VERMONT Blueprint for Health

Smart choices. Powerful tools.

Vermont Blueprint for Health Manual

Effective January 1, 2016

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Table of Contents

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. Unified Community Collaboratives

4.1.1 Unified Community Collaboratives - Principles & Objectives.

Historically, an array of meetings focused on quality and coordination have been taking place in communities across Vermont. Most areas have Blueprint integrated health services workgroups as well as workgroups for participants in the provider network shared savings programs (ACOs). The Blueprint meetings are oriented towards coordination of community health team operations and services across providers in the community (community, horizontal) while the ACO meetings are oriented towards meeting the goals of the participating provider network (organizational, vertical). The same providers may be participating in multiple meetings, with overlapping but distinct work on coordination of services and quality.

There will now be development of a Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) in order to coalesce quality and coordination activities, strengthen Vermont's community health system infrastructure, and to help the three provider networks meet their organization goals. Where these UCCs are developed, they will serve the function of, and replace, the Blueprint Integrated Health Services (IHS) and Health Information Technology (HIT) workgroups described earlier.

In many areas of the state the proposed collaboratives represent a significant advancement in terms of the assortment of provider types who would participate in, and help lead, a unified

forum. They build on a strong community oriented culture in the state with the underlying premise that the UCC structure, with administrative support and an aligned medical home payment model, will result in more effective health services as measured by:

- Improved results for priority measures of quality
- Improved results for priority measures of health status
- Improved patterns of utilization (preventive services, unnecessary care)
- Improved access and patient experience

4.1.2 Unified Community Collaboratives – Activities.

As proposed, the UCCs will provide a forum for organizing the way in which medical, social, and long term service providers' work together to achieve the stated goals including:

- Use of comparative data to identify priorities and opportunities for improvement
- Use of stakeholder input to identify priorities and opportunities for improvement
- Develop and adopt plans for improving
    - quality of health services
    - coordination across service sectors
    - access to health services
- Develop and adopt plans for implementation of new service models
- Develop and adopt plans for improving patterns of utilization
    - Increase recommended and preventive services
    - Reduce unnecessary utilization and preventable acute care (variation)
- Work with collaborative participants to implement adopted plans and strategies including providing guidance for medical home and community health team operations

4.1.3 Unified Community Collaboratives – Structure & Governance.

To date, Blueprint project managers have organized their work based on a collaborative approach to guiding community health team operations and priorities. In most cases, this has stimulated or enhanced local innovation and collaborative work. The three new medical provider networks have each established a more formal organizational structure for improving quality and outcomes among their constituents. The provider networks are looking to establish improved collaboration and coordination with a range of service providers in each community. The proposed collaboratives build from these complimentary goals and capabilities, enhance community coordination, and improve the ability for each provider network to achieve their goals. This is accomplished using a formal structure with a novel leadership team that balances the influence of the three medical provider networks, and the influence of medical, social, and long term providers.

We are proposing that the UCC in each HSA have a leadership team with up to 11 people based on the following structure:

- 1 local clinical lead from each of the three provider networks in the area
    - OneCare
    - CHAC
    - HealthFirst (not present in all HSAs)
- 1 local representative from each of the following provider types that serves the HSA
    - VNA/Home Health
    - Designated Agency
    - Designated Regional Housing Authority
    - Area Agency on Aging
    - Pediatric Provider
- Additional representatives selected by local leadership team (up to total of 11)

The proposal is for the leadership team to guide the work of the UCC in their service area with responsibilities including:

- Developing a plan for their local UCC
- Inviting the larger group of UCC participants in the local service area (including consumers)
- Setting agendas and convening regular UCC meetings (e.g. monthly)
- Soliciting structured input from the larger group of UCC participants
- Making final decisions related to UCC activities (consensus, vote as necessary)
- Establishing UCC workgroups to drive planning & implementation as needed

The UCC leadership team will be supported in their work with the following resources:

- Leadership team participation from each ACO provider network in the area
- Organizational support from the ACO provider networks
- Goals and objectives established by ACO provider networks
- Convening and organizing support from the Blueprint project manager
- Support on quality work from Blueprint practice facilitators
- Blueprint HSA grants structured to support the work of the UCC
- Collaboration between the Blueprint and UCC leaders on analytics & evaluation
- ACO Provider network performance reporting on the ACO population
- Blueprint profiles with comparative performance reporting on the whole population, including the results of core ACO measures (practice, HSA levels)
- Ongoing programmatic collaboration (Blueprint, Provider Networks, UCC leaders, others)
- Modification to medical home payments to support provider networks and UCC goals

Governance – Balancing Statewide Standardization, Regional Control, & Local Innovation. There will be a higher level (statewide) leadership team that mirrors the local UCC leadership team. The state level leadership team will guide coordination and quality priorities including: adoption and implementation of statewide standards (e.g. medical home standards); recommendations on selection of core measure subsets for payment models; eligibility requirements and structure of payment models; methods for assessment of compliance with standards; methods for attribution and empanelment; review of measure results and performance; recommendations for statewide improvement on key outcomes; and recommendations for service models to meet statewide needs. This work will inform, evaluate, and guide the work of the regional UCCs. In order to be successful, the state level leadership team will be balanced and represent the same key provider groups that are on the local UCC leadership teams including: a representative for each of the three ACO networks; a representative for VNAs and Home Health; a representative for the Designated Agencies; a representative for the Area Agencies on Aging; a representative for the regional Housing Authorities; and a representative for Pediatric providers. This leadership team may choose to add additional members up to a recommended total of 11 in order to be able to function as a leadership team and make decisions. The leadership team may convene a larger group of stakeholders to inform decision making as part of a state level collaborative, and convene workgroups as necessary. The central Blueprint team will serve a convening and support role for the state level leadership team in a similar manner as proposed for the regional UCCs. In effect, a state level structure will be established that will mirror the regional structures, and help to guide their work for matters where standardization and consistency are necessary. It is worth emphasizing that the recommendation for this type of structure emerged widely during the development of the UCC plan and was expressed by stakeholders including: leadership for the three ACOs; leadership for VNAs and Home Health; leadership for the Designated Agencies; leadership for the Area Agencies on Aging; and leadership for Designated Regional Housing Authorities.

What also emerged was the need for balance, primarily the need to preserve the role for regional leadership to guide local decision making, organization, and innovation. Regional UCC leadership teams will respond to state level guidance and recommendations with local decisions on matters such as: methods for implementation of statewide standards; balancing statewide clinical priorities with local needs; and determination of methods for local implementation, organization, and ongoing improvement of service models. This structure highlights the design principle of regional innovation applied to common standards and guidelines. Regional energy and ownership, with comparative reporting and shared learning across regions, is likely to result in the emergence of more effective coordination and quality initiatives.

Another key design principle is a leadership continuum with mirrored leadership teams at the state and local levels. This design increases the likelihood that the state and local leadership teams share similar overarching interests and priorities, and that state level guidance will be relevant for local UCCs.

4.1.4 Unified Community Collaboratives – Basis for Regional Health Systems.

As UCCs mature, they have the potential to emerge as governing and fiscal agents in regionally organized health systems. This could include decision making and management of community

health team funds, Blueprint community grants, and ultimately budgets for sectors of health services (e.g. pre-set capitated primary care funds). In order to be effective an agent for cohesive regional systems, it is essential for UCCs to establish leadership teams, demonstrate the capability to engage a range of providers in sustained collaborative activity (medical, social, and long term support providers), demonstrate the capability to lead quality and coordination initiatives, and demonstrate the ability to organize initiatives that tie to overall healthcare reform goals (e.g. core measures). Ideally, UCCs will demonstrate effective regional leadership to coincide with opportunities offered by new payment models and/or a federal waiver in 2017.

4.1.5 Unified Community Collaboratives – Opportunity to Guide Improvement.

Current measurement of regional and practice level outcomes across Vermont highlights opportunities for UCCs to organize more cohesive services and lead improvement. When adjusted for differences in the population, there is significant variation in measures of expenditures, utilization, and quality. The variation across settings offers an opportunity for UCC leadership teams and participants to examine differences, and to plan initiatives that can reduce unnecessary variation and improve rates of recommended services.

4.1.6 Unified Community Collaboratives - Quality and Performance Framework

Design Principles. There will be use of Vermont's core performance and quality measures, in conjunction with comparative performance reporting, to help guide UCC activities and medical home payments. This approach ties the work of medical homes and UCCs directly to priorities for state led health reforms as reflected by the core measure set, which was selected using a statewide consensus process as part of the Vermont Healthcare Improvement Program (SIM). The three medical provider networks share a common interest in the results of the core measures which are used to determine whether network clinicians are eligible for payment as part of shared savings programs (SSP).

There will be use of a subset of these measures, which can be consistently reported using centralized data sources, to provide targeted guidance for the work of the UCCs. The intent is that UCCs will work to improve the results on some or all of the subset, depending on local priorities and the decisions made by each UCC. The subset of measures will be also be used to generate an overall composite result for the service area (quality composite). The composite result will be used to determine whether medical homes are eligible for a portion of their augmented payment (see payment model).

In addition to the subset of core quality and performance measures, this model incorporates use of the Total Resource Utilization Index (TRUI), a standardized and case mix adjusted composite measure designed for consistent and comparable evaluation of utilization and cost across settings. Comparative results of the TRUI, adjusted for differences in service populations, can be used in combination with more granular utilization measures to identify unequal healthcare patterns and opportunities for UCC participants to reduce unnecessary utilization that increases expenditures but doesn't contribute to better quality. TRUI will be used to determine whether

medical homes are eligible for an additional portion of their augmented payment (see payment model).

Used together, the two composite measures promote a balance of better quality (core quality and performance) with more appropriate utilization (TRUI). Linking quality payments to measure results for the whole service area establishes interdependencies and incentives for medical home providers to work closely with other collaborative participants to optimize outcomes. Routine measurement and comparative reporting provides UCCs with the information they need to guide ongoing improvement. In this way, the measurement framework serves as the underpinning for a community oriented learning health system and helps UCCs to:

- Establish clear measurable goals for the work of the collaborative
- Guide planning and monitoring of quality and service model initiatives
- Align collaborative activities with measurable goals of state led reforms
- Align collaborative activities with measurable goals of shared saving programs

Measure Set. Implementation of this model depends on selection of a subset of quality and performance measures from the full core measure set that was established thru VHCIP. The intent is for a *meaningful* limited set that can be measured consistently across all service areas, using centralized data sources that are populated as part of daily routine work (e.g. all payer claims database, clinical data warehouse). Ideally, measures will be selected that maximize measurement capability with existing data sources, prevent the need for additional chart review, and avoid new measurement burden for providers. At the same time, work should continue to build Vermont's data infrastructure so that more complete data sets and measure options are available. Vermont's full set of core measures are shown in Appendix 1, with the subset that can currently be generated using centralized data sources shown below:

- Plan All-Cause Readmissions
- Adolescent Well-Care Visit
- Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)
- Follow-up after Hospitalization for Mental Illness, 7 Day
- Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Developmental Screening in the First Three Years of Life
- Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
- Mammography / Breast Cancer Screening
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite
- Appropriate Testing for Children with Pharyngitis
- Cervical Cancer Screening

- Influenza Vaccination
- Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg
- Pneumonia Vaccination (Ever Received)
- Ambulatory Sensitive Condition Admissions: Congestive Heart Failure
- Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use - Adult
- Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) – Adult
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Process to select measures. Given the importance of these measures, a stepwise process is recommended to select a subset that will be used to help guide the work of UCCs, and as the basis for a performance portion of medical home payments.

- Leadership from the three provider networks recommends a consensus subset. It is essential for medical home clinicians to help prioritize the subset since their payment is partly tied to service area results. This first step allows the primary care community to coalesce around a subset of measures, which are selected from an overall set that represents state level reform priorities (statewide consensus process).
- The consensus subset, recommended by the three provider networks, should be vetted thru key committees to assure that a balanced subset is selected (meaningful, practical, and usable). Committees to be considered include: VHCIP - Quality & Performance Measurement Workgroup, Payment Models Workgroup, Core Committee; BP - Executive Committee, Planning & Evaluation Committee.

Attributes that should be considered when selecting the subset include:

- Will improvement in these measures contribute in a meaningful way to the goals of Vermont's health reforms (e.g. quality, health, affordability)
- Is there a real opportunity for service areas to improve the results of these measures with better quality and coordination (UCC work, medical homes)?
- Is sufficient data currently available so that these measures can be measured in all service areas?
- Can measure results be generated and routinely reported, in a usable format, for use by UCC participants?
- Are regional and national benchmarks available for these measures?

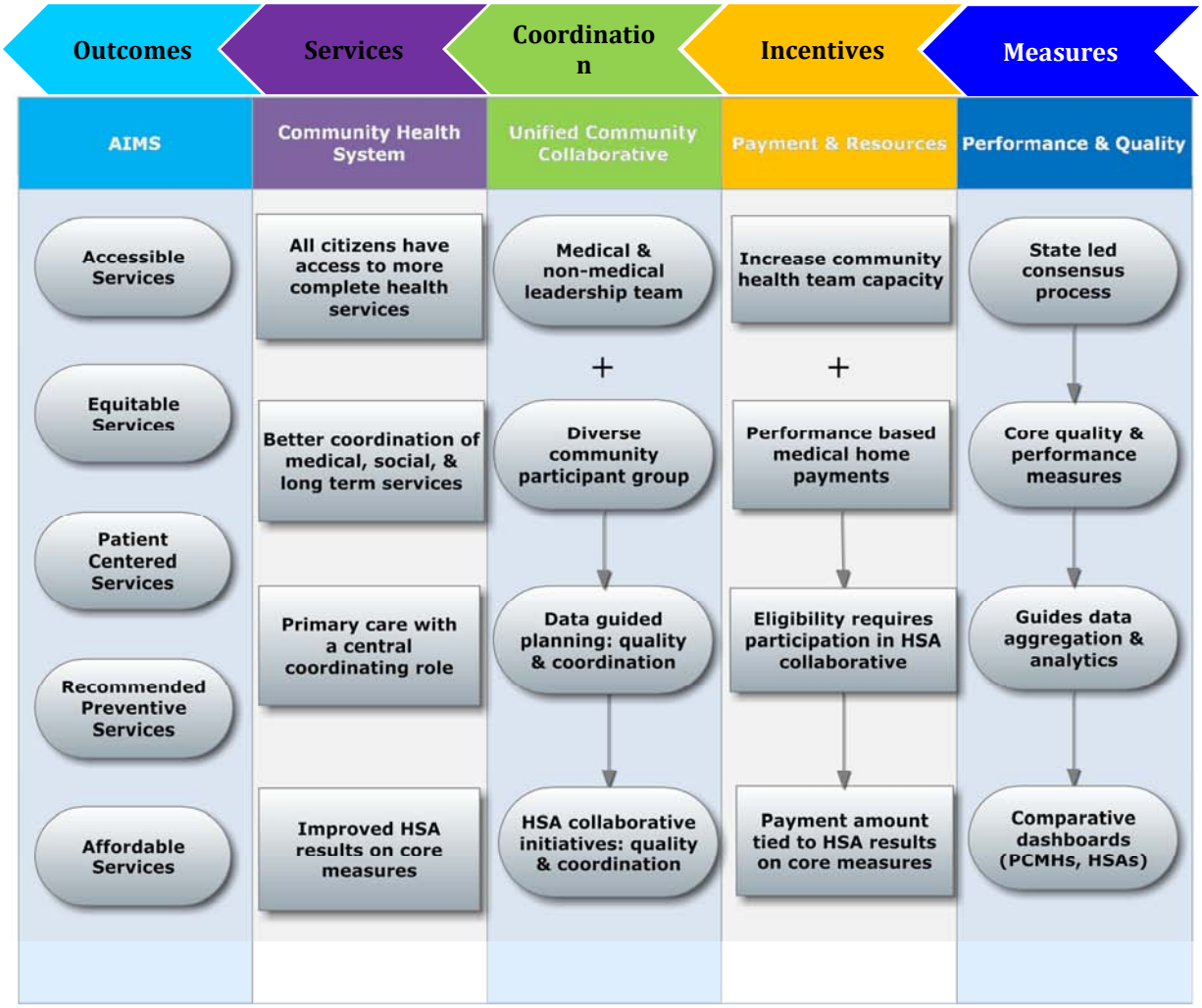
Linking Healthcare & Population Health. The most substantial improvement in results for these core performance and quality measures is likely to be achieved by addressing the medical, social, economic, and behavioral components that converge to drive poor health outcomes. Although the core measures are oriented to the healthcare sector, the program and payment strategies outlined in this plan stimulate interdependency and coordination of a broader nature. The

makeup of the collaborative leadership team, decision making process, and link between medical home payment and service area outcomes are all designed to assure that citizens have access to more cohesive and complete services. Collectively, the plan is a first step in using comparative measurement as a driver for a broader community health system. However, an important next step would be to incorporate measures that reflect non-medical determinants as part of the framework to guide community health system activities. As part of this plan, it is recommended that the VHCIP Population Health workgroup work with provider network leadership and other stakeholders to identify a subset of core population health measures that can be reliably measured and used in concert with the current core quality and performance measures.

4.1.7 Unified Community Collaboratives - Strategic Framework for Community Health Systems

This model is intended to provide Vermont's citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services. Strategically, the model starts with Vermont's consensus based core performance and quality measures, and positions these measures as drivers for local community level learning health systems. Medical home financial incentives are in part tied to service area results for these core measures and to their participation in local collaborative initiatives. The collaboratives are designed to lead initiatives which will improve quality and performance, including the results of core measures, thru better coordination. Ultimately, data guided community initiatives, involving medical and non-medical providers, will provide citizens with direct access to more complete and effective services. The use of core measures as proposed, with detailed information on local variation and outcomes, is a substantial step towards a performance oriented community health system. Results to date in Vermont suggest that medical homes working with community health teams, and other local providers, will lead to a measurable increase in recommended preventive services and a reduction in unnecessary and avoidable services. The strategic framework to achieve the desired aims is outlined below.

Figure 1. Strategic Framework.



4.2. 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.

4.2.1 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.

4.3. Advanced Primary Care Practice

4.3.1 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.

4.3.2 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 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, 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 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.

Payment is contingent on on the practice's NCQA recognition, or qualifying NCQA score, under medical home standards. All scores must be validated by NCQA. 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 and is contingent on each Blueprint practice's NCQA recognition, or qualifying NCQA score, 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,

[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.)

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 NCQA PCMH scores to payers. 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 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.

5.1.1 PCMH PPPM Payment Model

The PCMH PPPM 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 Medicare, the criteria and levels of PCMH PPPM payments remain the same as those in effect on July 1, 2015 (consistent with the negotiated payment criteria of the Medicare Multi-Payer Advanced Primary Care Practice Demonstration in Vermont, and consistent with the PCMH payment levels in Appendix 6). 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 & UCC Participation.
    - Requires successful recognition on 2014 NCQA standards (any qualifying score)
    - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum

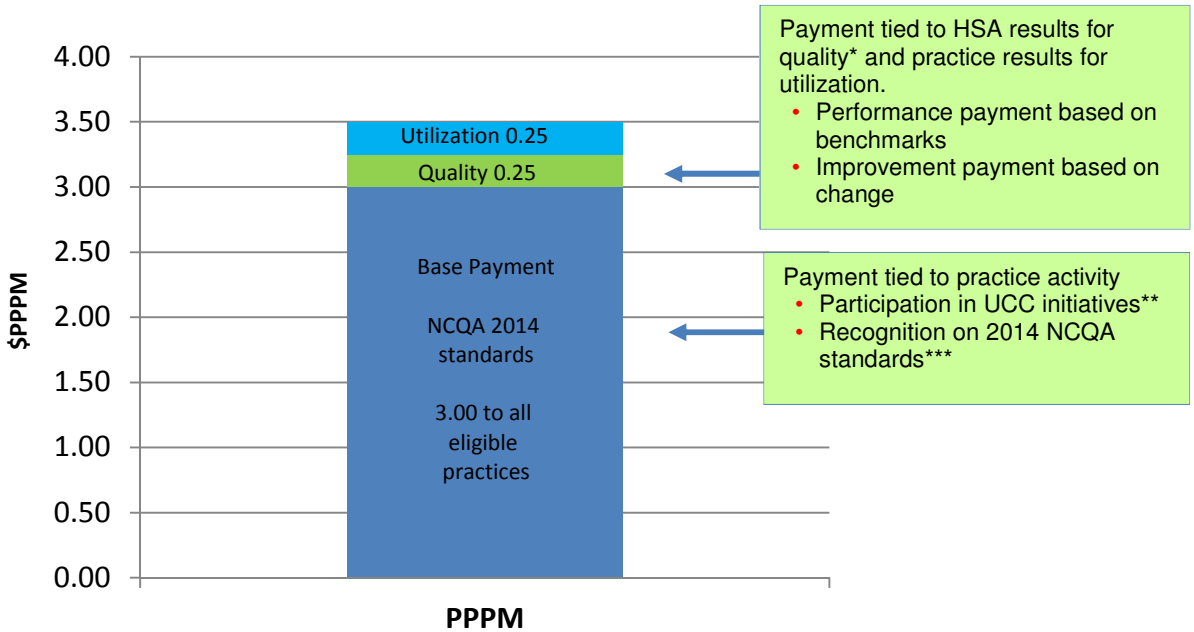
requirement is active participation with at least one UCC priority initiative each calendar year.
    - All qualifying practices receive $3.00 PPPM

- Quality Performance Component: Based on Hospital Service Area (HSA) results for Quality Index.
    - Three payment levels up to $ 0.25 PPPM 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 PPPM 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 PPPM

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



*Incentive to work with UCC partners to improve service area results.
**Organize practice and CHT activity as part of at least one UCC quality initiative per year.
***Payment tied to recognition on NCQA 2014 standards with any qualifying score. Emphasizes priority 'must pass' elements.

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 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 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 number of attributed 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-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[4], 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

[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, 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.

[4] 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.

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-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.
    a. Related to this option, NCQA-recognized practices active in the Blueprint as of July 1, 2015 will not incur a penalty of reduced Medicare Blueprint payments related to NCQA score from July 1, 2015 to December 31, 2016, as long as they maintain NCQA recognition or adequate progress toward NCQA recognition as described in Section 5.3.1.

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' will attest to making progress on NCQA PCMH recognition as defined below no later than March 31, 2016 and again by September 30, 2016. Progress may be audited or monitored by the Blueprint. 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 audits or monitoring checks 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 the Blueprint 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
VHCIP Core Quality & Performance Measures

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 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 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	Included 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	Included 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	Included 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.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized /Endorsed	Included 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 Recognized/Endorsed	Included 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 • 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 situsedin 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 the Blueprint of non-recognition, or date on which practice decides to postpone scoring date.	August 31, 2015
Blueprint 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
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
3rd-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 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

APPENDIX 6
NCQA Scores-To-Payment-Levels Lookup For Medicare PCMH Payments

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.