CHT payments are scaled based on the population of payer-claims-attributed Blueprint patients per month (PPPM). Commercial and Medicaid payers pay $2.77 per payer-claims-attributed patient per month (PPPM), and Medicare pays roughly $2.47 per payer-claims-attributed patient per month (PPPM) (with some variation for Medicare by year).

CHT payments, and by extension the number of full time equivalent (FTE) CHT staff members, were originally based on $350,000.00 annually for each population unit of 10,811 payer-claims-attributed Blueprint patients, or an average of $2.70 per payer-claims-attributed patient per month (PPPM) across all payers. For historical comparison, this is equivalent to a rate of 0.25 FTEs, or $17,500.00 annually, for each population unit of 1,000 practice-reported Blueprint patients, or $1.46 per practice-reported patient per month, given an observed average ratio of practice-reported to payer-claims-attributed patient counts of approximately 1.85 (1.90 for commercial and Medicaid; 1.69 for Medicare) for the period of Calendar Years 2013 through 2014: $17,500.00 / 12 months / 1,000 patients * 1.85 payment adjustment ratio = $2.70 PPPM.

Medicare funding was originally based on a rate of $6.71 PPPM for Medicare-claims-based patient attributions to PCMHs, to cover the combined costs of CHT and SASH services. Against that amount, Medicare's CHT contributions were set at roughly $2.47 per payer-claims-attributed patient per month, and the remainder was available for SASH panels.

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

Adapted from Section 5.2 of our latest Blueprint Manual (Effective 10/1/2018):
https://blueprintforhealth.vermont.gov/implementation-materials