VERMONT Blueprint for Health

Smart choices. Powerful tools.

Vermont Blueprint for Health Manual

Effective July 1, 2022

Department of Vermont Health Access
Blueprint for Health
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1. Introduction to Blueprint for Health Manual

1.0. 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. The Blueprint works with a broad range of stakeholders to implement a health services model that is designed to:

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

A 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, specifically Patient-Centered Medical Homes, 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, payers, and providers of health services (medical and non-medical) to implement the Blueprint's Multi-payer PCMH model in their community, and to become part of a statewide Learning Health System. The Blueprint model includes the following components: multi-insurer payment reforms that support PCMHs and community health teams; and an evaluation and quality improvement infrastructure to support a Learning Health System which continuously refines and improves itself.

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

1.1. Process for Updating Blueprint for Health Manual

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

2. Advisory Groups

2.1. Blueprint Executive Committee

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

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

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

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

2.2. Blueprint Payment Implementation Work Group

Purpose: The purpose of the Blueprint Payment Implementation Work Group is to implement the payment reforms that support PCMHs and community health teams, design the payment mechanisms and patient attribution strategies, modifications over time, and to make recommendations to the Blueprint Executive 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 PCMHs and community health teams
- Administrative and project management leadership in each Health Service Area
- Commissioner of the Department of Vermont Health Access or designee

Meeting Frequency: The Blueprint Payer Implementation Work Group shall meet no fewer than six times annually. The work group 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 All-Payer Model (APM) and the Blueprint program in their HSA. Lead administrative entities within each HSA will also receive multi-insurer payments to support hiring of Community Health Teams, and therefore must be Centers for Medicare and Medicaid Services (CMS) eligible providers.

4. Design & Implementation

4.1. Statewide Health Reform

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

4.1.1 *Accountable Care Organization*

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

4.1.2 *All-Payer Model*

The Vermont All-Payer ACO Model (APM) is based on an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care, with Medicare's participation. The APM enables the three main payers of health care in Vermont—Medicaid, Medicare, and commercial insurance—to pay for health care differently than through fee-for-service reimbursement. It provides Vermont the opportunity to improve health care delivery to Vermonters, changing the emphasis from seeing patients for episodic illness to providing longitudinal and preventive care. (See https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/.)

4.1.3 *Population Health and Clinical Priorities*

Through the Vermont All-Payer ACO Model Agreement, specific target population health outcomes were set for Vermont to improve access to primary care, reduce deaths from suicide and drug overdose, and reduce prevalence and morbidity from chronic disease. To achieve these outcomes, the Accountable Care Organization in the state has established clinical priorities with their members, and the Blueprint supports these efforts.

4.1.4 *Health Service Areas*

To achieve the All-Payer Model population health outcomes and ACO clinical priorities, the Blueprint and ACO have focused on supporting and making joint investments into communities to innovate and organize their health services. Thirteen communities or geographic regions, known as health service areas, have emerged in Vermont. These health service areas are roughly based around the areas served by Vermont's hospitals and their associated primary care services and have significant overlap with State of Vermont human services districts and the regions served by the designated mental health and home health agencies. A listing of HSAs by town names is found in Appendix 8.

4.2. Community Collaboratives

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

The intent of the Community Collaboratives is to:

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

Community Collaboratives often use the Accountable Community for Health (ACH) framework, by addressing the medical and non-medical needs that affect outcomes, including social, economic, and behavioral factors. These needs and the impact they have on population health are routinely referred to as the Social Determinants of Health. Interventions may include the integration of high-quality medical care, mental health services, substance use treatment, long-term services and supports, social services, and community-wide primary prevention efforts.

4.2.1 *Community Collaboratives—Governance*

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

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

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

The governing body works across organizational boundaries to assess the outcomes in the Health Service Area, compares outcomes to state population health and ACO goals in a community health needs assessment, establishes local goals, monitors progress towards those goals, establishes a plan and workgroups to achieve the goals, allocates financial and human resources from individual organizations to achieve collective outcomes, and jointly seeks funding and support for local projects. The Blueprint Program Manager often facilitates Community Collaborative meetings and workgroups in their HSA.

4.2.2 *Community Collaboratives—Workgroups*

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

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

4.3. Community Health Team

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

4.3.1 *Community Health Team Plan*

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

- a list of CHT staff, including roles, credentials, staffing locations, and FTEs; and
- quarterly reports detailing the CHT staffing as well as regular updates to the Blueprint portal.

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

4.3.2 *Community Health Team Budget*

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

This budget shall be provided to the State upon request and shall be available to the Community Collaborative, allowing for appropriate measures to protect employee privacy.

4.3.3 *Community Health Team Evaluation*

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

4.3.4 *Community Health Team Staffing*

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

- The Administrative Entity will provide CHT staff based on the CHT staffing plan.
- The Administrative Entity will provide organizational support for the operations of the CHTs, including ongoing mentoring and supervision of team members and the CHT Leader. The CHT Leader will be responsible for the day-to-day supervision of CHT staff members.
- The Administrative Entity, under the direction of the Community Collaborative, will direct CHT staff to work on activities outlined in quadrants in the population health model.
- The Administrative Entity will work collaboratively with the State and the ACO to prepare and launch new initiatives and service layers as they arise. The Program Manager will coordinate recruitment and hiring or subcontracting of those resources according to State direction.
- Community Health Team vacancies, including those created when additional CHT funding becomes available through new initiatives, will be filled within 60 days.

4.3.5 *Community Health Team Integration*

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

- Medication Assisted Treatment (MAT) licensed, registered nurses and licensed, Master's prepared substance use disorder or mental health counselors for office-based treatment of opioid use disorder;
- Women's Health Initiative (WHI) licensed, Master's prepared mental health professionals to work in WHI practices;
- SASH® (Support and Services at Home) teams of wellness nurses and care coordinators throughout the state for Medicare and Medicaid beneficiaries living in affordable congregate housing and Medicare beneficiaries in surrounding communities for assistance with health promotion and aging safely at home;
- Vermont Chronic Care Initiative (VCCI) nurse case managers for intensive, short-term treatment of certain Medicaid patients;

- Commercial payer case managers;
- Recovery Centers;
- Agency of Human Services; and
- Designated Agencies.

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

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

The Program Manager shall document and report to the State:

- Respective roles of the Core CHT and other care management providers, including ACO resources such as Clinical/Quality Consultants;
- CHT model evaluation results and specific plans to address gaps;
- Alignment with the care coordination model;
- Clear referral protocols and methods of communication between area care management programs; and
- Well-coordinated and non-duplicative services for participants.

4.3.6 ***Medication-Assisted Treatment***

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

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

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

4.3.7 ***Women's Health Initiative***

Women receive substantial preventive care services in various settings. Through the Women's Health Initiative, women's health specialty providers Blueprint Patient-Centered Medical Homes are providing enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC). New staff, training, and payments support effective follow-up to provider screenings through brief, in-office interventions, and referral to services for mental health, substance use, trauma, partner violence, food, and housing.
The Women's Health Initiative helps ensure that women's health providers, Patient-Centered Medical Homes, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.
A complete list of Vermont Blueprint practices that participate in the Women's Health Initiative is available with a link to their website.

(See Section 7)

4.4. Blueprint Program Management

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

4.4.1 ***Program Management—Program Monitoring***

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

4.4.2 ***Program Management—State Meetings***

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

- Blueprint Executive Committee meetings;
- Blueprint Payment Implementation Work Group meetings;
- Program Manager meetings;
- ACO Clinical Committees;
- Care Coordination Core Team meetings; and
- Information Technology meetings.
- Monthly Spoke meetings

- Monthly Women's Health Initiative meetings
- Ad hoc meetings for new initiatives

4.4.3 *Program Management—Community Collaboratives*

The Program Manager role includes supporting the Community Collaborative/ACH. Support often includes recruiting relevant committee members, working with committee chairs, if applicable, and members to set agendas, recording decisions made during meetings, monitoring progress on work that will be completed by members between meetings, including what will be completed, by whom and by when, following-up with members between meetings to ensure progress is being attained, identifying and preparing presenters prior to the meetings, ensuring effective communication between members during the meetings, and reporting the progress of the Community Collaborative to the committee and workgroup members.

4.4.4 *Program Management—Practice Outreach and Participation in Health Reform*

The Program Manager shall maintain ongoing relationships with all primary care (internal medicine, general medicine, geriatric medicine, family medicine, pediatric medicine), women's health, and substance use disorder treatment practices within the health service area, as evidenced by at least annual outreach to non-Blueprint practices and ongoing outreach to Blueprint practices, in order to encourage their participation in the broad set of health reform initiatives (PCMH, CHT, MAT, WHI, self-management, and ACO) and Community Collaborative activities. Annual outreach shall include an in-person meeting with each practice, or if the practice refuses to meet, then documentation of an electronic or paper memo.

The Program Manager shall:

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

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

4.4.5 ***Program Management—Recruit Participation in Quality Improvement***

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

- Providing access to relevant data reports and interpretation of these reports, such as Blueprint analytic reports, Emergency Department (ED) use, inpatient admissions, data on trends in hospital readmission rates, population outreach reports, access to lists of patients for each practice, and other relevant patient data.
- Evaluating practices' effective use of ACO analytic resources, such as ACO reports, Workbench One, Care Navigator, or other ACO self-serve analytics tools;
- Reporting at check-in meetings on progress of quality improvement projects between practices, specialists, hospitals, and community organizations based on core clinical measures and State healthcare reform initiatives, including APM measures, ACO clinical priorities, and population health measures;
- Developing referral processes to Blueprint-sponsored self-management programs into primary care and women's health practice workflows, including a feedback loop back to primary care providers;
- Providing education on, and CHT staff support for, empanelment and panel management, such as best practices and technical assistance as needed;
- Organizing learning events (using training funds to support speaker costs), such as providing logistical support for local meetings of primary care practices and creating innovative opportunities for learning and communication between primary care practices; and
- Developing and coordinating co-management and referral agreements with practices in the health home neighborhood (integrated community).

4.4.6 ***Program Management—MAT and WHI Practice Contacts***

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

4.4.7 ***Program Management—Health Reform Communication***

The Program Manager shall be responsible for communicating directly with practices as frequently as necessary on changes in statewide health care reform policies and

procedures, especially as they affect practice processes, participation requirements, involvement in other State or national reform or billing efforts, ACO activities, and Blueprint program payment levels and practice eligibility criteria. The Program Manager shall communicate updates received from the State in a timely fashion.

4.4.8 *Program Management—Unified Performance Reporting and Data Utility*

In the Administrative Entity's Health Service Area, the Program Manager shall coordinate, support, and partner with others in activities that strengthen data passed into, and available for reporting from, Vermont's Health Information Exchange and health information technology and data infrastructure, including Care Navigator, Workbench One, or other systems as available.

4.4.8.1 Care Management and Analytic Tools

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

4.4.8.2 Community Health Team Recording of Patient Encounters

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

4.4.9 *Program Management—Payment Processes*

4.4.9.1 Data Collection and Entry

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

Detailed information on providers, practices, and CHT administrative entities is required by commercial and public payers in order to implement enhanced payments. The State provides the Blueprint Provider Directory (https://blueprintforhealthportal.vermont.gov/) to Program Managers as the data collection tool for required information according to the following schedule:

CHT/MAT/WHI Staffing and Practice Information:	October 15 January 15 April 15

Enter updated CHT/MAT/WHI staffing and Practice information. This includes practice closures, mergers, and openings.	July 15
Monitor NCQA PCMH Recognition: Each quarter, the State shall notify and identify to the Program Manager a cohort of Practices which are scheduled to undergo NCQA PCMH recognition approximately 6 months in the future. For those identified Practices, the Program Manager, in partnership with the assigned Blueprint QI Facilitator, shall closely monitor and report on progress toward reviewing and updating policies, protocols, and practices for the reporting date, including indicating which Quality Improvement Projects/Measures are being selected as part of PCMH recognition. The Program Manager and QI Facilitator will ensure all appropriate Practice and provider information is updated in the Blueprint Portal (or other data reporting system) accordingly.	October 15 January 15 April 15 July 15 (for each such date, with respect to Practices identified to Subrecipient within the prior quarter)
New Practice Total Unique Patient Counts: For practices new to the Blueprint, enter Practice-level patient counts to determine CHT staffing ratios.	December 15 March 15 June 15 September 15

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

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

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

4.4.9.2 Payment Communication

The Program Manager shall be responsible for communicating updates on payment-related processes to practices as they occur based on updates received from the State and for working with practices and parent organizations to identify and communicate questions, concerns, risks, and issues to the State as they arise, with follow up completed as appropriate.

4.5. Patient-Centered Medical Homes

4.5.1 *Definition*

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

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

4.5.2 *NCQA Recognition*

Overview: The Blueprint requires that practices meet the NCQA PCMH standards (as well as the other requirements) as they become and maintain their status as Blueprint Patient-Centered Medical Homes. The standards can be found on the NCQA website at http://www.ncqa.org, and 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 a PCMH, Vermont practices must achieve and maintain NCQA PCMH recognition.. The start of the process is defined by NCQA as the date that a practice submits their initial documentation and payment to NCQA on the Q-Pass portal.

4.6. Quality Improvement Program

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

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

Specifically, the QI program facilitates practices and communities to achieve improvement of clinical quality measures, patient experience measures, care coordination, practice transformation, and reducing variation in outcomes. It does this through building ongoing relationships with the stakeholders that the Quality Improvement Facilitators work with – primary care practices, specialty practices, and community collaboratives - that are flexible to individualized needs and connected to quality improvement efforts and priorities at the community and state levels.

4.6.1 *Quality Improvement (QI) Facilitation*

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

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

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

Practices engaging in QI agree to meet with Quality Improvement Facilitators on a weekly, biweekly, or monthly basis and commit a quality improvement team to work through the quality improvement process in order to design, test, and implement changes in practices and processes towards quality improvement aims.

Quality Improvement Facilitators will work with each engaging practice to:

- Assess the practice using quality improvement assessment tool(s) recommended by the state
- Compile assessment and relevant data for the practice to assist with identifying potential opportunities for quality improvement
- Assist a practice to convene a quality improvement team
- Coach the practice through data-driven decision making, goal and priority setting,

action planning, change management, and change measurement
- Research best practices on quality improvement strategies to address problem areas or opportunities identified by the practice
- Engage expert consultation, share best practices, and/or connect practices with necessary resources to assist with achieving quality improvement aims.

The Quality Improvement Facilitators will also help practices/organizations prepare for and maintain National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) and Patient-Centered Specialty Practice (PCSP) Recognition:
- Identify applicable clinical standards.
- Assess the practice's current workflows against standards.
- Develop a work-plan and timeline for achieving standards and/or recognition.
- Determine which current policies, processes, and systems meet the applicable standards and which do not.
- Provide guidance on what changes would meet the standard or improve the chance of recognition.
- Assist practices in assembling documentation needed for submission to NCQA or other accountable body; and
- Assist practice with submitting materials and support phone calls for recognition on an ongoing basis to NCQA or other applicable recognition body.

QI Facilitators will visit each site or organization no less than monthly. QI Facilitators will provide appropriate levels of consultation based on factors such as the practice's available internal and additional external resources and the length of time until the standards and/or QI goals are met. QI Facilitator Staff provide regular consultation in response to practice questions between meetings via phone and email.

To support communities, the Blueprint or the ACOs may host learning collaboratives or group learning activities for communities or healthcare affiliated organization. As required, QI Facilitators will:
- Help design and/or implement learning collaboratives or statewide learning activities.
- Participate in regularly scheduled planning meetings as frequently as once per week for up to 4 months prior to and during the collaborative.
- Assist practice teams participating in the learning collaborative to establish group goals and norms.
- Assess differences between how care is being delivered against best practices or clinical standards.
- Provide guidance on what changes would improve the identified measure of clinical process.
- Develop a work plan and timeline to meet between learning sessions, and to implement quality improvement cycles with the current practices.
- Complete assigned deliverables between meetings. Deliverables may include researching best practices, developing power points, preparing data collection

sheets, and producing tools to assist communities in implementing the target strategies.

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

The QI facilitator will also support Community Collaboratives/Accountable Communities for Health to improve performance on All-Payer Model objectives and ACO clinical priorities. QI Facilitators work with Community Collaboratives to:

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

4.6.2 *Quality Improvement Facilitator—Caseloads and Coverage*

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

4.6.3 *Quality Improvement Facilitator—Requirements and Reporting*

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

QI Facilitators provide peer-to-peer mentoring and support to other QI Facilitators, Accountable Care Organizations (ACOs) and Blueprint staff, based on expert level

knowledge and experience in the NCQA PCMH and PCSP or other standards, which may include sharing information and examples of processes that have passed review, interpreting feedback from NCQA or other body on submission, providing shadowing opportunities, and hosting education sessions during facilitator and field staff meetings.

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

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

4.7. Community-Based Self-Management Peer Support Programs

Program managers will support the efforts of the Department of Health as they administer locally based and/or Statewide opportunities to engage Vermonters in self-management programs to improve and maintain their own health.

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

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

5.1. Patient-Centered Medical Home (PCMH) Payments

The Blueprint will provide payers with practice roster information received from practices and NCQA recognition status for all Blueprint practices. Payers will use the practice roster information to calculate claims-based Blueprint patient attributions for each practice, as specified in Appendices 1 and 3. Based upon the NCQA PCMH recognition status, as

described earlier, the insurers will multiply the number of a practice's attributed beneficiaries by the appropriate dollar amount to generate a PCMH Per 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 1, 2, and 3. If a patient has an equal number of qualifying visits to more than one practice, they will be attributed to the one with the most recent visit. Patient attributions for members of Blueprint-participating self-insured plans will be included. Attribution is refreshed at least quarterly.

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

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

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

The enhanced PCMH PPPM payment is based on the number of patients that are attributed to the practice by each insurer. The attribution method used by all insurers is intended to determine the practice's active caseload. At present, insurers attribute all patients that have had a majority of their primary-care visits (Evaluation & Management Code) to the practice in the last 24 months. Vermont's insurers have elected to apply these look back periods based on their beneficiaries' demographics, recommended health maintenance, and health related risks.

The PCMH per person per month (PPPM) payment is designed to support the operations of

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

The attribution methodology found in Appendices 2 and 3 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 engaging practices or practices required to undergo new PCMH recognition (due to consolidation, merger, or acquisition) will be effective on the first of the month or quarter (dependent on payer) after the date that the Blueprint transmits the NCQA engagement date to payers. Changes in payment resulting from subsequent receipt of the key PCMH NCQA dates will be implemented by the payer on the first of the month or quarter after the NCQA dates are received by the payer from the Blueprint. Practices must maintain their NCQA PCMH recognition in accordance with NCQA's policies and procedures (except as otherwise specified in Section 5.3).

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

5.1.1 *PCMH PPPM Payment Model (Medicaid and Commercial Insurers)*

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

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

Quality Performance Component:

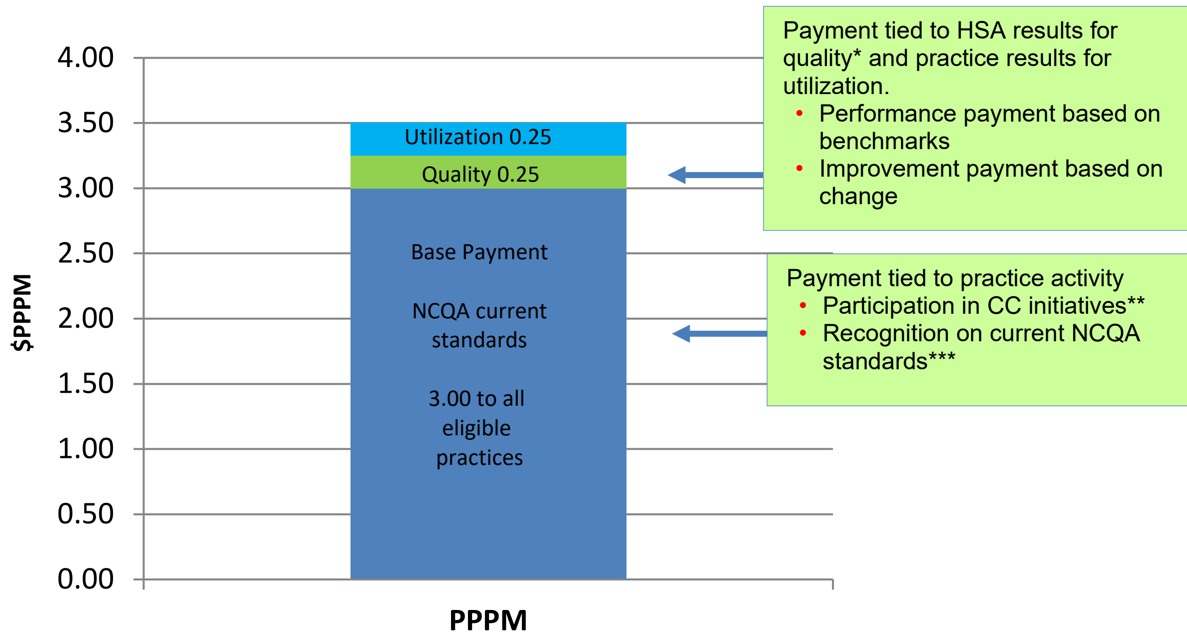
- Based on Hospital Service Area (HSA) results for Quality Index.
- Multiple payment levels up to $ 0.25 PPPM based on total score of the four quality performance measures.
- Points for each measure are achieved through meeting or surpassing benchmarks and through improving from one twelve-month period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

Utilization Performance Component:

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

Total Payment = Base + HSA Quality Performance + Practice TRUI Performance
Total Payment ranges from $3.00 to $3.50 PPPM for commercial payers (or a higher base payment for Medicaid, as approved by that payer).

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



*Incentive to work with CC partners to improve service area results.
**Organize practice and CHT activity as part of at least one CC quality initiative per year.
***Payment tied to engagement and subsequent recognition on current NCQA PCMH standards

The PCMH practice payment model is designed to promote collaboration and interdependent work by linking a portion of each practice's potential earnings to measure results for the whole service area (HSA). It is also intended to more directly focus efforts on improved health outcomes and reduced growth in health expenditures. In theory, the combination of the Community Collaborative 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 the future. 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 community collaboratives including attention to variable and unequal outcomes on core measures; and, coordination with collaborative partners to improve services.
- Requires that practices engage and maintain NCQA recognition.
- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization)

- Rewards coordination with Community Collaborative partners to achieve better results on service area outcomes for a composite of core quality measures (directly links incentives for medical homes to statewide healthcare reform priorities)
- Rewards coordination with Community Collaborative partners to achieve better practice results for the total resource utilization index (TRUI) (case mix adjusted), which has a predictable impact on healthcare expenditures (directly links incentives for medical homes to statewide healthcare reform priorities)

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

5.2. Community Health Team Payments

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

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

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

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

For purposes of the Blueprint payment specifications, "number of patients" means the number of total unique Vermont patients in Blueprint-participating practices with a majority of their primary-care claims-coded visits to the practices during the previous 24 months. Appendix 2 contains the algorithm to be used by Blueprint practices to calculate and report total unique Vermont Blueprint patients, and Appendix 3 contains the algorithm to be used by payers to calculate and report total unique Vermont Blueprint patients. Patient attributions for members of Blueprint-participating self-insured plans will be included.

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

The payer will make CHT payments monthly or quarterly, as determined by the payer in conjunction with the Blueprint Director, upon receipt of an invoice sent by the CHT administrative entity to the payer (if an invoice is required by the payer) by the 15th calendar day of the month or the 15th calendar day of each quarter. Invoices will reflect the administrative entities' CHT payments as determined by the Blueprint based on the total unique Vermont patients in Blueprint-participating practices. Changes in the amount of financial support due to scaling up or down of CHT capacity will be made by the Blueprint quarterly, and will be reflected in invoices from the CHT administrative entity (if applicable) and payments from the payer.

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

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

patient. The Blueprint will also provide payers with a monthly practice roster and NCQA recognition status.

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

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

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

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

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

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

The action plan must have the following 3 components:

1) Identification of the reason(s) for the practice not achieving NCQA PCMH recognition,

2) A clear plan for targeted improvement with identification of parties responsible for the steps to take, and
3) A clear timeline for targeted improvement.

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

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

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

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

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

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

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

The action plan will be developed within 30 days of failure to achieve recognition within the 12-month time period set by NCQA, or within 15 days of the decision to postpone the scoring date. If it is not developed within the applicable time frame, CHT payments for that practice's patients will end on the last day of the quarter in which the applicable time frame ends. If an action plan is developed, the additional CHT payments related to that practice's patients will decline by 25% for each quarter after the quarter in which the applicable time frame ends, until recognition is achieved.

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

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

If the practice does not achieve recognition within the additional 3-month time period for extended recognition set by the Blueprint for Health, insurers will have the option of recouping the practice's practice PPPM payments back to the date on which those payments would have ended (i.e. – last day of the month following the date on which the practice failed to achieve NCQA recognition within the 12-month time period for recognition set by NCQA.

6. Medication-Assisted Treatment

The Hub and Spoke System of Care for opioid use disorder (OUD) is designed to create an integrated system between the two settings where Medication-Assisted Treatment (MAT) is provided and to coordinate the MAT treatment settings with the broader health and human services systems. The two MAT settings are: "Opioid Treatment Programs (OTPs)" where medications are dispensed and patients can be seen daily, and "Office-Based Opioid Treatment (OBOT)" practices where medications are prescribed and patients are seen less frequently. The OTPs in Vermont are called "Hubs," and these are addictions specialty programs best suited for patients who are experiencing a more severe course of addiction and/or who are best treated with methadone. The OBOTs in Vermont are called "Spokes" and these may be primary care medical practices, Ob-Gyn, outpatient psychiatry, or outpatient addictions treatment programs. Although patients may be seen as frequently as three times a week, many patients are seen monthly in Spoke settings. As such, the Spokes may serve patients with specific needs (for example pregnancy or co-occurring health conditions) and/or who are relatively stable in recovery.

6.1. Hub & Spoke System of Care

The Hub & Spoke system of care is supported by a Health Home State Medicaid Plan Amendment that provides categorical eligibility for Health Home services for Medicaid members with OUD. Every Medicaid Member with OUD must be provided with at least one health home service monthly. The Health Home services are detailed in table below. An additional requirement of the Health Home is that the Blueprint must report on the Medicaid Adult Core Measures for members receiving MAT. Local System of Care The expectation is that the patients move between Hubs and Spokes based on their clinical needs. In addition, the Hubs are expected to provide consultation support to the Spoke practices and to rapidly admit unstable patients referred from Spokes. In turn, as patients who receive Buprenorphine related products at Hubs stabilize, they are expected to be referred to Spokes for ongoing care. Each Medicaid Member receiving MAT is also expected to have an identified Primary Care Provider with whom care is coordinated. Each local

Health Services Area is responsible for organizing a system to triage access to both the Hub and Spoke services based on matching the clinical needs and preferences of patients to the area settings.

Spokes are Office Based Opioid Treatment settings, located in communities across Vermont. At many Spokes, addictions care is integrated into general medical care, like treatment for other chronic diseases.

- The Spokes are mostly primary care or family medicine practices, and include obstetrics and gynecology practices, specialty outpatient addictions programs, and practices specializing in chronic pain.
- Prescribers in Spoke settings are physicians, nurse practitioners, and physician's assistants federally waivered to prescribe buprenorphine. They may also provide oral naltrexone or injectable Vivitrol.
- People with less complex needs may begin their treatment at a Spoke, other patients transition to a Spoke after beginning recovery in a Hub.
- Spoke care teams include one nurse and one licensed mental health or addictions counselor per 100 patients. These Spoke staff provide specialized nursing, counseling and care management to support patients in recovery, this staff assures team-based care and helps primary care providers balance MAT patient care with the needs of their full patient panel. State Oversight, Supplemental Funding, Quality and Measurement Support
- The Hub & Spoke concept was first introduced by John Brooklyn, MD and the model was designed and operationalized by the State of Vermont through the Blueprint for Health, the Department of Vermont Health Access, and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs.
- The State of Vermont pays for Hub and Spoke services via Medicaid. The Hub programs bill a monthly bundled rate, and the Blueprint distributes funds to support Spoke staffing through its existing Community Health Team payment infrastructure.
- The State of Vermont provides oversight for the program, helping communities monitor treatment needs, waitlist length, average time to treatment, and program performance.
- The Blueprint for Health provides each Vermont community with a data profile showing Hub & Spoke patient demographic data and key program measures, to support data-driven quality improvement.

6.1.1 *Implementation of Spoke Practices*

All Spoke practices must utilize and implement the following:

- Program Manager will integrate Spoke staffing as part of the Community Health Team
- Participate in Learning Collaboratives, training events, and other educational and networking opportunities.
- Full implementation and documentation of the required Health Home Services (HHS) and Health Home Measures (HHM)

- Strong referral pathways to Hubs.
- If a primary care site, build a network of referral pathways for when specialty care is needed.
- If a specialty care site, build a network of referral pathways for when primary care is needed.
- If your local Emergency Department is conducting Rapid Access to Medication (RAM) inductions, a collaboration on referral pathways as appropriate.

Expectations of Blueprint Central Staff and Program Managers

All Blueprint Central Staff and Program Managers support Spoke practices with the following:

- Organization and delivery of training and learning events.
- Flow of Medicaid funding consistent with active caseloads for Spoke staffing.
- Data and analytics.
- Hiring and organizing Spoke staff in each participating practice.
- Seeking to support technical assistance needs of the practices.
- Quality Improvement (QI) facilitation to implement spoke programming and pathways to care

6.1.2 *Medicaid Spoke Staff Payment Process*

Payments are based on the average monthly number of unique patients in each Health Service Area (HSA) for whom Medicaid paid a Buprenorphine or Vivitrol pharmacy claim during the most recent three-month period. This is designed to reflect the active caseload for each provider and for the region. The pharmacy claims include information that identifies the provider, the patient, and the medication prescribed. The total number of unique patients served is rounded to next increment of 25 to arrive at a total count in the region for staffing purposes. For example, a count of 167 patients in active treatment is rounded to 175 for the staffing model. This allows staff to be hired and deployed increments of .25% Full Time Equivalent (FTE).

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

<table>
<tr><th><u>Spoke RN</u></th><th><u>Spoke Counselor</u></th></tr>
<tr><td>

Assures patient has active relationship with PCP
Coordinates and provides access to high quality health care services according to evidence-based clinical practice guidelines. Examples of health care issues that might be addressed:

Prevention of infectious diseases

HIV/Aids
Tuberculosis
STDs
Hepatitis C

Additional indications for RN assessment, planning, intervention and evaluation:

Pregnancy/Pre-natal Care
Parenting Skills
Tobacco use/Cessation
Co-occurring Mental Illnesses
Dental Health
Chronic illnesses: HTN, Diabetes, Obesity, CAD, Chronic Pain, Depression
Nutrition
Personal Hygiene

<u>Health Home Services</u>:

Comprehensive Care Management
Care Coordination
Health Promotion
Comprehensive Transitional Care

ER Utilization
Hospital Re-admission

Individual/Family Support
Referral to Community Services
Referral to Community Health Team

<u>HEDIS Measures (To be required):</u>

Self-management Skills
Body Mass Index
Health Screenings
Tobacco Cessation Screening
Care Transition
HTN Control

</td><td>

Must be either a licensed Social Worker, Mental Health Counselor, Marriage and Family Counselor, Psychologist, or other related Masters prepared and licensure recognized professional in Vermont.
Provides initial cognitive/behavioral risk assessments
Observes, describes, evaluates, and interprets behavior as it relates to substance abuse
Constructs with client an action plan based on client needs
Counsels and works with patient to modify harmful, addictive behaviors/lifestyle
Facilitates and supports the client's choice of strategies that maintain treatment progress and prevent relapse
Conducts home visits as needed
<u>Health Home Services:</u>

Comprehensive Case Management
Care coordination
Individual/Family Support
Referral to Community Services
(such as transportation, housing, parenting supports, job skills)

<u>HEDIS Measure (To be required):</u>

Self-management Skills
Depression Screening
Care Transition

</td></tr>
</table>

7. Pass-Through Funding and Waivers

7.1. Pass-Through Funding

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

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

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

7.2. Staffing Waivers

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

The request should address the following:

- Why there is a request to hire or employ someone with a lower credential?
- What is the timeframe for employing the person of lower credential?
- A summary of the candidate's work and education experience, and why the Blueprint Program Manager thinks he or she would be an appropriate hire.

- The candidate's resume and/or curriculum vitae (CV).

There must be an indicated plan that this individual will receive sufficient clinical hours and supervision in order to obtain licensure. The Blueprint Executive Director will respond to the request The timeframe for less credentialed employment cannot be longer than two years. If the individual is not licensed in the set timeframe, Blueprint Medicaid funds will no longer be used to support that position.

8. Women's Health Initiative

Women receive substantial preventive care services in various settings. Through the Women's Health Initiative, women's health specialty providers and Blueprint Patient-Centered Medical Homes provide enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC). Additional staff, training, and payments support effective follow-up to provider screenings through brief, in-office intervention, and referral to services for mental health, substance use, trauma, partner violence, food, and housing.
The Women's Health Initiative helps ensure that women's health providers, Patient-Centered Medical Homes, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.

A complete list of Vermont Blueprint practices that participate in the Women's Health Initiative is available with a link to their website.

8.1. Women's Health Initiative Practices

Women's Health Initiative (WHI) practices attest to implementing and maintaining the WHI strategies (section 8.2) and receives WHI payments (section 8.3). Eligible medical practices or clinics include:

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

8.2. WHI Expectations and Strategies

WHI strategies were identified to address the risks for unintended pregnancy and to improve the health of women and their children. The strategies focus on improving health and reducing health risk, enhancing family planning services, addressing barriers to accessing long-acting reversible contraception (LARC), and most to moderate

contraceptive choices. Practices who choose to participate in the Women's Health Initiative agree to implement and maintain the WHI strategies. Blueprint Assistant Directors and the Community QI Facilitator meet regularly with Program Managers and key stakeholders to implement WHI.

8.2.1 *Expectations of Participating Practices*

Participating practices sign and submit a Women's Health Initiative attestation form. The attestation form clearly describes the expectations for participating practices and for adoption and implementation.
A participating practice agrees to:

- Blueprint PCMH practices will incorporate their Community Health Team member in support of WHI goals and strategies.
- Specialty clinics will work with their Blueprint Program Manager to hire a behavioral health specialist who will be incorporated into the practice in support of WHI goals and strategies.
- Provide Family Planning Counseling: The WHI practice will update and/or implement a policy and procedure for evidence-based, comprehensive family planning counseling including implementing "One Key Question."

8.2.1.1 Stock LARC

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

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

1200-1299	at least 21 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1300 or greater	at least 24 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant

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

8.2.1.2 Offer Same Day LARC Insertion

The WHI practice will develop and implement a policy and procedures to provide same-day insertion for those women who choose LARC as their preferred birth control method. WHI practices are also eligible to receive LARC Skills Based Training. Participating WHI providers are offered a free CME/CEU-accredited LARC insertion training. A typical training agenda includes:

- IUD Clinical Recommendations, Contraindications, Insertions, and Removals (didactic) (IUDs: Mirena, Kyleena, Liletta, Skyla, Paragard)
- IUD Insertion and Removal Practice with VirtaMed GynoS™ Simulation Model 8
- MERCK FDA – Approved Nexplanon Training

8.2.1.3 Screening for Social Determinants of Health

The WHI practice will screen women for social determinants such as: depression, harm to self or others, substance abuse, inter-partner violence, and food and housing insecurity. The WHI practice will develop and implement policies and procedures for screenings. One Key Question and screenings should be conducted minimally at the initial visit, annually, and post-partum.

8.2.1.4 Develop Referral Networks

The WHI practice will develop referral protocols and written agreements with at least three (3) community-based organizations to see patients within one (1) week of being referred for family planning services.

The WHI practice will develop a referral protocol and written agreement with at least one (1) patient-centered medical home (PCMH) primary care practice to accept patients identified as not having a primary care provider.

8.2.1.5 Reporting

When available through the State-appropriated vendor, connect the practice's electronic medical record to the Vermont Health Information Exchange and the clinical data warehouse at Vermont Information Technology Leaders (VITL) to allow clinical data to be collected, analyzed, and utilized in performance measurement and performance payment calculations.
The WHI practice will implement continuous quality improvement into the practice, including tracking WHI practice data and conducting regular analysis to identify opportunities for interventions and improved outcomes.

The WHI practice will submit Staffing and Practice Demographics Reports each quarter, prior to the fifteenth (15th) day of the first month of each calendar quarter (January, April, July, and October), the BP Project Manager or designee shall enter and update WHI staffing and practice demographics information.

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

8.3. Women's Health Initiative Payments

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

Payments include:

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

8.3.1 *WHI Insurers or Payers*

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

8.3.2 *Women's Health Initiative (WHI) Attribution*

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

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

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

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

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

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

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

Each WHI-participating insurer or payer will also report attribution to the Blueprint. At the beginning of each calendar quarter (generally within 15 days of the start of each calendar quarter), each WHI-participating insurer or payer will send the Blueprint a list of the counts of WHI-attributed patients and WHI practice PMPM payments made for the

prior calendar quarter broken out by practice (including Blueprint Practice ID) and payment month. This reporting will enable payment verification and rollups across WHI-participating payers at the practice and Health Service Area (HSA) levels.

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

8.3.3 *WHI Practice PMPM Payment*

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

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

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

8.3.4 *Supplemental WHI Community Health Team (CHT) Payments*

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

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

CHT Floor: For practices with at least one (1) full-time equivalent women's health provider and less than 600 attributed current active WHI patients, a CHT floor or minimum CHT payment of $3,250 monthly (or $39,000 annually) was established with the intent of funding at least 0.5 full-time equivalent community health team member per practice. For practices who are receiving payments based on the CHT floor, WHI-participating insurers or payers will share in the cost of the monthly payment of $3,250, proportional to their share of the WHI attributed patient population (claims-attributed total unique WHI patients). WHI-participating insurer or payer proportions will be derived retrospectively from the prior quarter WHI practices' attribution. Practices that have less than one (1) full-time equivalent provider and less than 600 attributed WHI patients will be pro-rated on a case-by-case basis. This CHT floor will not apply to Blueprint Patient-Centered Medical Homes (PCMH) with participating WHI providers.

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

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

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

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

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

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

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

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

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

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

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

The action plan must have the following 3 components:

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

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

3. A clear timeline for targeted improvement.

The action plan will be developed within 30 days after one year of participation in the Women's Health Initiative.

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

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

8.5. Participation in the WHI for Patient-Centered Medical Homes

Blueprint Patient-Centered Medical Home practices are encouraged to participate in the WHI and are eligible for the WHI PMPM and one-time capacity payment for their attributed Blueprint PCMH patients who are women between the ages of 15 and 44 years (inclusive). Attribution methodology for PCMHs can be found in sections 5.1 and Appendix 3. Practices that receive the CHT PMPM payments for their Blueprint PCMH rostered providers are not eligible for the supplemental WHI CHT payments for these providers.

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

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

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

8.2

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

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

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

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

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

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

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

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

9. APPENDIX 1

Primary Care Attribution Codes

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

Primary-Care Patient Attribution Codes (CPT, HCPCS, and Revenue)
Administration of Health Risk Assessment • 96160-96161
Evaluation and Management - Office or Other Outpatient Services • 99201-99215[5]
Consultations - Office or Other Outpatient Consultations • 99241-99245
Nursing Facility Services: • 99304-99318
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • 99319-99340
Home Services • 99341-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354-99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358-99359
Preventive Medicine Services • 99381–99387 • 99391–99397
Counseling Risk-Factor Reduction and Behavior-Change Intervention • 99401–99404 • 99406-99409 • 99411–99412
Online Digital Evaluation and Management • 99421-99423
Principal Care Management Services • 99424-99427
Other Preventive Medicine Services – Unlisted preventive: • 99429

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

Primary-Care Patient Attribution Codes (CPT, HCPCS, and Revenue)
Chronic Care Management • 99437, 99487, 99489-99491
Non-Complex Chronic Care Management • 99439
Telephone Evaluation and Management • 99441-99443
Newborn Care Services • 99460-99465
Assessment and Care Planning for Patients with Cognitive Impairment • 99483
Behavioral Health Integration Services • 99484, 99492-99494
Transitional Care Management Services • 99495-99496
Advanced Care Planning (services identified by these codes furnished in an inpatient setting are excluded) • 99497-99498
HCPCS Codes: • G0071 (RHC/FQHC virtual communication services) • G0402 (welcome to Medicare visit) • G0406-G0408 (inpatient/tele follow-up) • G0425-G0427 (inpatient/ED teleconsult) • G0438-G0439 (annual wellness visits) • G0442 (alcohol misuse screening service) • G0443 (alcohol misuse counseling service) • G0444 (annual depression screening service) • G0463 (services furnished in ETA hospitals) • G0506 (chronic care management) • G0511 (FQHC chronic care management services, monthly bundle) • G2010 remote evaluation of patient video/images • G2012, G2252 (virtual check-in) • G2025 (RHC/FQHC telehealth) • G2058 (non-complex care management) • G2061-G2063 (online assessment) • G2064-G2065 (principal care management services) • G2212 (prolonged office or other outpatient visit for the evaluation and management of a patient) • G2214 (psychiatric collaborative care model)

Primary-Care Patient Attribution Codes (CPT, HCPCS, and Revenue)
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

10. APPENDIX 2

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

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

2. Identify all patients who are Vermont residents.

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

11. APPENDIX 3

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

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

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

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

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

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 National Provider Identifiers (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.

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

10. For insurers paying quarterly: if a new practice goes live in the third month of a quarter, add that practice to the attribution and payment schedule for the

subsequent quarter. Payment would be made for the first month of participation, but it would be based on the attribution for the subsequent quarter and would be included in the subsequent quarter's payment. For example, if a practice becomes recognized on March 1, payment for March 1 through June 30 would occur by May 15.

12. APPENDIX 4

EXAMPLES OF PAYMENT IMPACTS ON:

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

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

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

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

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

13. APPENDIX 5

VERMONT BLUEPRINT WOMEN'S HEALTH INITIATIVE (WHI)
PPPM COMMON ATTRIBUTION ALGORITHM
WHI-PARTICIPATING COMMERCIAL INSURERS AND MEDICAID

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

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

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

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

WHI Attribution Codes (CPT, HCPCS, and Revenue)
WHI Unique Codes
Asymptomatic Bacteriuria Screening in Pregnant Female • 87081, 87084, 87086, and 87088
Breast and Ovarian Cancer Susceptibility, Genetic Counseling and Evaluation for BRCA Testing • 96040
Breast Cancer Screening • 77052, 77055-77057, and 77063 • G0202
Breast Feeding Support, Supplies and Counseling • A4281-A4286 • E0602-E0604 • S9443
Cervical Cancer Screening

WHI Attribution Codes (CPT, HCPCS, and Revenue)
• 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, and 88175 • G0101, G0123, G0141, G0143-G0145, G0147, and G0148 • Q0091
Chlamydia Screening • 86631, 86632, 87110, 87270, 87490, 87491, and 87800
Contraceptive Methods • A4261, A4264, A4266, and A4268 • J7297, J7298, J1050, J7300, J7301, J7303, J7304, J7306, and J7307 • S4981, S4989, and S4993 • 11976, 11980-11983, 57170, 58300, 58301, 58565, 58600, 58605, 58611, 58615, 58661, 58671, and 96372
Diabetes Screening • 82947 and 83036
DXA Scan • 77080
Global OB-Covered Well-Woman Visits • 59400, 59425, 59426, 59430, 59510, 59610, 59614, 59618, and 59622
Glucose Screening • 82950 and 82951
Gonorrhea Screening • 87850, 87590, and 87591
Hepatitis B Virus Infection Screening for Pregnant Female • 87340
Hepatitis C Screening • 86803
HIV Screening and Counseling • 86689, 86701-86703, 87390, and 87534-87536 • G0432-G0435
HPV DNA Testing • 87620-87625
Iron Deficiency Anemia Screening • 80055, 85013, 85014, 85018, 85025, and 85027
Rh(D) Incompatibility Screening in Pregnant Female • 86901
STI Counseling • 86593, 86695, and 86696 • G0445
Syphilis Infection Screening • 86592 and 86780
Well-Woman Visits • S0610, S0612, and S0613

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

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

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

15. Insurers will run their attributions at least quarterly. Medicaid plans to continue to run their attribution monthly.

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

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

14. APPENDIX 6

Health Service Areas by Town Names

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

Health Service Areas by Town Names

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