Report of the Vermont State Auditor

DOUGLAS R. HOFFER
Vermont State Auditor

Vermont Blueprint for Health

Blueprint Is Not Demonstrating Whether It Is Improving Health Outcomes or Controlling Health Care Costs

February 3, 2025

Rpt. No. 25-02

Mission Statement

The mission of the Auditor's Office is to hold State government accountable by evaluating whether taxpayer funds are being used effectively and identifying strategies to eliminate waste, fraud, and abuse.

Audit Team

Matt Miller, Senior Auditor
Vickie Heller, Senior Auditor
Jonathan Kingston, Audit Manager

DOUGLAS R. HOFFER
Vermont State Auditor

132 STATE STREET • MONTPELIER, VERMONT 05633-5101
PHONE: (802) 828-2281
AUDITOR@VERMONT.GOV • WWW.AUDITOR.VERMONT.GOV

Dear Colleagues,

Vermont Blueprint for Health (Blueprint) is a Vermont program that aims to improve the quality of health and health care while improving control over health care costs. The program cost about $37 million annually in 2022 and 2023.

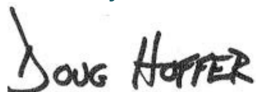
Because of the importance to the State of improving health outcomes and controlling health care costs, we performed an audit to evaluate whether Blueprint measures and reports whether Vermonters' health and the quality of health care have improved <u>as a result of Blueprint's activities</u>. We found that the program is unable to demonstrate its effectiveness at a Statewide level. This was due to several reasons.

One reason for this is that Blueprint has not conducted a statewide analysis of the program's impact on the health care sector and has not produced a recent, credible assessment of cost savings. When we asked Blueprint if they were claiming the program saved almost $3 billion between 2019 and 2022, as suggested by charts in their public reporting, Blueprint officials stated their analysis was not claiming any savings because they had not conducted further analysis to determine if the reported cost differences between different groupings of Vermont patients were in any way due to Blueprint.

Another issue we identified is that Blueprint's public reporting is insufficient to accurately portray the program's impact. For example, multiple times in a recent annual report, Blueprint included more than 180,000 Vermonters whose primary care is not associated with the Blueprint program in the population for whom statistics were provided. As a result, the Blueprint annual report serves more as a statement about the overall health of Vermonters than a statement about the Blueprint's impact. In addition, Blueprint did not explain why the measures it reports on are important, describe improvement or lack thereof with each measure, or assess progress against goals.

As seen in Appendix IV, Blueprint and Agency of Human Services management have agreed with our recommendations. However, they did not "wholly" agree with our findings, providing a comparison of substance misuse and mental health claims for patients attributed to Blueprint compared to non-attributed patients and a patient satisfaction survey as examples of analysis of their performance. Neither actually assessed Blueprint's impact on the outcomes, reaffirming our findings that Blueprint is not assessing the impact of the program, and has not set targets or goals for the program to achieve.

Sincerely,



DOUGLAS R. HOFFER
State Auditor

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Vermont State Auditor

132 STATE STREET • MONTPELIER, VERMONT 05633-5101
PHONE: (802) 828-2281
AUDITOR@VERMONT.GOV • WWW.AUDITOR.VERMONT.GOV

ADDRESSEES

The Honorable Jill Krowinski
Speaker of the House of Representatives

The Honorable Philip Baruth
President Pro Tempore of the Senate

The Honorable Phil Scott
Governor

Ms. Sarah Clark
Secretary, Agency of Administration

Mr. Adam Greshin
Commissioner, Department of Finance and Management

Ms. Jenney Samuelson
Secretary, Agency of Human Services

Dr. DaShawn Groves
Commissioner, Department of Vermont Health Access

Dr. John Saroyan
Executive Director, Blueprint for Health

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Highlights

Vermont Blueprint for Health (Blueprint) is a program that aims to improve the quality of health and health care for Vermonters while improving control over health care costs, by focusing on increasing high-quality primary care, preventative care, and care coordination. Blueprint was budgeted to spend about $37 million annually in 2022 and 2023, with most of the money going directly to health care providers.

Our audit objective was to evaluate whether Blueprint measures and reports whether Vermonter's health and quality of health care have improved as a result of Blueprint's activities. In other words, can Blueprint demonstrate that the program is improving health outcomes and are they providing enough information to Vermonters to be accountable to them? As part of our objective, we also considered whether Blueprint's efforts to control health care costs have been successful or can even be judged. Our audit mostly focused on Blueprint activities from 2021 onwards. We did not assess or review Blueprint's expansion programs such as the Pregnancy Intention Initiative or Hub and Spoke opioid treatment system.

Findings

Overall, Blueprint has not sufficiently planned, analyzed, or reported its efforts to improve overall population health and to control health care costs. Without quantifiable goals and an assessment of progress towards those goals, the extent to which Blueprint is impacting Vermonter's health and controlling health care costs is unclear.

Blueprint Does Not Have a Strategic Plan as Required by Law (and Best Practice), Nor Have They Set Quantifiable Goals

Blueprint officials do not have a current strategic plan, despite being required to by statute. Blueprint's Executive Committee, a diverse group of outside experts and stakeholders that advises Blueprint leadership, requested a strategic plan in 2022. Though the Blueprint Director indicated one was being worked on, no further information about the request was ever recorded.

Beyond not having a strategic plan, Blueprint officials have not set targets or goals for the measures Blueprint reports on. State guidance discusses how setting baselines and targets are important components of program management.

Blueprint Is Not Assessing the Program's Impact and Was Misleading About a Reported Cost Savings

Blueprint receives annual health measure data from a contractor but does not analyze it for statewide or program trends. According to the website of the Agency of Human Services, in which Blueprint is located, programs should be able to answer questions such as 'how well are we doing?' and 'is anyone better off due to this program?' Blueprint does not answer these questions, and cannot due to its limited analytic efforts.

Further, Blueprint has not performed a recent credible assessment of the program's impact on cost savings. Instead, Blueprint has made misleading claims regarding program savings. In the 2023 Annual Report and elsewhere, Blueprint reported that they did an analysis that showed Blueprint's effectiveness in controlling health care costs. However, after we asked questions about this analysis, including whether Blueprint was claiming that the program saved almost $3 billion between 2019 and 2022. Blueprint officials stated that their analysis was not claiming any savings and acknowledged they had not conducted further analysis to determine if the cost differences discussed in the analysis were in any way due to the Blueprint program.

Blueprint Did Not Report All Required Information, and Other Reporting is Insufficient to Inform Policymakers on the Status of the Program

Blueprint did not report on savings as required by statute. Additionally, Blueprint did not show the impact of the Blueprint program because Blueprint included data of Vermonters *who were not part of the program* for most of the reported measures. Further, Blueprint did not provide important context when discussing the program. For example, unlike other Agency of Human Services reporting, Blueprint did not explain why the reported measures are important, describe improvement or lack thereof with each measure, or assess progress against goals. Blueprint's reporting also did not explain that measures reported in previous years are recalculated in subsequent years, making comparisons with prior reporting and between various Blueprint reports extremely challenging. That is, data presented in, say, 2023, may be revised in 2024. Not only might this affect conclusions drawn in 2023, but since the earlier year reports are not revised to reflect later updates, Vermonters cannot look at the reports across time. Finally, we identified multiple errors in Blueprint's annual reports including one error that persisted in the 2021 through 2023 Annual Reports.

Recommendations

We made several recommendations intended to improve the Blueprint program including that Blueprint complies with the law by creating a strategic plan, and that Blueprint assesses its impact on the quality of health care.

Background

Vermont's Blueprint for Health began as a pilot in 2006 to identify ways to improve health care for Vermonters. Currently, Blueprint is housed in the Agency of Human Services (AHS) and the program's main components focus on implementing improvements in primary care—including health care coordination and efficiency, patient experience and outcomes, and quality of services—while at the same time reducing costs.

Primary Care Focus: Patient-Centered Medical Homes (PCMHs) and Community Health Teams (CHTs)

The Blueprint program is intended to help primary health care providers receive and maintain recognition as a "patient-centered medical home" or PCMH—meaning the practice adheres to a set of national quality standards established by the National Committee for Quality Assurance, addressing patient care activities, staff training, electronic health data, and performance measurement. These standards are intended to comprehensively improve health care outcomes and help control costs.

In 2016, Blueprint reported that it had reached a saturation point converting primary care practices to PCMHs, stating there were 129 at the time. As of January 2024, Blueprint reported that 130 practices were recognized as PCMHs.[1] According to Blueprint officials, there are approximately 30 to 35 primary care practices in Vermont that do not participate in the program. According to AHS, the practices not participating in the program are small independent practices, many of which are naturopathic practices or practices that do not accept insurance.

The upfront and ongoing cost of Blueprint PCMH recognition can vary, depending on the size of the practice and the extent to which it already has, for example, established processes for maintaining quality assurances and electronic health data. The National Committee for Quality Assurance website includes information on PCMH recognition fees.

To incentivize health care practices to participate, Blueprint providers receive supplemental monthly payments for each patient above and beyond the standard payments providers receive for services. These "per member per month" payment amounts are established by the State and are paid by insurers. Beginning in 2016, Blueprint added two additional supplemental payments that are based on each practice's performance as compared to

[1] According to the Blueprint website, one practice is located in New Hampshire.

other practices. Blueprint's most recent reported annual budget for PCMH provider payments was $12.3 million for 2023.

Assisting the PCMHs at the regional level are Community Health Teams (CHTs). CHTs are multi-disciplinary teams that are a shared resource for PCMHs or are embedded into larger PCMHs. The CHTs enhance preventative services and coordinated care. CHT staff include care coordinators, social workers, health coaches, and dietitians.

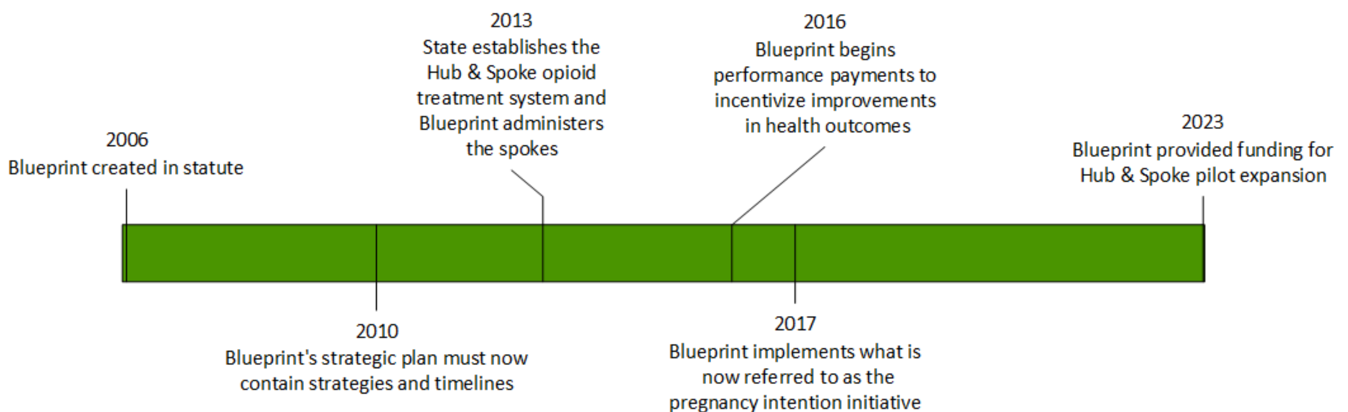
Blueprint Oversight and Organization

Currently, the Blueprint Central Office reports to the Director of Health Care Reform within AHS and is comprised of an Executive Director, two assistant directors, and four staff who help oversee the program. Blueprint also has an Executive Committee which is comprised of a diverse group of outside experts and stakeholders to advise Blueprint leadership.

Statutes lay out a number of duties for the Blueprint Director, including collaborating with various Commissioners and other stakeholders to assess and recommend improvements to the Blueprint program; to provide guidance to participating practices and insurers; and to regularly report on Blueprint's activities to the legislature and public.

In addition to building the PCMH and CHT models, Blueprint has also implemented several expansion programs that target specific health areas, such as an opioid treatment program and a women's reproductive health program called the Pregnancy Intention Initiative. Exhibit 1 highlights Blueprint's evolution over the years.

Exhibit 1: Timeline of Selected Events in the Blueprint Program



Objective: Evaluate Blueprint's Measuring and Reporting of Improvements to Vermonters' Health and Health Care Costs

Overall, Blueprint officials have not sufficiently planned, analyzed, or reported their efforts to improve overall population health and to control health care costs. Without quantifiable goals and an assessment of progress towards those goals, shared in a transparent and clear manner, it is unclear the extent to which Blueprint is impacting population health and controlling health care costs.

Finding 1: Blueprint Does Not Have a Strategic Plan as Required by Law (and Best Practice), Nor Have They Set Quantifiable Program Goals

Blueprint Does Not Have a Strategic Plan

Statute requires that the Director of Blueprint oversee the development and implementation of a strategic plan in collaboration with the Commissioners of Health, Mental Health, Vermont Health Access (DVHA), and Disabilities, Aging, and Independent Living. This strategic plan must describe specific initiatives, implementation timelines, and strategies.

Strategic planning, including a resulting strategic plan, is the starting point of an effective performance measurement system in that it forms the basis for the identification of goals to be accomplished, strategies for meeting those goals, and measures for gauging the extent to which they have been achieved. This concept is mirrored on the Governor's strategic plan website. Strategic plans are intended to be "living" planning documents that provide transparency and accountability, are referenced regularly and updated, and are used by management as the means to ensure progress in achieving outcomes. In addition to developing a strategic plan, statute requires Blueprint to review the plan biennially and update it as necessary.

Blueprint officials told us that in their opinion Blueprint's annual reports meet all the statutory requirements documenting Blueprint's strategic planning, but none of Blueprint's annual reports for the last several years outline any strategies, actions, or associated timelines. Since these elements are required by statute to comprise a strategic planning document, and Blueprint has not included any of them in their annual reports, we conclude that Blueprint does not have a strategic plan, and therefore, is not in compliance with state law.

While Blueprint's Director is tasked in statute to oversee the development and implementation of the strategic plan, Blueprint's Executive Committee is charged with making recommendations to modify Blueprint's strategic plan.

We reviewed committee meeting minutes from the last several years, and in March 2022 the minutes specify that the committee requested that Blueprint bring a strategic plan before it. The minutes state that Blueprint's Director, via "continued collaboration" would "continue to develop" strategic plans. However, the topic didn't appear again in the Executive Committee meeting minutes until two years later, in March 2024, when Blueprint's Director gave a **presentation to the committee on statutory changes he intended to propose to the Legislature which included deleting from statute the requirement to develop a strategic plan**. The minutes and supporting materials presented to the committee describe this and the other deletions as "technical fixes" or "housekeeping changes". The minutes do not note whether members had questions or comments on the removal of the requirement. The topic didn't appear on any meeting agendas in the months that followed.

Blueprint Does Not Have Targets/Goals for Their Measures

Blueprint officials confirmed the program has not adopted any statewide targets or goals for any of the health quality and performance measures Blueprint is required to adopt and report to the legislature as part of Blueprint's annual report. Targets/goals are a basic planning component of measuring program performance described in State guidance to agencies on performance measurement. Blueprint officials indicated that instead of creating Statewide goals they focus on helping individual providers establish their own goals.

While Blueprint has not set any statewide goals or targets, other health care departments in AHS *have* set statewide goals or targets, and a further discussion of those can be found in Appendix III.

The lack of a strategic plan and lack of goals or targets for specific performance measures result in a Blueprint program that is unable to explain what the program is striving for, other than making general statements about improving health without any specific goals to be reached or timelines to be met.

Finding 2: Blueprint Is Not Assessing the Program's Impact and Was Misleading About a Reported Cost Savings

While Blueprint did not adopt statewide targets or goals for any health measures Blueprint does collect data to calculate annual results for a variety of health care measures. For example, Blueprint, through a contractor, calculates *the rate of Heart Failure Hospital Admissions* for various regions across the State.

Per the guidance on AHS's website regarding performance measurement, programs should be able to answer questions such as 'how well are we doing?' and 'is anyone better off because of this program?' However, **Blueprint has not recently conducted any type of analysis of the annual health measure results to identify the program's impact on statewide trends, reasons for the improvement or lack of improvement in the areas of health measured, or reasons for regional differences.**

Additionally, Blueprint has not analyzed whether the performance bonus payments it has been making to providers since 2016 have had any impact. Blueprint officials could not provide any evidence that they have ever determined the effectiveness of the performance bonuses and the utilization bonus payment.

Blueprint officials provided multiple responses throughout the audit when we asked for evidence of analyses they have done to assess the program's impact on population health statewide, and the overall impact of incentive payments to providers. Blueprint stated in responses that, (1) they publish the data on their website [where anyone who opts to review it may do so,] (2) they work with individual providers to help each entity meet its goals, and (3) the information they present to various legislative committees each year serves as an annual evaluation of the Blueprint program. They stated that the annually tabulated data may also be used to address special requests from the executive or legislative branches, or questions from the Blueprint staff and Executive Committee.

> Reader Note: The distinction we are drawing is between tabulating data (which Blueprint does) and using that data to assess performance and inform future action (which Blueprint does not). Data is important, but only in service of analysis.

Blueprint conducted an analysis of patient claims related to mental health or substance use disorder which compared Blueprint attributed patients to those not attributed to Blueprint as well as an analysis of patient experience surveys. However, neither of these analyses sought to determine the cause of the differences or changes identified. As a result, none of these differences

can be attributed to the Blueprint program or demonstrate Blueprint's impact since establishing a causal link was not part of the analysis.

Further, Blueprint's recent lack of comprehensive analyses of the program's impact also extends to health care costs. The 2023 Annual Report contains a comparison of health claims costs between Blueprint attributed and non-Blueprint attributed Vermonters, which is shown in Exhibit 2 below.

Exhibit 2: Blueprint's Misleading Table on Claims Costs, Found in their 2023 Annual Report

Per Member Per Year Medical and Pharmacy Claims for All Individuals

Year Ending	Blueprint Attributed	Non-Blueprint Attributed	Difference
2019	$8,059.97	$10,435.74	$2,376.17
2020	$7,711.31	$10,298.18	$2,586.86
2021	$8,254.25	$11,005.17	$2,750.91
2022	$8,580.73	$11,253.14	$2,672.41

Blueprint officials told us the difference noted here is not a claim of cost savings and that they did not analyze if Blueprint is the reason for this difference.

However, after we asked questions about the table, including if this table is purporting to represent almost $3 billion in savings.[2] Blueprint officials stated they were not claiming that this table showed savings resulting from the Blueprint program and acknowledged they had not conducted further analysis to determine if the differences were in any way due to the Blueprint program. Yet, Blueprint's 2023 Annual Report misleadingly claims that the analysis "provides a recent year update to past work done on the Blueprint's effectiveness at controlling health care costs…"

These misleading claims of cost savings were not exclusive to the 2023 Annual Report, as these claims can also be found in another 2024 report to the Legislature. In that report, Blueprint cited this same cost difference and claimed that this difference was another data point showing Blueprint's positive impact on the cost of primary care in Vermont. **Legislators and Vermonters, therefore, should not rely on information in these reports that appears to indicate that Blueprint is achieving massive savings for program participants when an analysis has not been conducted to determine if Blueprint is the cause of the cost differences.**

Blueprint has similarly presented selective data painting a distorted picture of the program's financial performance in multiple briefings to the Legislature (and highlighted on the program's website) when they noted that

[2] Average number of Blueprint attributed Vermonters over 4 years (279,935) multiplied by the average difference over 4 years ($2,596.59) = $2.9 billion.

a Centers for Medicare and Medicaid Services study in 2017 found that the Blueprint program resulted in $64 million in Medicare savings. What Blueprint officials did not mention in their briefing materials, though, is that this same study found expenditures for child Medicaid beneficiaries increased between $57 and $67 million relative to the comparison group, and expenditures for adult Medicaid beneficiaries increased by $40 million. **This type of selective reporting does not provide appropriate government transparency to the Legislature and Vermonters.** After all, Medicare savings accrue solely to the federal government. Nearly half of all Medicaid cost increases, on the other hand, are borne by Vermont State funds.

Blueprint officials told us that an actual cost savings analysis is outside the budget and resources of the Blueprint program. Indeed, even if Blueprint performed such an analysis, it is likely to be of limited use because, as demonstrated in the evaluation of the Vermont All-payer ACO Model, isolating the effect of one health care reform effort from others may not be possible. This does not excuse Blueprint from clearly informing the Legislature and Vermonters of what the cost differences mean and any limitations of that information.

The effectiveness of Blueprint and its impact on Statewide health care quality and cost is currently unknown without meaningful analyses. As a result, the Executive and Legislative branches of government cannot make informed decisions about the future of the Blueprint program.

Finding 3: Blueprint Did Not Report All Required Information, and Other Reporting is Insufficient to Inform Policymakers on the Status of the Program

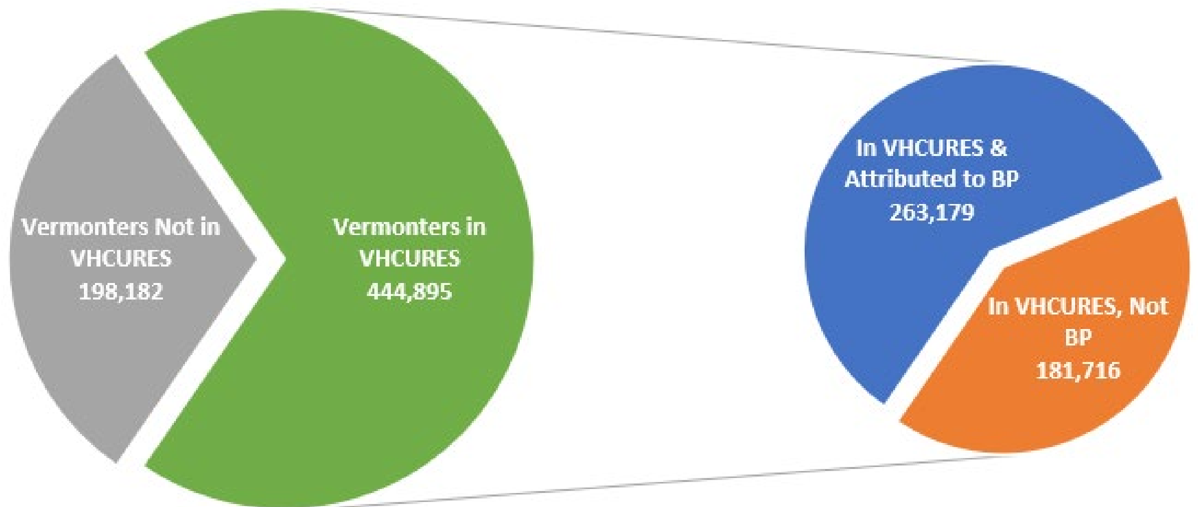
As discussed previously, Blueprint's use of claims data is not an accurate reflection of actual health care costs. As a result, Blueprint is not reporting on savings as required by statute.

Most Measures Include a Large Number of Vermonters Not Attributed to Blueprint

In addition to not reporting savings as required, the majority of measures in the recent annual reports do not show the impact that PCMHs and CHTs are having on Vermonter's health. Therefore, these annual reports do not serve as annual evaluations of the Blueprint program as Blueprint officials have purported them to be.

Blueprint uses the VHCURES population[3] (Green piece of the large pie chart in Exhibit 3 below) when reporting most measures. However, by doing this, Blueprint officials have included roughly 41 percent (182,000 Vermonters) *who are not part of the Blueprint program* to be included in the published data (Orange piece of the pie). Prior annual reports also consistently used the VHCURES population for the vast majority of measures.

Exhibit 3: Number of Vermonters in VHCURES and Attributed to Blueprint (BP)



Source: SAO analysis of Blueprint data from the 2023 Annual Report as reported on page 25.

The inclusion of Vermonters who are not part of Blueprint obscures the impact of the Blueprint program. Some of these individuals could even have primary care providers that are out of state. Dartmouth Health, New Hampshire's largest health care provider, reports that 40 percent of its patients are Vermonters and that they are the second largest provider of care to Vermonters.[4] As a result, it is very plausible that some Vermonters are receiving primary care out of state. For reasons such as this, these measures are more a reflection on the overall health of Vermonters than a reflection of Blueprint's efforts.

Also, when Blueprint discusses the Blueprint attributed population, Blueprint uses the label "PCMH Primary-Care-Attributed Population". However, this

[3] VHCURES, or the Vermont Health Care Uniform Reporting and Evaluation System, is Vermont's all-payer claims database. Some self-insured health care plans are not required to submit data to this system, as well as insurance claims for federal employees and members of the military.

[4] Some of Dartmouth Health's facilities are in Vermont such as the Mt. Ascutney Hospital and Health Center and the Southwestern Vermont Medical Center.

label may lead readers to assume that those not attributed to Blueprint do not receive their care from PCMHs. While all PCMHs in Vermont participate in Blueprint, this label does not include Vermonters who receive care from PCMHs outside of Vermont that do not participate in Blueprint.

Annual Reports Do Not Provide Sufficient Information to Understand Whether Blueprint is Improving Vermonters Health and Health Care

Further, as shown in Exhibit 4, Blueprint's reporting on measures only displays a graph and no additional context. Blueprint does not provide any explanation or information on how the measure was chosen, whether or how the data may be limited, or ultimately what it tells the reader about Blueprint's effect on health care in Vermont. Other AHS reporting, such as reporting on Vermont's Medicaid population contains this additional context. Appendix III provides comparisons showing the additional information other AHS programs provide.

As previously discussed, Blueprint has not set goals/targets for the reported measures. While Blueprint has not done this, the Vermont Department of Health, AHS, and DVHA *do set targets for other programs*. This can also be seen in Appendix III.

Exhibit 4: Example of Missing Context in the 2023 Annual Report

No target/goal to indicate whether these numbers are good or bad.

No additional context to explain what the graph is telling readers.

2023 Blueprint Annual Report

Health Care Quality Measures

NQF1448 Developmental Screening in the First Three Years of Life (DEV), By HSA (Proportions):

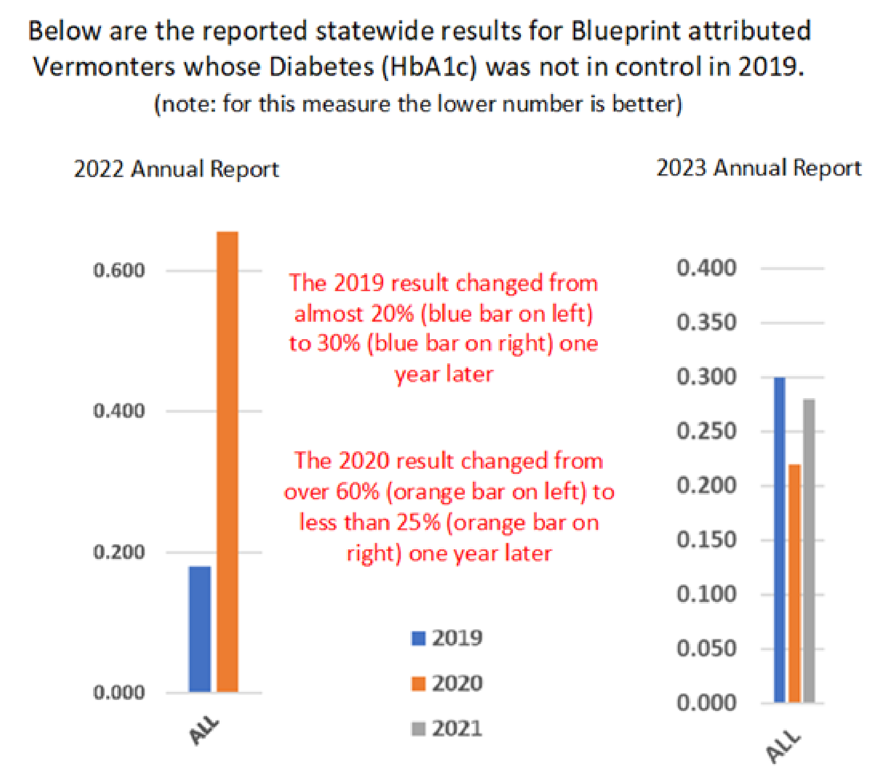
PCMH Primary-Care-Attributed Population

Inconsistent Information Does Not Allow Users to Understand Trends

Moreover, Blueprint's annual reports do not disclose that the data in each annual report cannot be reliably compared with prior annual reports due to unreported methodological changes. Exhibit 5 below illustrates the confusion that would present a Vermonter trying to

track diabetes management (referred to as HbA1c not in control) over time.

Exhibit 5: Example of Historical Data Changing Between Annual Reports



Further, when Blueprint discusses the number of Vermonters attributed to Blueprint, they are inconsistent with their reported number and do not explain why there is such variance. As seen in Exhibit 6, Blueprint's 2023 Annual Report included two different numbers as to how many patients are attributed to the Blueprint program.

Exhibit 6: Examples of Different Numbers for the Blueprint Population

Report	Date of Report	Reported Number of Blueprint Patients
2023 Annual Report (Page 11)	January 31, 2024	294,653
2023 Annual Report (Page 25)	January 31, 2024	263,179

The report did not include an explanation of why the numbers were different. According to Blueprint officials, this difference is due to using different data

sources, but they did not explain why different data sources would differ to such a degree. Publishing such varied numbers with no explanation can be confusing to readers.

In addition to the lack of clarity and consistency in Blueprint's reporting, we found multiple errors in Blueprint's reporting, including:

- An error in Blueprint's 2021 through 2023 Annual Reports erroneously indicated that certain data was related to bonus payment measures when it was not. After this issue was discussed with Blueprint officials, Blueprint corrected the 2023 Annual Report.

- Using different numbers to state how many and what percent of primary care practices in Vermont are PCMHs. Blueprint officials told us they do not keep an exact number of practices in Vermont but reported 90 percent of practices in Vermont being PCMHs in the 2023 Annual Report. When we asked about this figure, however, Blueprint officials said they should have reported slightly less than 80 percent of practices were PCMHs.

Conclusions

AHS says that programs should be able to answer the question 'are people better off because of this program?' This question is elusive in Blueprint's case. The lack of strategic plan and quantifiable targets for reported measures means Vermonters are not informed on what the program is striving to achieve on a Statewide level. Compounding this lack of clarity, Blueprint's annual reports present a number of health statistics, but most measures include Vermonters who are not part of the Blueprint program, rendering the information of little use to determine the effectiveness of Blueprint itself. Because of all these factors, Vermonters cannot know if Blueprint is improving health outcomes or saving money.

Recommendations

We recommend that the Secretary of the Agency of Human Services direct the Executive Director of Blueprint to implement the recommendations in Exhibit 7.

Exhibit 7: Recommendations and Related Issues

Recommendation	Report Pages	Issue
1. Develop a strategic plan that describes implementation timelines and strategies for initiatives as required in statute.	5-6	Statute requires that Blueprint have a strategic plan describing the initiatives and implementation timelines and strategies.
2. Review the strategic plan at least biennially and update it as necessary.	5	Statute requires Blueprint to review the strategic plan biennially and update it as necessary.
3. Adopt a statewide target/goal for each reported measure.	6	Blueprint has not set a target/goal for these measures they report on, leaving readers unsure how to place the reported measures in context with Blueprint's expectations.
4. Annually, conduct analyses using the health measure results and strategic plan components. Ensure the analysis addresses: the reason for improvement or lack of improvement in each area of health measured, and reasons for variances in different areas of the State and attempts to assess Blueprint's impact on statewide health.	7	Blueprint has not recently conducted any type of analysis of the annual health measure results to identify the program's impact on statewide trends, reasons for the improvement or lack of improvement in the areas of health measured.
5. When comparing cost differences between Blueprint attributed and non-attributed patients, be clear as to what that information means, and explain any limitations.	8-9	Blueprint analyzed the cost difference between Blueprint attributed and non-attributed patients and in their reports to the Legislature and Vermonters, they inferred that this analysis showed that Blueprint is saving money. When we questioned Blueprint officials about this, they explained that their reports did not analyze cost savings, and their reports do not demonstrate that Blueprint is saving money. However, Blueprint did not explain the limitations of their analysis in those reports.
6. Publish annual reports that provide sufficient information for readers to understand whether Blueprint is improving Vermonter's health and health care.	9-14	Blueprint's recent annual reports have not provided sufficient information for readers to understand whether Blueprint is improving Vermonter's health and health care.

Management's Comments and Our Evaluation

On January 24, 2025, AHS provided written comments on a draft of this report, which are reprinted in Appendix IV. Our evaluation of these comments is found in Appendix V.

Appendix I
Scope and Methodology

Audit Scope

The audit scope mostly focused on Blueprint's core activities from 2021 onwards.

Audit Methodology

To address our objective, we reviewed Vermont Title 18, which establishes the Blueprint program and includes requirements for creating and routinely updating a strategic plan, with the input of various stakeholders; adopting quality and performance measures for the program in specific areas of health; and annually reporting on progress regarding initiatives and performance measures to gauge the program's impact on health and health care costs.

We also reviewed Blueprint and other documents to identify management's processes and practices for meeting these requirements. These included the Blueprint Manual; Blueprint annual reports, performance payment profiles, and other reports to the legislature; Blueprint Executive Committee published meeting minutes, agendas, and handouts; the AHS Global Commitment to Health reports; Blueprint's grant agreements with local health service areas; and the State's contract with OnPoint.

We also reviewed best practice and guidance documents regarding performance management and measures, and the VHCURES database and related controls.

We conducted interviews with Blueprint and AHS management, and staff from the Green Mountain Care Board. Over the audit, we requested that Blueprint management provide us with all documentation maintained regarding performance measurement and analysis of annual data results. Management also directed us to the Blueprint website, and we reviewed all information and documents published there.

Our review period for this audit generally focused on calendar years 2021 through 2023, though when necessary for context on the program's evolution and practices prior to the current Blueprint Director, we reviewed annual reports and other information back to 2016.

As it pertains to internal controls, we limited our work to assessing Blueprint's reporting in recent public reports. We considered the State's internal control guidance when evaluating the results of our work.

Appendix I
Scope and Methodology

Compliance with Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II
Abbreviations

AHS	Vermont Agency of Human Services
BP	Blueprint
CHT	Community Health Team
DVHA	Department of Vermont Health Access
PCMH	Patient-Centered Medical Home
VHCURES	Vermont Health Care Uniform Reporting and Evaluation System

Appendix III
Additional Information Provided in Other AHS Reports

Exhibits 8 and 9 show examples of how other AHS reports contain additional context such as targets, discussions on methodology, and explanations as to why a measure is important. These are all pieces of information that Blueprint does not provide, as shown in Exhibit 3.

Exhibit 8: AHS's 1115 Global Commitment to Health Waiver 2023 Annual Report

Published targets are found on the website

Explanation of why this measure is important

Discussion of methodology

PM WHI Medicaid: HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)

Year	Value		Trend
2022	74.4%	–	↘ 3
2021	77.6%	–	↘ 2
2020	78.5%	–	↘ 1
2019	83.3%	–	↗ 1
2018	81.6%	–	↘ 1
2017	81.7%	–	↗ 2
2016	80.1%	–	↗ 1
2015	75.8%	–	↘ 2
2014	79.7%	–	↘ 1

Story Behind the Curve

This measure looks at whether adult members receive preventive and ambulatory services. It looks at the percentage of Vermont adults with Medicaid who have had a preventative or ambulatory visit to their physician. Consider the other side of this measure: How many patients never access the system? If they never access the healthcare system, how does preventive care and counseling (diet, exercise, smoking cessation, seat belt use, etc.) occur? This measure is an indicator as to whether there may be barriers to our beneficiaries accessing preventive care.

Partners

1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This measure shows the percentage of Medicaid-primary members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

This is a Healthcare Effectiveness & Data Information Set (HEDIS) administrative measure.

Based on the advice of their External Quality Review Organization (EQRO), DVHA's rates include only Medicaid Primary beneficiaries in HEDIS administrative measures as of 2014.

Exhibit 9: Vermont Department of Health's Healthy Vermonters 2030 Website

Comparison of progress against target

% of children who had a developmental screening in the first 3 years of life

2021	59%	65%	↗ 1
2020	58%	65%	↘ 1
2019	61%	65%	→ 0

Story Behind the Curve

Updated: February, 2024

Author: Early Childhood Program, Vermont Department of Health

This indicator, or population measure, is part of our Healthy Vermonters 2030 data set. Read more about how this data helps us understand and improve the well-being of people in Vermont on the Healthy Vermonters 2030 webpage.

Because this data is meant to show how the health of our state changes during the decade from 2020-2030, some indicators may have very few data points for now. Keep checking back to see the progress our public health system and partners are making.

We want to see the percent of children who receive a developmental screening in the first three years of life increase to 65% or higher by 2030.

The percent of developmental screening has significantly increased from 46% in 2015 to 59% in 2021 (see Notes on Methodology section for changes in data reporting). This improved trend is a result of considerable work that has occurred in Vermont to advance developmental screening across early care, education, and medical home settings.

Looking for more data?

- Look at previous data similar to this indicator from our 2020 Scorecards.
- See the corresponding national Healthy People 2030 objective for the proportion of children who receive a developmental screening.

Explanation of why this measure is important, its impact on Vermonters, and a discussion of the racial disparities that exist with this measure

Why Is This Important?

Developmental screening is a whole-population strategy to promote healthy development and ensure early identification of children at risk for developmental delays. Mandated by several federal entities, it requires implementation across early childhood settings including early care and education, Head Start, IDEA Part C Early Intervention, IDEA Part B Prekindergarten, Children with Special Health Needs, pediatric health care, early childhood mental health, home visiting and family support services.

Developmental and behavioral screening is an integral function of the primary care medical home and a quality measure (NCQA HEDIS Core-8): The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life, that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age. It is a priority indicator across Vermont's Blueprint for Health, OneCare Vermont (ACO), and national entities such as the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) Bright Futures Guidelines, Title V Maternal and Child Health Services Block Grant, Early, Periodic, Screening, Diagnostic, and Treatment Medicaid benefit, and Help Me Grow. Developmental screening is now a required component of Vermont's Quality Recognition and Improvement System (STARS) for childcare, preschool and afterschool programs.

This data informs multiple state action plans including the State Health Improvement Plan, Vermont's Early Childhood Action Plan, the Building Bright Futures Strategic Plan, and the Family and Child Health Strategic Plan.

Equity and Impact

Early childhood is a critical time that provides the greatest opportunities to influence the trajectory of a child's life. With 90% of brain development occurring in the first five years of life, early experiences, relationships, and environments have a deep and lasting impact on development and lifelong health. When parents struggle to meet basic needs, their stress can affect their child's emotional and physical health. Growing research shows that children who grow up with prolonged, or toxic, stress face significant health, wellbeing, and economic challenges as adults.[1] In Vermont, seven out of every ten children have one or more factors that place them at risk for a developmental or behavioral delay (risk factors include maternal depression, parental stress, linguistic and cultural diversity, poverty, and rural isolation, etc.).[2] Early and universal screening can identify children with behavioral and developmental concerns who need a more comprehensive evaluation and linkage to developmental services. Timely evaluation and follow up can identify concerns that can be addressed early in the child's development, leading to better long-term outcomes for the child.

The ability to break out data by different demographic characteristics such as race/ethnicity, socioeconomic status, immigration/citizenship will help us to learn more about different outcomes in Vermont, and where resources may be applied to historically marginalized communities.

Significant current racial disparities exist nationally in the referral of children for developmental screening. BIPOC (Black, Indigenous, and People of Color) children, specifically Black and Asian, are less likely to be diagnosed by their pediatric provider and less likely to receive developmental services after diagnosis.

How We Can Improve

To help reach our target of screening all children for development at recommended intervals, Help Me Grow hosts the Ages and Stages Questionnaires (ASQ) Online system for free to all Vermont providers/educators. For each positive screen, the closed loop referral process will ensure that families are aware of, and have access to IDEA services, resources, and supports. You can find the new 2020-2021 Annual Report on the Help Me Grow website.

Discussion of methodology

Notes on Methodology

Our current data source is the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer medical claims database. Since mid-2016, VHCURES contains an estimated 75% of Vermonters' medical claims.

This indicator will soon reflect a new data source, the Universal Developmental Screening Registry (USDR). This is a data collection and communication system to improve early identification across sectors. Use of USDR data for the Healthy Vermonters 2030 indicator will provide a more accurate and comprehensive measure of screening rates across providers. The USDR also offers a population measure of child wellbeing. There are currently over 20,000 screening results in the ASQ Online system that are being integrated with the USDR.

Appendix IV
Comments from Management

The following is a reprint of management's response to a draft of this report. Our evaluation of these comments is contained in Appendix V.

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

January 24, 2025

Sent via email to Doug.Hoffer@vermont.gov

Doug Hoffer
Vermont State Auditor's Office
132 State Street
Montpelier, VT 05633

The Blueprint for Health's Responses to Vermont State Auditor's Office Report, Blueprint is not Demonstrating Whether it is Improving Health Outcomes or Controlling Health Care Costs

Dear Auditor Hoffer:

Thank you for the opportunity to respond to the above-mentioned audit of the Blueprint for Health ("Blueprint"), a State Auditor's Office ("SAO") audit intended to evaluate whether Blueprint measures and reports whether Vermonter's health and quality of health care have improved as a result of Blueprint's activities.

See our comment 1 on page 25.

This letter represents the Blueprint's response to the audit. There are several places in the report where the Blueprint believes additional context is needed and warranted. Specifically, the Blueprint seeks to clarify that the Blueprint does in fact set measurable targets and goals; and that the Blueprint does assess program impact in a variety of ways. Accordingly, this letter response will focus primarily on findings 1 and 2.

Although the Blueprint does not wholly agree with either of those findings, the Blueprint does wish to thank the SAO for the SAO's work on this audit and for the recommendations in the audit report. The Blueprint believes the recommendations themselves are valuable and hopes to implement them. Accordingly, this letter will close with a summary of those recommendations and a projected timeline for the implementation of each.

Finding 1: "Blueprint Does Not Have a Strategic Plan as Required by Law (and Best Practice), Nor Have They Set Quantifiable Program Goals"

The Blueprint Program does not have a strategic plan in a specific document, and we agree that this should be rectified.

See our comment 2 on page 25.

Due to the lack of a single strategic plan, it may be unclear that the Blueprint does have targets and goals for measures. The Blueprint works with practices to set and achieve targets relating to the selected measures. In addition to the national benchmarks and NCQA requirements, most Blueprint measures also have goals set by other entities which the Blueprint works to help practices achieve. Please see a list of these measures and their targets in the table below. These targets, in conjunction with national benchmarks, serve as the basis for the quality improvement work conducted by Blueprint.

MEASURE_NAME	Target Set At	Target Set By	Reference
NQF2372 HEDIS Breast Cancer Screening (BCS)	52%	DVHA	DVHA Scorecards
HEDIS Child and Adolescent Well-Care Visits (WCV) 3-21	61%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
HEDIS Child and Adolescent Well-Care Visits (WCV) 12-17	59%	VDH	Healthy Vermonters 2030 https://embed.clearimpact.com/Scorecard/Embed/84433
NQF0033 HEDIS Chlamydia Screening in Women, 16-24y (CHL)	56%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
NQF1800 HEDIS Asthma Medication Ratio (AMR) of controller meds to total asthma meds of .50 or greater	66%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
NQF3489 HEDIS 7-Day % With Follow-Up After Emergency Department Visit for Mental Illness (FUM)	62%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
NQF3489 HEDIS 30-Day % With Follow-Up After Emergency Department Visit for Mental Illness (FUM)	73%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
NQF3488 HEDIS 7-Day % With Follow-Up After Emergency Department Visit For Alcohol Use (FUA)	38%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
NQF3488 HEDIS 30-Day % With Follow-Up After Emergency Department Visit For Alcohol Use (FUA)	53%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359
NQF1448 Developmental Screening in First Three Years of Life (DEV)	65%	VDH	Healthy Vermonters 2030 https://embed.clearimpact.com/Scorecard/Embed/84433
NQF0018 HEDIS Hypertension with BP in Control (<140/90 mmHg) (CBP)	80%	VDH	https://www.healthvermont.gov/sites/default/files/documents/pdf/HPDP%20Hypertension-Management-
NQF0059 HEDIS Diabetes HbA1c Not in Control (>9%) (DPC)	45%	DVHA	DVHA Scorecards https://embed.clearimpact.com/Scorecard/Embed/88359

<u>Finding 2: "Blueprint Is Not Assessing the Program's Impact, and Was Misleading About a Reported Cost Savings"</u>

See our comment 3 on page 25.

The Blueprint Program did not make statements regarding cost savings; the Program made statements regarding differences in costs. A difference in cost is not a savings. The Blueprint will strive to be clearer about this in the future.

The Blueprint Program has conducted analyses on the impact of the program, for example:

See our comment 4 on page 25.

- The evaluation and analysis of the Blueprint's impact on emergency department visits for MH/SUD patients, or the trends of proportion of individuals with MH/SUD conditions at Blueprint practices. These bullet points were included in the 2023 Annual Report and were statistically significant. The Blueprint provided the analysis leading to these

conclusions to the auditors in response to the questions of 26 March 2024. [Provided to the SAO during Audit]

- The presentation to Executive Committee of 11/16/2023 which contains a summary of additional analyses done regarding Blueprint PCMH attributed lives as compared to lives attributed to non-Blueprint primary care practices. [Nov 16 2023 ExecComm Minutes.pdf]
- The analysis of the annual CAHPS survey, including trending over 5 years, statistical testing, and a further breakdown and analysis of the specialty care measure. [Minutes_BP_Exec.Cmte_._JULY_18_2024.pdf, Microsoft Word - 2023_Summary_Report.docx]
- The Community Health Profiles [Community Health Profile 2020-2022 v3.xlsx] which contain comparisons of all measures for Blueprint-attributed lives, non-Blueprint attributed primary care lives, and lives attributed no primary care practitioner. These Community Health Profiles provide annual comparisons of measures covering three years.

Finding 3: "Blueprint Did Not Report All Required Information, and Other Reporting is Insufficient to Inform Policymakers on the Status of the Program"

The Blueprint Program acknowledges that the complexity of the program and overutilization of specialty terms have adversely impacted the transparency of reporting. The Blueprint will endeavor to improve clarity in reporting.

SAO RECOMMENDATIONS AND BLUEPRINT RESPONSES

Recommendation 1: "Develop a strategic plan that describes implementation timelines and strategies for initiatives as required in statute."

The Blueprint for Health concurs with the recommendation and shall craft a unified strategic plan by 31 December 2025.

Recommendation 2: "Review the strategic plan at least biennially and update it as necessary."

The Blueprint for Health concurs with the recommendation and shall implement a biennial review and update process for the strategic plan; the review schedule shall be included with the strategic plan, released by 31 December 2025.

Recommendation 3: "Adopt a statewide target/goal for each reported measure."

The Blueprint for Health concurs with the recommendation and shall include information regarding measure targets in the strategic plan discussed above.

Recommendation 4: "Annually, conduct analyses using the health measure results and strategic plan components. Ensure the analysis addresses: the reason for improvement or lack of

improvement in each area of health measured, and reasons for variances in different areas of the State and attempts to assess Blueprint's impact on statewide health."

The Blueprint for Health concurs with the recommendation and shall include these additional details in its annual reports commencing within one year of the release of the strategic plan, not later than with the 2026 Annual Report (delivered to the Legislature in January 2027).

Recommendation 5: "When comparing cost differences between Blueprint attributed and non-attributed patients, be clear as to what that information means, and explain any limitations."

The Blueprint for Health concurs with the recommendation and shall better explain comparisons of costs between Blueprint PCMH attributed lives and non-Blueprint primary care attributed lives in the Annual Report starting in the 2025 Annual Report (delivered to the Legislature in January 2026).

Recommendation 6: "Publish annual reports that provide sufficient information for readers to understand whether Blueprint is improving Vermonters' health and health care."

The Blueprint for Health concurs with the recommendation and shall take steps to improve the accessibility and readability of its reporting, beginning in the 2025 Annual Report (delivered to the Legislature in January 2026).

We thank the SAO again for the time and work spent on this audit.

Sincerely,

Monica Ogelby — Digitally signed by Monica Ogelby Date: 2025.01.23 17:57:19 -05'00'

Monica Ogelby
Vermont State Medicaid Director

CC: Jenney Samuelson, AHS Secretary
Dr. John Saroyan, Blueprint Director

Appendix V:
Our Evaluation of Management's Comments

In accordance with generally accepted government auditing standards, the following tables contain our evaluation of management's comments.

Comment #	Management's Response	Our Evaluation
1	*Specifically, the Blueprint seeks to clarify that the Blueprint does in fact set measurable targets and goals; and that the Blueprint does assess program impact in a variety of ways.*	We disagree with both of these points and expand on this point in the following comments.
2	*Due to the lack of a single strategic plan, it may be unclear that the Blueprint does have targets and goals for measures. The Blueprint works with practices to set and achieve targets relating to the selected measures. In addition to the national benchmarks and NCQA requirements, most Blueprint measures also have goals set by other entities which the Blueprint works to help practices achieve. Please see a list of these measures and their targets in the table below.*	The targets in the table provided were not set by the Blueprint program. For example, the target and reference columns for all the measures set by DVHA refer to targets and results for Vermont's Medicaid population, not the Blueprint population. We specifically mentioned in the draft that other AHS entities set targets for other programs on report page 6 and provide examples in Appendix III to contrast how Blueprint has not done this.
3	*The Blueprint Program did not make statements regarding cost savings; the program made statements regarding differences in costs.*	As we stated on page 8, in two separate reports, the 2023 Annual Report and Blueprint's Act 51 report to the Legislature, Blueprint connected the difference in costs with a claim that the differences in cost represented Blueprint's success/effectiveness in controlling or reducing the cost of health care. It is misleading to state that these claims never implied a cost savings when they mention success in reducing or controlling costs. Reducing the growth of cost or reducing the cost implies that without the intervention, the cost would be greater.
4	*The Blueprint Program has conducted analyses on the impact of the program.*	We added a paragraph starting on page 7 acknowledging Blueprint's analyses mentioned in their response to a draft of this report. However, we note in that paragraph that these analyses did not seek to study the impact of Blueprint.