. 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.

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 and Blueprint-advance, or frontloaded, 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. The number of patients also will include the attributed number of unique Vermont patients in primary care practices that are scheduled to be scored under National Committee for Quality Assurance ("NCQA PCMH") standards during the following two quarters, and that wish to receive CHT services in advance of, or frontloaded to, their scoring date. 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).[2] [3] Commercial and Medicaid payers will pay $2.77 per payer-

[2] 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,

claims-attributed patient per month (PPPM), and Medicare will pay $2.47 per payer-claims-attributed patient per month (PPPM).

Advance, or frontloaded, CHT payments will be paid at rate equivalent to that for Blueprint practices, by all payers except Medicare, for patients in practices scheduled to be initially scored during the following two quarters. The Blueprint will work with CHT administrative entities to ensure that the advance, or frontloaded, CHT payments are used to provide core CHT services (in accordance with a CHT plan approved by the Blueprint) to patients in those frontloaded practices.

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, and advance, or frontloaded, CHT payments as determined by the Blueprint based on the total unique Vermont patients in practices scheduled to be scored during the following two quarters. Changes in the amount of financial support due to scaling up or down of CHT capacity will be made by the Blueprint quarterly, and will be reflected in invoices from the CHT administrative entity (if applicable) and payments from the payer.

The Blueprint will provide reports to the payers and to CHT administrative entities reflecting changes in total unique Vermont patients and CHT financial support for each HSA no later than the fifth business day of each calendar quarter. The information in these reports will be based on total unique Vermont patient data provided by payers to the Blueprint, based on claims attributions, 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 scores from the Vermont

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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 months / 1,000 patients * 1.85 payment adjustment ratio = $2.70 PPPM.

[3] 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.

Child Health Improvement Program (VCHIP) 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-participating practices, as well as the total unique Vermont patients in practices scheduled to be scored within the next two quarters that wish to receive CHT services in advance of their scoring dates. 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 and/or practices scheduled to be scored within the following two quarters that wish to receive CHT services in advance of their scoring dates.

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.

5.3. NCQA Recognition and PCMH PPPM and CHT Payments 2015 and 2016.

Background – In 2015 the Blueprint Executive Committee, took under consideration changes to Blueprint payments for PCMH PPPM and CHT, neither of which had been increased since inception in 2008. Practices reported that their costs to become NCQA PCMH recognized exceeded the amount they were receiving in PCMH PPPM payments and they would not be able to sustain their participation in the Blueprint without increases. In response, NCQA recognition was designated as temporarily discretionary for Blueprint practices currently recognized under the 2011 NCQA PCMH Standards until January 1, 2016. In 2015 practices could choose without penalty of reduced payment to:

1) Maintain continuous NCQA PCMH recognition through one of NCQA's pathway, which may include a full rescore on all elements, submitting for renewal or by piloting the new sustaining process
2) Allow their recognition to lapse and develop a plan to achieve NCQA PCMH recognition not later than December 31, 2016, and participate in monitoring of progress related to that plan.

5.3.1 Procedure for sustaining NCQA PCMH recognition and PCMH PPPM 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 postponement of the scoring date such that NCQA recognition will lapse, or failure to achieve recognition), the practice and the Blueprint will develop an action plan with a clear timeline for achieving subsequent recognition. The action plan must have the following 3 components:

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

The action plan will be developed within 30 days of when the NCQA recognition will lapse. NCQA PCMH recognition will be achieved no later than December 31, 2016.

If an action plan is not developed as stated above, the additional CHT payments and PCMH PPPM payments related to that practice's patients will end on December 31, 2015 or the last day of the quarter during which NCQA recognition lapses, whichever comes later. Practices' progress on NCQA PCMH recognition will be monitored not later than March 31, 2016 and again by September 30, 2016. Practices will need to demonstrate progress on achieving 3 NCQA PCMH must pass elements: Standard 3 Element D; Standard 4 Element B; and Standard 6 Element D. Satisfactory progress will be determined as follows:

By March 31, 2016:

NCQA PCMH Standard 3D – The practice will provide a list of preventive services reports they can generate and a timeline for outreach for each report. If the practice is using the renewal process they will demonstrate they are able to show outreach completed in year 1 for at least 2 factors. All practices will need to articulate the connection of the services they have selected for outreach to the UCC priorities and projects.

NCQA PCMH Standard 4B – The practice will provide a list of at-risk populations on which they will focus, a sample report or documentation of their ability to produce an actionable list for the identified populations, and a timeline for implementing the care plans. The practice will articulate how the populations they have chosen related to UCC priorities and projects.

NCQA PCMH Standard 6D – The practice will provide a list of performance improvement priorities and a timeline for when they will begin to work on each priority. If the practice is using the renewal process, they will show data they used from year 1. The practice will articulate how their chosen priorities related to the UCC priorities and projects.

By September 30, 2016:

NCQA PCMH Standard 3D – The practice will demonstrate they have completed 80% of the outreach required to pass this standard or can demonstrate they have completed work to achieve 2 factors. If using the renewal process the practice will show documentation of outreach in year 1 and year 2 for 2 factors, will provide data from year 2 on at least 2 other services for which they have or will do outreach, and an outreach plan for a third preventive service.

NCQA PCMH Standard 4B – The practice will provide examples of the care plans for all at-risk populations the practice has chosen to focus on and will demonstrate that they have reviewed a sample of records to check use of the care plans by individual providers at a level that would ensure the practice passes the chart audit.

NCQA PCMH Standard 6D – The practice will provide the data from year 1 and year 2 for all the projects on which they will submit. The practice will demonstrate that they have completed a performance improvement project that meets at least 5 factors.

If progress is not achieved, during the monitoring checks by VCHIP then payment will end the last day of that quarter. If progress is being made, the additional CHT and PCMH PPPM payments related to that practice's patients will remain in place through 2016 ending on December 31, 2016 if recognition is not achieved.

5.3.2 Procedure for reducing CHT payments for frontloaded practices if initial NCQA recognition is not attained

Regarding advance CHT funding for practices scheduled to be scored during the following two quarters, if a practice that is scheduled to be scored does not achieve NCQA recognition as scheduled (due to either a postponement of the scoring date or failure to achieve recognition), the practice and the Blueprint Associate Director will develop an action plan as described above.

The action plan will be developed within 30 calendar days of receipt of the initial score from VCHIP or NCQA in the event of a failure to achieve recognition, 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.

APPENDIX 1
NCQA Scores-To-Payment-Levels Lookup

Enhanced Provider Payment based on 2011 and 2014 NCQA Standards ($ PPPM for each provider)	
NCQA PPC-PCMH Score, in Points	**Average PPPM Payment (in $)**
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	0.00
30	0.00
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Level One (35-59 pts.)

Level Two (60-84 pts.)

Level Three (85-100 pts.)

Requires 6 of 6 must pass elements.

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 • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–

CPT-4 Code Description Summary
99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner
Medicare-Covered Wellness Visits: Codes G0404, G0438, and G0439

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 sitused in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members/beneficiaries to select a primary care provider, attribute those members/beneficiaries to that provider if the provider is in a Blueprint-recognized or Blueprint-advance (frontloaded) 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 • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact

CPT-4 Code Description Summary
• 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

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 • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397

CPT-4 Code Description Summary
Medicare Covered Wellness Visits • **G0402** - Initial Preventive Physical Exam ("Welcome to Medicare" visit) • **G0438** - Annual wellness visit, first visit • **G0439** - Annual wellness visit, subsequent visit
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner

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. FRONTLOADED PRACTICE THAT DOES NOT ACHIEVE RECOGNITION

The following table outlines relevant time frames for a hypothetical current practice with a rescore date of September 1, 2015 and an NCQA recognition lapse date of September 28, 2015:

Event	Date
Practice notified by VCHIP of non-recognition, or date on which practice decides to postpone scoring date.	August 31, 2015
VCHIP rescore date.	September 1, 2015
NCQA recognition lapse date.	September 28, 2015
Action Plan due date, indicating revised rescore 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
Site visit by VCHIP to practice to determine successful quarter 1 progress toward recognition.	January-March 2016
Date CHT and PCMH PPPM end if practice has not demonstrated progress toward NCQA PCMH recognition.	March 31, 2016
3rd-quarter VCHIP check-in.	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 frontloaded practice with an original score date of December 1, 2015 (assume that practice postpones scoring):

Event	Date
Frontloading begins	April 1, 2015
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
Practice-related advance 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 advance 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 advance 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 advance 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 advance 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