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VERMONT Blueprint for Health
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Revised Response to Comments submitted by Interested Parties to:
Bulletin 10-19, Department of Vermont Health Access (DVHA), Blueprint for Health Rules

Responses to General Comments:

DVHA appreciates the time and engagement demonstrated by the organizations and individuals responding to the proposed Rules in Bulletin 10-19 and the cooperative, positive spirit in which they were submitted. Several overarching themes are present in a substantial number of the comments. This response will first address those common themes and then respond to comments on specific sections of the proposed Rule in the order they appear in Bulletin 10-19.

Many comments raised questions about the distinction DVHA has made between the Blueprint for Health Proposed Rule and *Blueprint for Health Manual*. The statutory requirement for developing a Rule in connection to the Blueprint is actually quite narrow. It is only found in 18 V.S.A. Chapter 13 § 707. However, because § 706 and § 708 reference an appeals process under 3 V.S.A. Chapter 25, and because Chapter 13 as a whole codifies the evolution of the Blueprint's from pilot to program implementation, the Department deemed it appropriate to propose a somewhat broader set of Rules.

The Proposed Rules in Bulletin 10-19 reference the structure and program elements of the Blueprint, as defined in 18 V.S.A. Chapter 13 and as expanded upon, in plain language, in the implementation *Manual.* Comments raised questions both about whether it was appropriate to defer program implementation detail to the *Manual* and further, questioned the fact that the *Manual* was not marked "Draft." As addressed below, the Department believes that this approach reflects legislative intent to implement reform as "a learning health system." built upon a bedrock of transformed, highly functioning primary care, providing rapid-cycle feedback of information to health policy makers, staff managing the Blueprint implementation, and clinical professionals. Both the Proposed Rule and the *Manual* reflect the Department's commitment to both expand the Blueprint and implement overall health and payment system reform under the "continuously improving organization" paradigm.

Together, the Rule[1] and *Manual* provide venues and processes for public input related to the Blueprint's legislative mandate for geographic and programmatic expansion. This approach is consistent with the collaborative nature of the Blueprint's development, and reflects the Department's on-going commitment to partnership with the stakeholders with whom the Blueprint's ultimate success depends. This approach also

[1] as amended in Final Proposed Rules to be submitted to the Legislative Committee on Administrative Rules later in December.

reflects the historic development of Blueprint policy, as well as the public conversations about same, in the Blueprint Executive Committee and other advisory committees and work groups, as well as the annual, iterative legislative process relating to the Blueprint from 2006 through the current year. In short, the development of the Blueprint program has been an extraordinarily public, collaborative process stretching back over many years, and nothing in either the proposed Rules or the *Manual* contemplates changing that.

The Department has elected to defer many of the operational details of expansion implementation to the *Manual* in order to preserve the strength of the Blueprint's historical, collaborative approach. From the Blueprint's inception (in its current form) as a pilot following passage of Act 71 of 2007 to the enactment of Act 128 this year, the program's strength has been its consensus-driven process. Indeed, the Blueprint's evolution has been a painstakingly public process.

Flexible, nimble innovation has been a hallmark of the consensus-driven process that resulted in today's Multi-payer Advanced Practice Primary Care (MAPCP) model and the program articulated in Chapter 13. The Department's intent in separating the implementation processes in the *Manual* from the more prolonged and time-consuming process of formal Rule making is to ensure the opportunity for continued innovation and flexibility. Indeed, given the legislative mandates for rapid geographic expansion of the Blueprint, the capacity to respond to and implement operational changes with agility is essential.

Recognizing that there are legitimate concerns about the opportunity for public input and comprehensive discussion before implementation of changes to the processes and procedures outlined in the Blueprint implementation *Manual*, the Department will amend both the Rule and the *Manual* to make clear that changes will not be made without sufficient public input and deliberation. These amendments will be included in the Final Proposed Rule at Rule 100 and referenced at 102.1, 102.2, and 104.1. They make it clear that the types of potential changes to the operational details highlighted by the comments about the *Manual* (adjusting payment methodologies, etc.) will only be made after a public discussion.

As has been the case since 2007 inception of the pilot, there will be ample opportunity for extended discussion and debate before anything is substantively altered. The current reimbursement structure of the Blueprint's MAPCP model was developed through an extensive, iterative, public process in which all interested parties had opportunity to engage. Nothing in the Department's proposed Rule or *Manual* contemplates changing that consensus-driven process. The only change is that, per 18 V.S.A. Chapter 13 § 706 and § 708, parties that do not agree with the outcome of that process have the opportunity for formal appeal.

It should be further noted that the Department routinely accompanies formal Rules with manuals and guidelines which supplement and further delineate its Rules. As an example, the Medicaid *Provider Manual* includes substantial additional detail beyond the Department's Medicaid Rules, and the *Health Care Programs Handbook* provides Medicaid beneficiaries with information in plain language beyond what is detailed in Rule.

Beyond the existence of the *Manual* itself, a second general theme in the comments focused not on the Proposed Rule's content but on the implementation *Manual's* content. Because the current process is to take and respond to comments on DVHA Proposed Rule 10-19, this is not the appropriate venue for detailed response to comments on the *Manual*, but there are several points worth noting before focusing on comments on the Rule itself.

As noted above, the Department proposes changes to the Rule and *Manual* to make explicit the public, collaborative, consensus-driven process used historically and to be utilized going forward for continuously improving the Blueprint, consistent with its role in creating a "learning health system" for Vermont. The *Blueprint for Health Manual* is not marked "Draft" because it is a dynamic document which will, in a sense, never be fully finalized. The changes to the Proposed Rule below articulate that revisions to the *Manual* will only be made after input from Blueprint stakeholders.

The Department's model for this public engagement process is the *Vermont HIT Plan* (VHITP), which responds to both state law and federal statutory and Cooperative Agreement requirements. The VHITP has undergone multiple revisions over the last 18 months, each of which has included an extensive opportunity for public comment. Each iteration of the VHITP was posted on-line and distributed directly to stakeholders. Each edition is revised to reflect the input and diverse opinions of many, many stakeholders who are continuously invited to be at the table.

The Department is fully committed to the process through which the Blueprint has evolved to its current state and has no expectation of a change in that public, consensus-driven process. The Department acknowledges that the transition of the Blueprint from a pilot to a statewide program for delivery system transformation represents substantial change in scope and scale. As such, the level of operational specificity and detail reflected in the *Manual* reflect the statutory changes to the Blueprint enacted by the legislature this year and the need for a more structured process to achieve the legislative mandate for expansion.

The process articulated in the *Manual* reflects the experience and "lessons learned" from the pilot communities. The *Manual* also reflects the need to provide communities new to the Blueprint MAPCP Integrated Medical Home and Community Health Team model with a road map for Blueprint implementation. The November 22 version is a first iteration and will, most assuredly, evolve over the coming months and years. The Department's intent with *The Blueprint for Health Manual* is to preserve and reflect the organic nature of the program's evolution and ensure flexible, nimble, rapid response to changes and improvements in the Blueprint expansion and implementation.

Responses to Specific (aggregated) Comments on the Proposed Rule:

Rule 100 – Blueprint for Health

A comment suggested changes to the wording of the section of the Rule defining the Blueprint. This language reflects the statutory definition of the Blueprint and will remain as published in the Proposed Rule.

As noted above, comments raised questions about detail included in the *Manual* that might better be included in the Proposed Rule. The Department agrees that the process for updating the *Manual's* content was not clear. The Final Proposed Rule will be changed accordingly.

<u>DVHA shall periodically publish a *Blueprint for Health Manual.* Changes to the *Manual* shall only be made after a thorough public process for comment, discussion, and consensus building. That public input process shall include an internet posting of draft revisions to the *Manual*, distribution of the draft to the Expansion Design and Evaluation Committee, the Blueprint Executive Committee, and the Payer Implementation Work Group and discussion of proposed *Manual* revisions in a minimum of two meetings of the Expansion Design and Evaluation Committee. Written and oral comments on proposed *Manual* revisions may be submitted to the Department.</u>

Comments raised questions about expectations for Blueprint participants' ability to fully control externalities and repercussions when, inevitably, they are unable to do so. The Department recognizes that participants in the Blueprint are partners in an evolving process of delivery system reform. As in other areas of life and business / organizational operation, there are factors and circumstances outside of individuals' and organizations' control. The most the Department can ask is that Blueprint participants work collaboratively to mitigate those risks and work together to improve the health and health care of Vermonters. The Blueprint is an invitation to participate in evolving to a more thoughtful, nuanced, higher quality and higher efficiency health care delivery system. It is not a process for playing "gotcha" with its partners / participants.

Rule 101.1 – Advisory Groups

A comment suggested that descriptions of the Advisory Groups should be within the Rule. The Advisory Groups are defined in statute and do not need to be defined again in Rule.

Rule 102 – Medical Home Requirements

Comments suggested that a group of practices owned in common should be considered as "a practice" for purposes of Medical Home designation. From its outset, the Blueprint has defined individual physical locations as a practice site, which is consistent with the approach of NCQA and how practices are scored. The Blueprint will continue to define "a practice" as an individual physical location.

Comments suggested that Vermont definition of Medical Homes should be more narrowly defined to follow national guidelines (such as the NCQA standards or CMS Medical Home guidelines). 18 V.S.A. Chapter 13 provides the definitions for the Department to implement the Blueprint Medical Homes based on the experience of the Blueprint pilot, including the outcome of multiple Pilot Design & Evaluation Work Group meetings, and extensive testimony over multiple legislative sessions. The legislation and Rule reflect the consensus for Blueprint Medical Home recognition developed collaboratively and codified by Act 128. The Department will implement the legislation as written.

A comment suggests adding geriatricians to the list of medical professionals eligible to participate as a Blueprint Medical Home. Geriatricians are by definition either family medicine or internal medicine specialists and thus are already included in the definition.

A comment suggests that reference to a "uniform assessment tool to assess a patient's health" implies a single state-wide tool. That is not the intent; practices are expected to use a uniform tool within a Medical Home but are free to choose from among many tools or develop their own. The Final Proposed Rule will be changed accordingly.

> C. use a uniform assessment tool <u>of the Medical Home's choice</u> to assess ~~a patient's~~ the health of all patients;

A comment suggests OB/GYN specialists should not be included in the list of professionals eligible to be recognized until their inclusion has been vetted through the Expansion, Design and Evaluation Work Group. The Department agrees that it is a complex issue to add OB/GYN specialists because some patients may receive care from both an OB/GYN provider and a family practice or internal medicine provider, raising

issues related to attribution. The Department will work with the Expansion, Design and Evaluation Work Group to ensure these issues are resolved prior to any recognition of an OB/GYN practice as a Medical Home.

Rule 102.1 – Application, Eligibility/Enrollment Criteria

A commenter corrects the Department's use of the term "Certified" Medical Home. The correct term is "Recognized." The Final Proposed Rule will be changed accordingly.

> The Blueprint utilizes the National Committee for quality Assurance (NCQA) standards for Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) model to evaluate and score practices to become and maintain their status as ~~Certified~~ recognized Blueprint Medical Homes.

Additionally, the Final Proposed Rule will be changed at 102.1 to reflect the process for revision of the *Manual*.

> The *Blueprint for Health Manual* describes the Blueprint Medical Home application, eligibility/enrollment and ~~certification~~ recognition process. Changes to the *Manual* shall only be made as described in Rule 100.

Rule 102.2 – Reimbursement

A comment suggests that changes to the reimbursement methodology should only be made through the Rules process. For the reasons articulated above, the Department believes it will be more operationally advantageous to have changes in reimbursement vetted through the Expansion, Design and Evaluation Work Group and reflected in formal changes to the *Implementation Manual*.

A comment suggests the definition of an Administrative Entity should be included in the Rule. The Department agrees and will add definition of the CHT Administrative Entity to the Final Proposed Rule.

> Reimbursement is described in the *Blueprint for Health Manual*. Changes to the *Manual* shall only be made as described in Rule 100. Reimbursement to Medical Homes from participating insurers and the Department of Vermont Health Access (DVHA) includes a per-person-per-month payment to the Medical Homes (or parent organization) for their attributed patients, and, payments to lead administrative entity (s) in each Hospital Service Area for the shared costs of operating the Community Health Team. A lead administrative entity shall be an organization recognized as an eligible Medicare provider. The lead administrative entity can hire Community Health Team members and / or distribute funds to other entities in the community to hire Community Health Team members. The Community Health Team members will be dedicated to supporting all recognized Medical Homes and their patients, and the goal of creating communities of well coordinated holistic health services.

Rule 102.3 – Health Information Technology Standards

A comment raises questions about the use of the term "bi-directionality" in section C. in the contexts of data exchange between the EHR and the Blueprint Registry, VITL's role in exchange, and privacy and security. Sections A. and B. specifically address the requirement to participate in the statewide health information exchange network and to follow privacy and security policies consistent with the *Vermont HIT Plan* which cover policies related to bi-directional exchange.

Rule 103 – Community Health Teams

A comment suggests that the list – and the intent of the statute at 18 V.S.A. §705 – is inclusive, not suggestive. The Department disagrees. Community health team members may include those described in the list but do not have to include all those listed. A comment suggests adding chiropractors to the list of health care professionals who may be included in but not limited to Community Health Team membership. The Department agrees and will add chiropractors, dentists, dental hygienists and other dental professionals, physical therapists, speech therapists, and occupational therapists to the list of examples of health care professionals from multiple disciplines who might be part of a Community Health Team. Another comment suggests substituting "public health professional" for "community health worker." Since the American Public Health Association, the federal Affordable Care Act, and the U.S. Department of Labor define "community health workers" as public health professionals, the Department will modify the list to add "and other public health professionals." The Final Proposed Rule will be changed accordingly.

> The Community Health Teams are multi-disciplinary teams developed at the local level to meet the specific needs of each community. Examples of CHT members include but are not limited to: nurses, care coordinators, social workers, counselors, health and wellness educators, nutrition specialists, community health workers and other public health professionals, pharmacists, chiropractic physicians, dentists, dental hygienists and other dental professionals, physical therapists, speech therapists, occupational therapists and other health care professionals from multiple disciplines.

A comment requests that Proposed Rule Section 103 D (2) reads "Local health department district office staff…" be changed to read "Department of Health District Director or designee…" The Final Proposed Rule will be changed accordingly.

> ~~Local health department district office staff~~ Department of Health District Director or designee for support of public health initiatives and coordination with specific health department initiatives.

Comments suggest that the language related to Community Health Teams is too prescriptive. The Department disagrees. The language in the Rule reflects the legislation, which was subject to extensive debate before passage of Act 128 by the General Assembly. The Department wishes to emphasize that the Community Health Team structure, composition, organization, and operation is to be designed, implemented, and continuously improved upon at the local community level. The CHT expectations expressed in the Rule can and will be achieved through many different strategies and unique solutions.

Rule 104 – Health Insurer Requirements

Comments suggest that insurers are required only to provide reimbursement to two Medical Homes in each of the Hospital Service Areas (HSA) during the expansion period prior to July 1, 2011. The Department disagrees. Extended discussion and testimony related to Act 128 during the 2010 legislative session made clear that the two per HSA expansion is a minimum, not a maximum. To further clarify this point, the Final Proposed Rule will be changed accordingly.

> ”Participation” in the Blueprint for Health means a health insurer shall provide reimbursement to all recognized Blueprint Medical Homes and designated Community Health Teams.

Rule 104.1 – Reimbursement to Medical Homes

A commenter corrects the Department’s use of the term “Certified” Medical Home. The correct term is “Recognized.” The Final Proposed Rule will be changed accordingly.

> Participating insurers will be notified of the new (~~certified~~ recognized) Medical Homes…

Comments expressed concern about the process by which changes to the Blueprint reimbursement model can be made. As noted in the preliminary response to the Comments, the Department agrees and the Final Proposed Rule will be changed accordingly.

> Reimbursement is described in the Blueprint for Health Manual. Changes to the *Manual* shall only be made as described in Rule 100.

Rule 105

Comments suggested that hospitals might be held responsible for meeting unobtainable technical specifications related to “establishing and/or maintaining connectivity to the state’s health information exchange (HIE) network.” As noted in the next sentence of the Proposed Rule, “[h]ospital’s participation in the HIE shall conform to the strategic and operational goals included in the most recent version of the *Vermont Health Information Technology Plan*.
(*http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10_.pdf*)

The Department is required to publish, beginning January 15, 2011, a “list of specific criteria” each hospital must meet. A table illustrating the expectations for hospital connectivity by July 1, 2011 expected to be articulated in the January 15, 2011 letter is included on the following page. Grants provided to VITL through the Blueprint and through state and federal HIT Funding will ensure the costs of this connectivity are met.

		Planned Goals / Benchmarks to be met by 6/30/11			
Hospital Service Area	**Hospital**	**Hospital Interfaces (1)**		**Blueprint Practices (2)**	**IZ Registry (3)**
		General Lab Result	ADT Demographics		
Barre	Central VT Medical Center	X	X	14	
Bennington	Southwest VT Medical Center	X	X	6	
Brattleboro	Brattleboro Memorial Hospital	X	X	2	
	Grace Cottage Hospital (4)				
Burlington	Fletcher Allen Health Care	X	X	9	2
Middlebury	Porter Hospital (4)			2	
Morrisville	Copley Hospital	X	X	3	
Newport	North Country Hospital (4)			6	
Randolph	Gifford Hospital	X	X	2	
Rutland	Rutland Regional Medical Center (4)	X		4	
St. Albans	Northwestern Medical Center	X	X	8	
St. Johnsbury	Northeastern VT Regional Hospital	X	X	5	
Springfield	Springfield Hospital	X	X	6	
White River Jct.	Mount Ascutney Hospital	X	X	2	1

Notes:
(1) The interface exists between the hospital and the VHIE.
(2) Practice-level interfaces; some practices may be direct to Docsite, by HSA.
(3) By HSA
(4) Hospital will be going live in 2011; not likely to be stable and undertake new development by 6/30/11 but will do so later in calendar 2011.

The Department will also publish a list of anticipated "specific criteria" for July 1, 2012, also to be paid through state and federal HIT Funding, in the January 15, 2011 letter.