Blueprint for Health – Technical Fixes Legislative Proposal

The Blueprint proposes to update the language in 18 V.S.A.§ 709 to better reflect the current state of the program in the required annual report.

The Proposed changes to 18 V.S.A.§ 709:

> (a) The Director of the Blueprint shall report annually, on or before January 31, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year and shall provide the report to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee.
>
> (b) The report required by subsection (a) of this section shall include the number of participating insurers, health care professionals, and patients; ~~the progress made in achieving statewide participation in the chronic care management plan, including the measures established under this subchapter;~~ the expenditures and savings for the period; the results of ~~health care professional and~~ patient satisfaction surveys; healthcare utilization and outcomes measures for the populations served by the Blueprint for Health program; ~~the progress made toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in this subchapter~~; and other information as requested by the Committees.

Details on these changes are as follows:

Strike “the progress made in achieving statewide participation in the chronic care management plan, including the measures established under this subchapter; ”. This change is due to the naming of ‘chronic care management’ and the expansion of the Blueprint’s programming. The use of the term ‘chronic care management plan’ causes confusion with the VCCI, which submits its own annual report. The Blueprint’s focus is on broader primary care initiatives rather than those designed to treat specific chronic conditions. Removing this language clarifies that the Blueprint’s annual report is not supposed to include the VCCI annual report. Furthermore, since the Blueprint is now an established program at most primary care practices in Vermont, reporting on the progress to achieving statewide participation is no longer relevant and is covered by the report on “the number of participating insurers, health care professionals, and patients”.

Strike “health care professional and”. This change is aimed at clarifying the intent that the Blueprint ensure the CAHPS survey is done annually. As written, it may be read as requiring a second survey of health care professional satisfaction, which is not and has never been incorporated into the Blueprint’s budget.

Add “healthcare utilization and outcomes measures for the populations served by the Blueprint for Health program;”. This change ensures inclusion in the annual report of the measures established under the subchapter.

Strike “the progress made toward creation and implementation of privacy and security protocols; information on progress made toward the requirements in this subchapter;”. With the advent of HIPPA, Vermont is no longer in need of the Blueprint creating additional privacy and security

protocols. In addition, the Blueprint is now an established program reflecting the requirements of the subchapter and additional initiatives. Removing this language updates Statute to reflect this.

Additional Housekeeping Changes for Consideration

The Blueprint also proposes the following updates to 18 V.S.A. §702 for consideration.

> § 702. Blueprint for Health~~;~~: strategic plan

Strike ";" and replace with ":". This change is a grammatical correction.

> § 702 (b)(1)(A) The ~~Commissioner of Vermont Health Access~~ Director of the Blueprint shall establish an executive committee to advise ~~the Director of~~ the Blueprint on creating and implementing ~~a strategic plan for the development of~~ the statewide system of chronic care and prevention as described under this section.
> Strike "Commissioner of Vermont Health Access" and replace with "Director of the Blueprint". This correction brings statute into alignment with the more mature Blueprint procedures.

Strike "a strategic plan for the development of". Since the Blueprint is now an established program, the phrase 'strategic plan for the development' no longer reflects the Blueprint's purpose.

> § 702 (e) ~~The strategic plan developed under subsection (a) of this section shall be reviewed biennially and amended as necessary to reflect changes in priorities.~~ Progress on Blueprint initiatives and a~~A~~mendments to the ~~plan~~ Blueprint's priorities shall be included in the report established under section 709 of this title.

Strike "The strategic plan developed under subsection (a) of this section shall be reviewed biennially and amended as necessary to reflect changes in priorities." Replace with "Progress on Blueprint initiatives and amendments to the Blueprint's priorities shall...." This change is intended to address the status of the Blueprint as an established program rather than a program under construction.

The entire updated text of 18 V.S.A. §702 is below:

> Subchapter 1: Blueprint for Health
> § 702. Blueprint for Health~~;~~: strategic plan
>
> (a)(1) The Department of Vermont Health Access shall be responsible for the Blueprint for Health.
>
> (2) The Director of the Blueprint, in collaboration with the Commissioners of Health, of Mental Health, of Vermont Health Access, and of Disabilities, Aging, and Independent Living, shall oversee the development and implementation of the Blueprint for Health, including a strategic plan describing the initiatives ~~and implementation timelines and strategies~~. Whenever private health insurers are concerned, the Director shall collaborate with the Commissioner of Financial Regulation and the Chair of the Green Mountain Care Board.

(b)(1)(A) The ~~Commissioner of Vermont Health Access~~ Director of the Blueprint shall establish an executive committee to advise ~~the Director of~~ the Blueprint on creating and implementing ~~a strategic plan for the development of~~ the statewide system of chronic care and prevention as described under this section. The Executive Committee shall include:

(i) the Commissioner of Health;

(ii) the Commissioner of Mental Health;

(iii) a representative from the Green Mountain Care Board;

(iv) a representative from the Department of Vermont Health Access;

(v) an individual appointed jointly by the President Pro Tempore of the Senate and the Speaker of the House of Representatives;

(vi) a representative from the Vermont Medical Society;

(vii) a representative from the Vermont Nurse Practitioners Association;

(viii) a representative from a statewide quality assurance organization;

(ix) a representative from the Vermont Association of Hospitals and Health Systems;

(x) two representatives of private health insurers;

(xi) a consumer;

(xii) a representative of the complementary and alternative medicine professions;

(xiii) a primary care professional serving low-income or uninsured Vermonters;

(xiv) a licensed mental health professional with clinical experience in Vermont;

(xv) a representative of the Vermont Council of Developmental and Mental Health Services;

(xvi) a representative of the Vermont Assembly of Home Health Agencies who has clinical experience;

(xvii) a representative from a self-insured employer who offers a health benefit plan to its employees; and

(xviii) 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.

(B) The Executive Committee shall engage a broad range of health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, and State and local government

in developing recommendations over time for modifications to statewide implementation of the Blueprint.

(2)(A) [Repealed.]

(B) The Director shall convene a payer implementation work group, which shall meet no fewer than six times annually, to design the medical home and community health team enhanced payments, including modifications over time, and to make recommendations to the Executive Committee. The work group shall include representatives of the participating health insurers, representatives of participating medical homes and community health teams, and the Commissioner of Vermont Health Access or designee. The work group shall comply with open meeting and public record requirements in 1 V.S.A. chapter 5.

(c) The Blueprint shall be developed and implemented to further the following principles:

(1) The Blueprint community health team should serve a central role in the coordination of medical care and social services and shall be compensated appropriately for this effort.

(2) Use of information technology should be maximized.

(3) Local service providers should be used and supported, whenever possible.

(4) Transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to the Blueprint model of health care delivery and payment.

(5) Implementation of the Blueprint in communities across the State should be accompanied by payment to providers sufficient to support care management activities consistent with the Blueprint, recognizing that interim or temporary payment measures may be necessary during early and transitional phases of implementation.

(6) Interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior; the physical, mental, and social environment; and health care policies and systems.

(7) Providers should assess trauma and toxic stress to ensure that the needs of the whole person are addressed and opportunities to build resilience and community supports are maximized.

(d) The Blueprint for Health shall include the following initiatives:

(1) Technical assistance as provided for in section 703 of this title to implement:

(A) a patient-centered medical home;

(B) community health teams; and

(C) a model for uniform payment for health services by health insurers, Medicaid, Medicare if available, and other entities that encourage the use of the medical home and the community health teams.

(2) Collaboration with Vermont Information Technology Leaders established in section 9352 of this title to assist health care professionals and providers to create a statewide infrastructure of health information technology in order to expand the use of electronic medical records through a health information exchange and a centralized clinical registry on the Internet.

(3) In consultation with employers, consumers, health insurers, and health care providers, the development, maintenance, and promotion of evidence-based, nationally recommended guidelines for greater commonality, consistency, and coordination among health insurers in care management programs and systems.

(4) The adoption and maintenance of clinical quality and performance measures for each of the chronic conditions included in Medicaid's care management program established in 33 V.S.A. § 1903a. These conditions include asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.

(5) The adoption and maintenance of clinical quality and performance measures, aligned with, but not limited to, existing indicators related to outcomes set forth in 3 V.S.A. § 2311 that are relevant to the Agency of Human Services, to be reported by health care professionals, providers, or health insurers and used to assess and evaluate the impact of the Blueprint for Health and cost outcomes. In accordance with a schedule established by the Blueprint Executive Committee, all clinical quality and performance measures shall be reviewed for consistency with those used by the Medicare program and updated, if appropriate.

(6) The adoption and maintenance of clinical quality and performance measures for pain management, palliative care, and hospice care.

(7) The use of surveys to measure satisfaction levels of patients, health care professionals, and health care providers participating in the Blueprint.

(8) The use of quality improvement facilitation and other means to support quality improvement activities, including using integrated clinical and claims data, where available, to evaluate patient outcomes and promoting best practices regarding patient referrals and care distribution between primary and specialty care.

(e) ~~The strategic plan developed under subsection (a) of this section shall be reviewed biennially and amended as necessary to reflect changes in priorities.~~ Progress on Blueprint initiatives and a~~A~~mendments to the ~~plan~~ Blueprint's priorities shall be included in the report established under section 709 of this title. (Added 2005, No. 191 (Adj. Sess.), § 5; amended 2007, No. 70, § 21; 2007, No. 71, § 5; 2009, No. 128 (Adj. Sess.), § 13; 2009, No. 156 (Adj. Sess.), § I.19; 2011, No. 63, § G.101; 2011, No. 171 (Adj. Sess.), § 28, eff. May 16, 2012; 2015, No. 11, § 17; 2017, No. 204 (Adj. Sess.), § 6; 2019, No. 128 (Adj. Sess.), § 7; 2021, No. 167 (Adj. Sess.), § 6, eff. June 1, 2022.)