Blueprint for Health Overview & Funding

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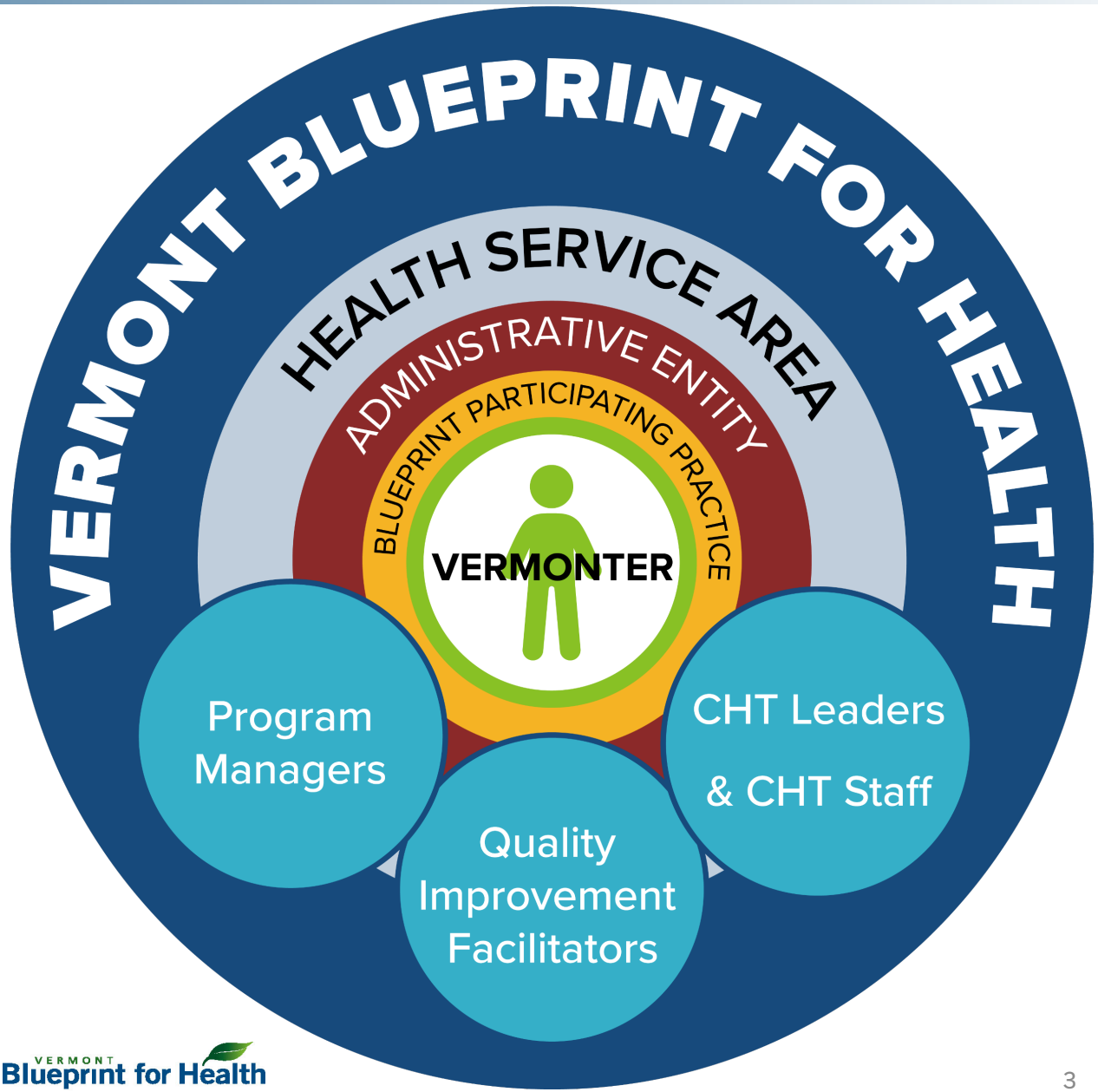
The Blueprint for Health:

- Focuses on building best practices and prevention services into primary and specialty care practices.
- Accessible to all patients, regardless of payer.
- Founded on Patient-Centered Medical Homes (PCMHs) and multi-disciplinary Community Health Teams (CHTs).
- Includes multiple initiatives.
- Medicare, Medicaid, and Commercial Insurers make payments to support the initiatives.

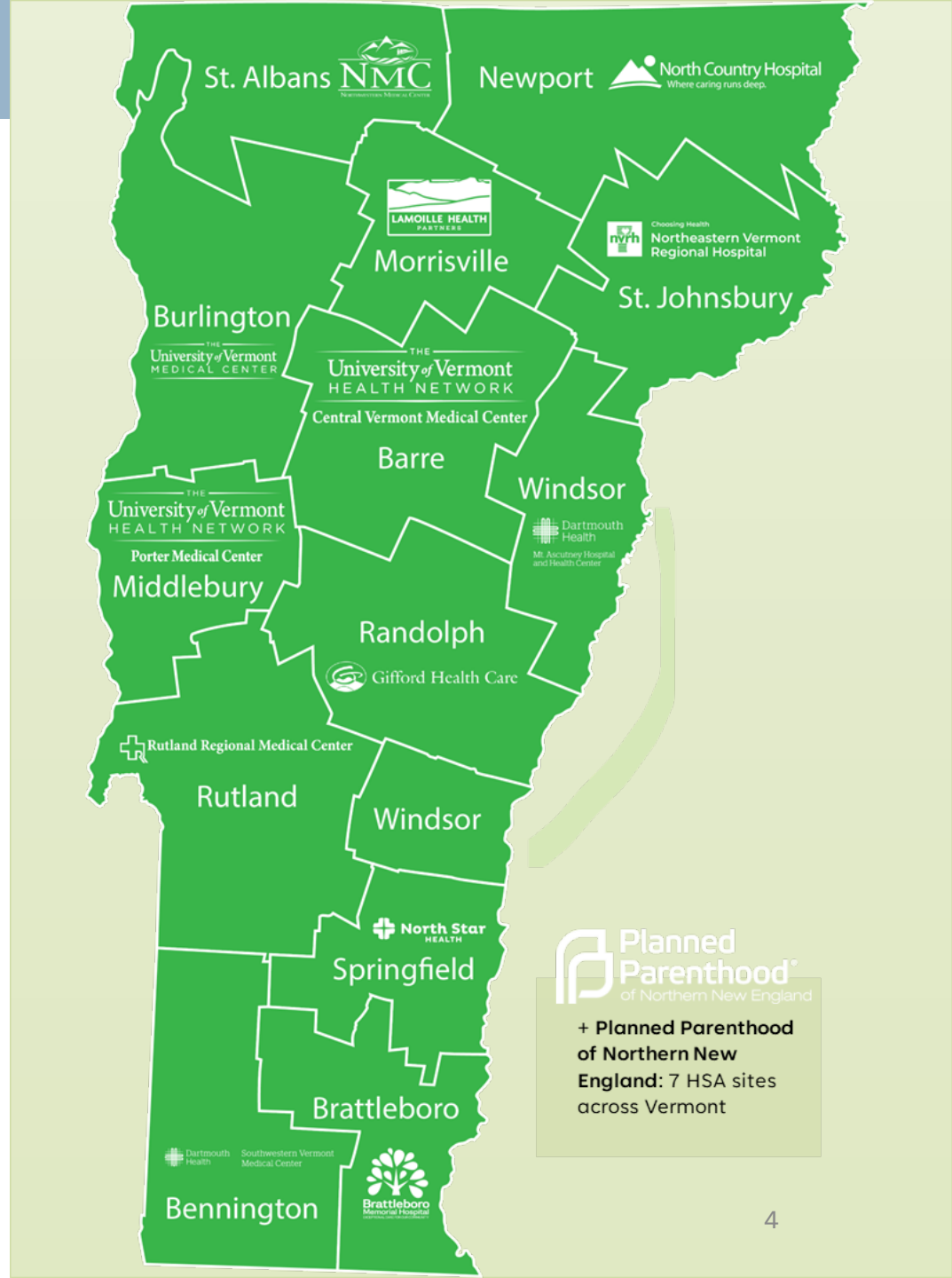
Organization

- Vermonters engage through Blueprint-participating practices.
- Practices receive support from Blueprint Program Managers, Quality Improvement Facilitators, and Community Health Teams.
- For organizational purposes, Blueprint assigns practices to a Health Service Area where an Administrative Entity helps manage the funding for CHTs, practices, and other support.



Health Service Areas and Administrative Entities

BARRE: Central Vermont Medical Center
BENNINGTON: Southern Vermont Medical Center
BRATTLEBORO: Brattleboro Memorial Hospital
BURLINGTON: University Vermont Medical Center
MIDDLEBURY: Porter Medical Center
MORRISVILLE: Lamoille Health Partners
NEWPORT: North Country Hospital
RANDOLPH: Gifford Medical
RUTLAND: Rutland Regional Medical Center
SPRINGFIELD: North Star Health
ST. ALBANS: Northwestern Medical Center
ST. JOHNSBURY: Northern Vermont Regional Hospital
WINDSOR: Mt Ascutney Hospital and Health Center



Vermont Blueprint for Health
Smart choices. Powerful tools.

Blueprint for Health Initiatives

Four primary initiatives and one new pilot initiative:

- Patient-Centered Medical Home model supports high-quality primary care.
- Community Health Teams provides care, care coordination, and links patients to services.
- Hub & Spoke system of care supports practices that provide medication to treat opioid use disorder.
- Pregnancy Intention Initiative provides access to services that support pregnancy intention and family planning.
- New in 2023: Mental Health Integration initiative embeds support for mental health and social drivers of health needs into primary care.

Patient-Centered Medical Homes (PCMHs)

A model of primary care delivery that seeks to provide accessible, comprehensive, whole-person-centered care in a coordinated and team-based fashion.

- Combines preventive care, acute and chronic disease management, and other services *in a single setting*.
- Practices must achieve and sustain recognition as a PCMH from the National Committee on Quality Assurance (NCQA).
- Studies show that NCQA PCMHs demonstrate:
  - Improved clinical outcomes
  - Increased patient engagement in follow-up and treatment
  - Decreased utilization of the emergency department

Community Health Teams (CHTs)

Support Primary Care Providers by:

- Identifying root causes of health problems
- Addressing and identifying mental health needs
- Screening for social drivers of health
- Providing team-based care

Serve, Care for, and Connect Patients through:

- Providing brief interventions
- Supporting management of chronic conditions
- Coordinating care
- Supporting improvements in well-being through team-based care.

No Cost to Patients or Providers

Spoke Initiative: Medication for Opioid Use Disorder

Medication for Opioid Use Disorder (MOUD) treatment is provided in multiple settings in Vermont, including:

- **Hubs**: clinics where individuals can receive Methadone and other treatment services, including in-patient services if needed.
- **Spokes**: primary & specialty care physicians who can prescribe MOUD in an office-based setting just like a regular doctor's office

The Blueprint supports **91 Spoke practices** throughout Vermont:

- Spokes receive funding for one FTE nurse, and one FTE counselor per 100 Medicaid patients served.
- Hired and deployed as part of Blueprint CHT though the administrative entity.

Pregnancy Intention Initiative (PII)

Comprehensive Family Planning

- Increases access to preconception counseling by asking about pregnancy intention
- Improves maternal and infant outcomes
- Contraceptive counseling to help reduce unintended pregnancies
- Same-day access to long-acting reversible contraceptives (LARC) and/or moderate to most effective contraception

Psychosocial screening, intervention, and navigation to services

- Enhanced screening that includes Social Drivers of Health
- Brief intervention and referral/navigation to treatment and services
- Care coordination agreements with Primary Care/Community Partners

Mental Health Integration into Primary Care Pilot

- In 2023, significant funds were appropriated for a 2-year pilot to increase CHT services by embedding mental health providers into primary care.
- The Mental Health Integration initiative focuses on:
  - Adding more support for Mental Health, Substance Use, and Social Drivers of Health across the lifespan.
  - Getting that support as close to patients as possible by placing team members in primary care practices.
  - Adding education opportunities for providers & team members.
  - Quality improvement supports to improve screening.

In Their Own Words

"The work we are able to provide is critical to the support of patients and our providers in our local spokes. I have had primary care providers tell me this is the most rewarding aspect of their job, and patients say, 'You've helped save my life.' "

—Primary Care Spoke Counselor, Barre HSA

"We are able to meet with people who need it, and we are connected right to primary care so they feel comfortable meeting with us. There also isn't a co-pay for our support, so they don't have to worry about the money component. I know we are helping people, and it wouldn't be possible without the Blueprint."

—CHT Staff Member, Brattleboro HSA

"Our wrap-around care had the benefits of preventing an Emergency Department visit, a potentially lengthy hospital admission, and increased hospital costs."

—PII Worker, Burlington HSA

Funding Mechanisms

How are Blueprint initiatives funded?

General Funding Mechanisms & Terminology

- Most Blueprint initiatives are funded through *per-member-per-month* (PMPM) payments made by various insurers/payers.
- The number of members a payer is to make payments on is determined by that insurer's *attribution* to a Blueprint practice.
  - Attribution is calculated by a standard algorithm that does the following:
    - Looks at the past two years of insurance claims
    - Counts the number of patients with at least one of a list of specific procedures at a Blueprint provider
    - If a patient has visits with these procedure codes at multiple providers, they will be counted at the most recent provider.
  - Makes sure that only one provider gets paid for each patient.

Blueprint Initiative Payers

- Medicare
  - Pays into Blueprint PCMH and Core CHT initiatives
  - Allowed by CMS agreement – ending this year
- Commercial Insurers (Blue Cross Blue Shield of VT, Cigna, MVP)
  - Pay into Blueprint PCMH and Core CHT initiatives
  - ERISA (self-funded, administrative services only, Medicare Advantage) plans are not all contributing
  - Some small insurers also do not contribute
- Medicaid
  - Pays into Blueprint PCMH, Core CHT, Spoke, and WHI initiatives
  - Only payer included in the Mental Health Integration initiative

Blueprint Payment Methodology through June 2025

Payer	PCMH Practice Base Payment PMPM	PCMH Practice Performance Payment PMPM	CHT Core PMPM	Spoke CHT PMPM	PII Practice PMPM	PII CHT PMPM	MHI Integration Per Practice Per Month
Medicare	$2.15	$0.00–$0.09	$2.80	$0.00	N/A	N/A	$0.00
Commercial Insurers	$3.00	$0.00–$0.50	$2.77	$0.00	$0.00	$0.00	$0.00
Medicaid	$4.65	$0.00–$0.50	$2.77	$163.75	$1.25	$5.42	$1,655–$9,990

Example: If a practice has 1,500 attributed patients; they would receive payments of about $4,500-$5000/month ($54,000-$60,000/year) depending on their mix of patients. The CHT would be funded at about $50,000/year to support that practice.
About 75% of Blueprint practices (~100) are at least this size; about 20% are at least double this size.

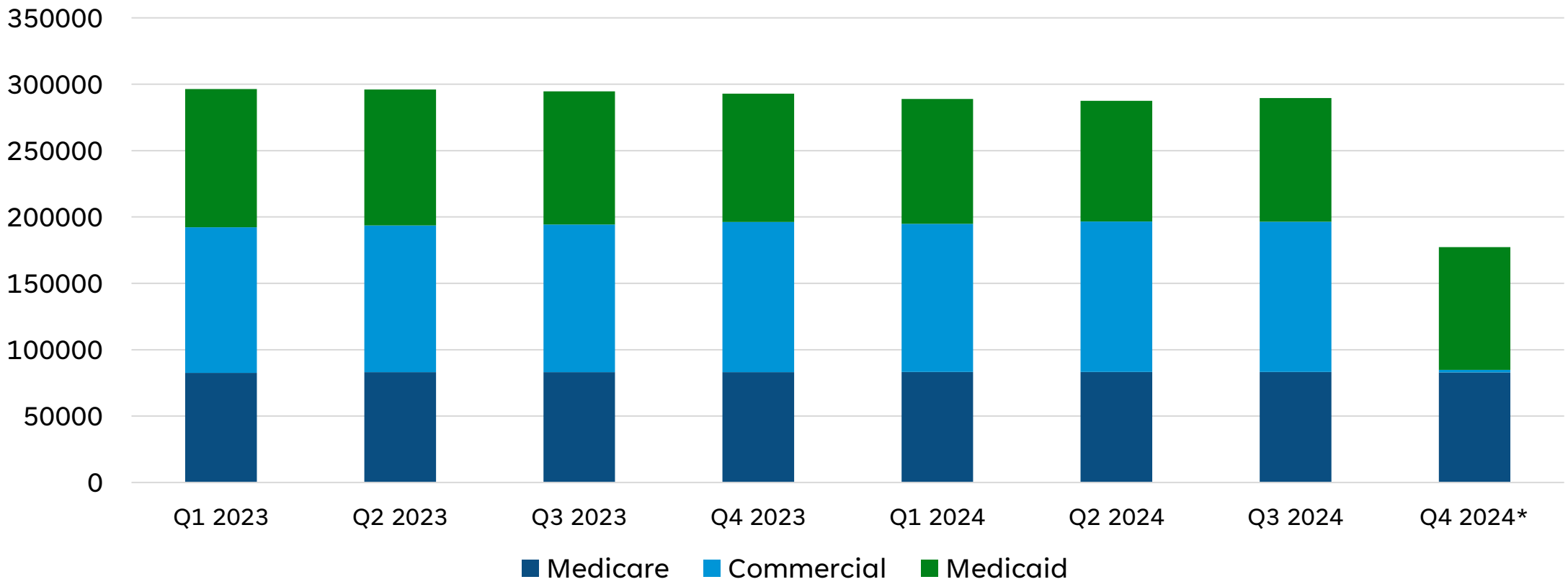
The Grand Overview

Payer	Initiative	Amount (2024, millions)	Notes
Medicare	PCMH	$2.6M	No agreement for 2026 payment
Medicare	Core CHT	$3.1M	No agreement for 2026 payment
Commercial Insurers	PCMH	$4.4M	Ongoing
Commercial Insurers	Core CHT	$3.7M	Ongoing
Medicaid	PCMH	$5.2M	Base/ongoing
Medicaid	Core CHT	$3.1M	Base/ongoing
Medicaid	Spoke MOUD	$6.1M	Base/ongoing
Medicaid	Pregnancy Intention	$1.0M	Base/ongoing
Medicaid	Mental Health Integration	$6.5M	one-time appropriation

Impact

For what does this funding pay?

Payer Attributed Blueprint Patients by Quarter

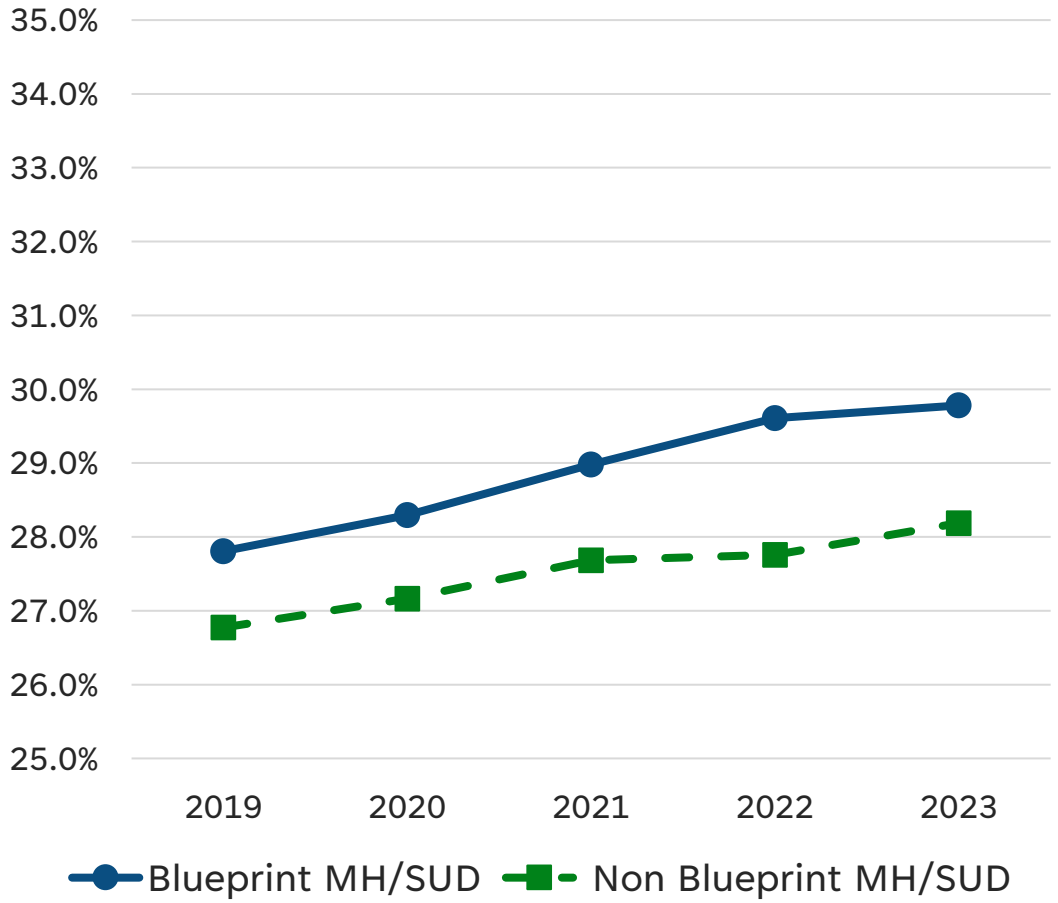


*Q4 2024 Commercial insurer data not yet available

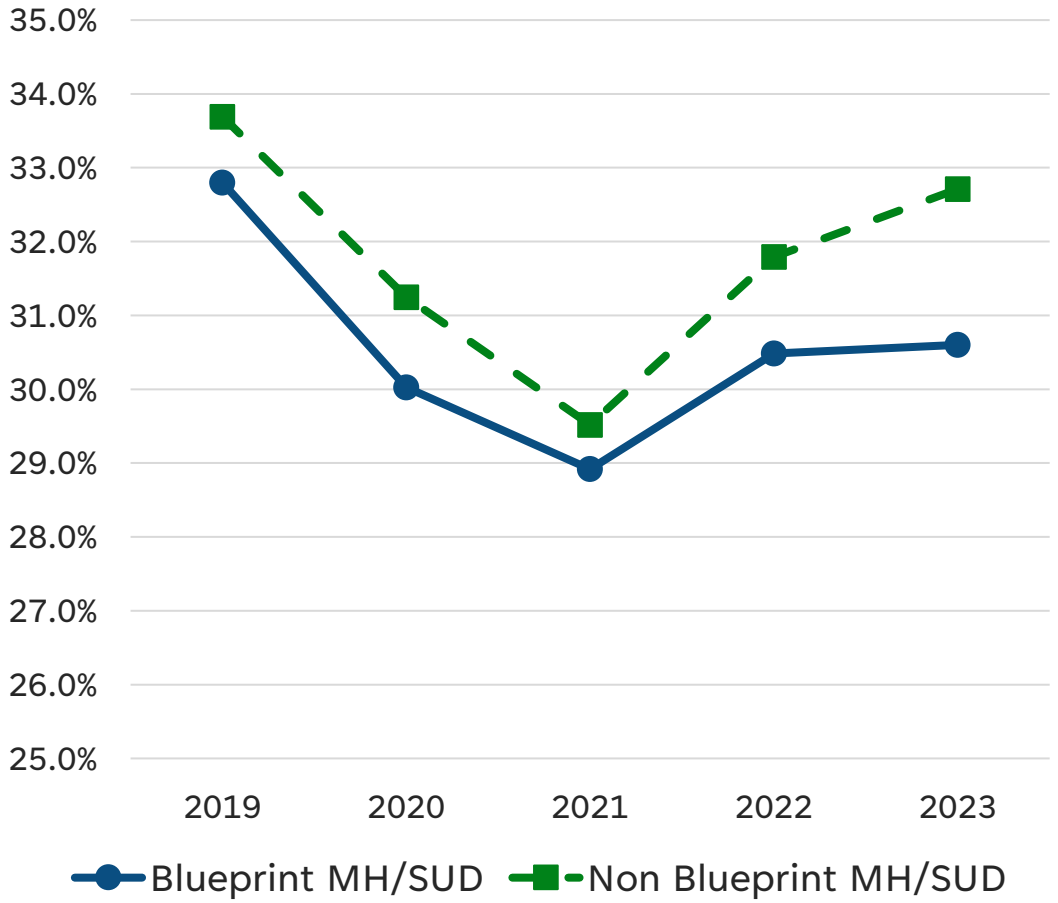
Emergency Department Visits

- One piece of data we follow is the number of individuals with emergency department visits related to various conditions.
- Helps identify if needs are being met before they become crises.
- Tracked through claims data submitted by insurers.
- Data is based on fiscal years.
- Categorize patients into a Mental Health and/or Substance Use category if the patient has at least one of a particular set of diagnosis codes indicating that they have such a condition.

Proportion of Patients in MH/SUD category



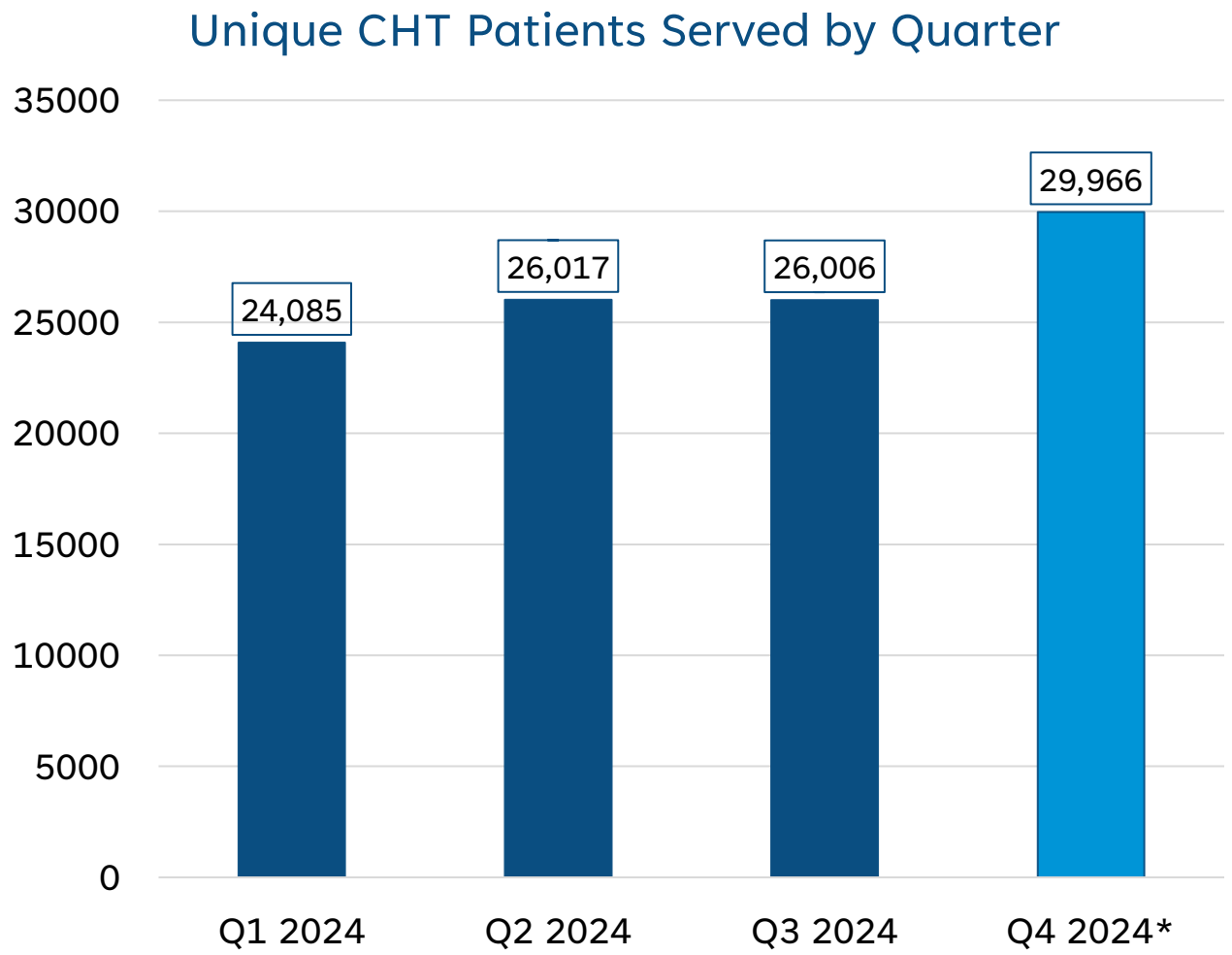
Proportion of Patients in MH/SUD category with ED Visits



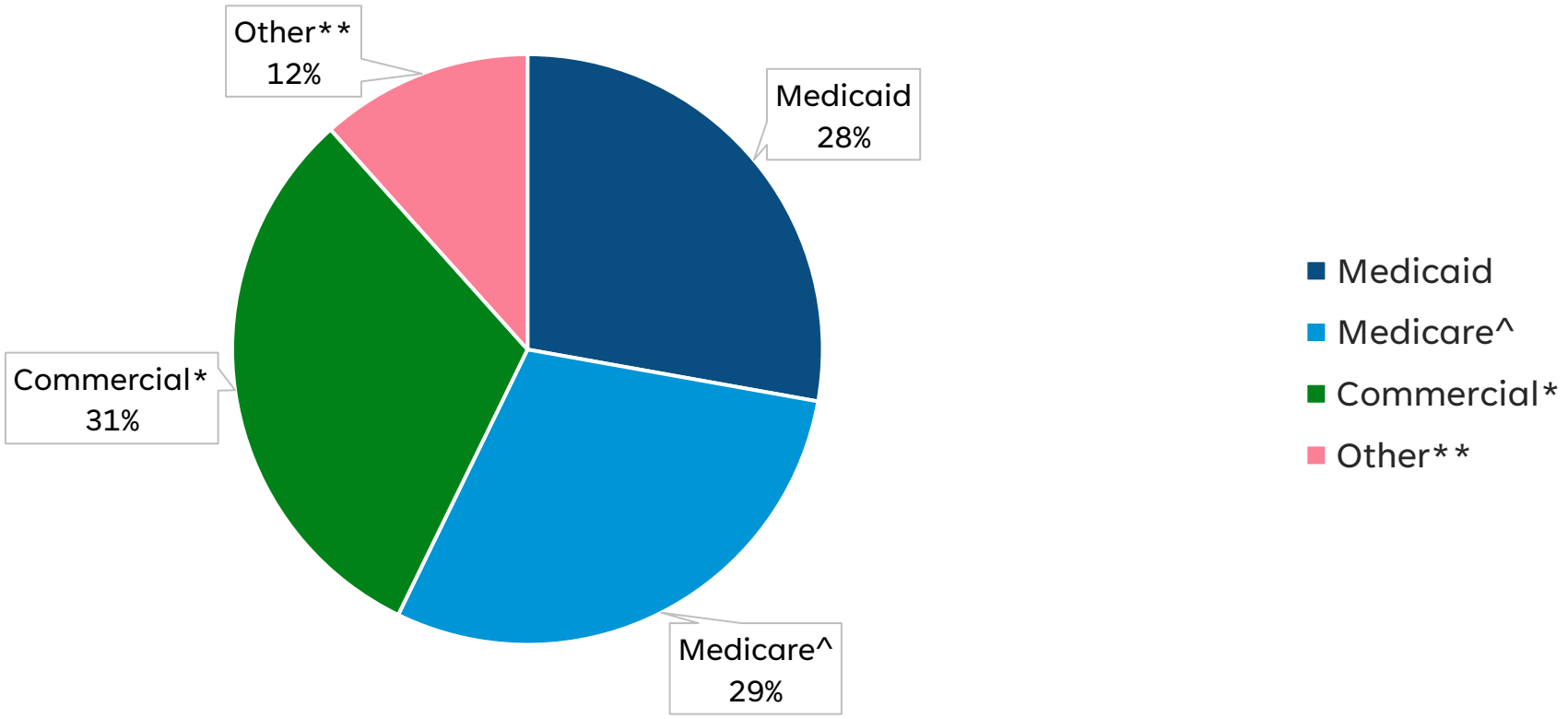
CHT Encounters

- Based on an average encounter rate of 3 per quarter, CHTs have 75,000 to 90,000 encounters with patients each quarter.
- Totals 300,000 to 400,000 services a year.

*Q4 is not entirely reported yet.

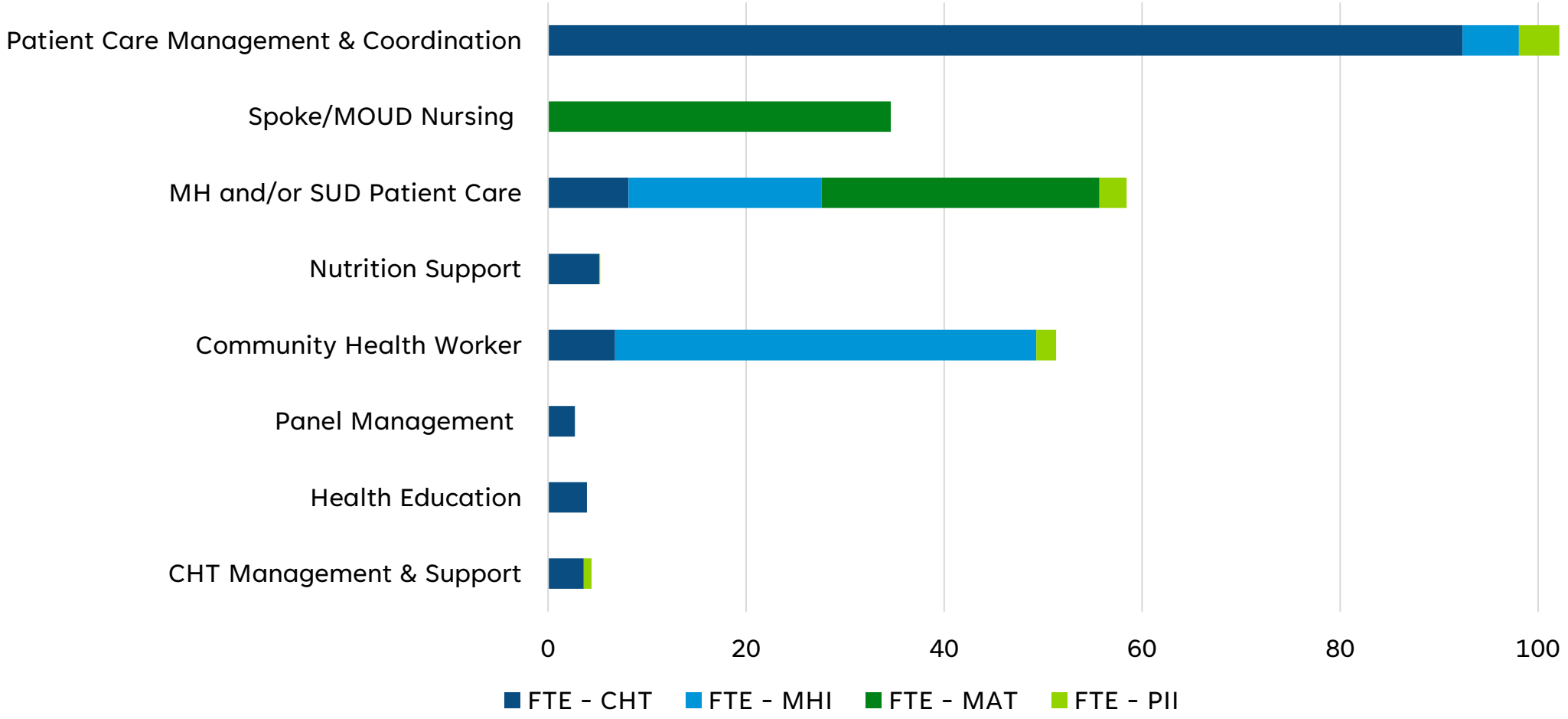


CHT Patients Served by Insurance Type Q4 2024



^ Includes Medicare Advantage, *BCBS, Cigna, MVP, **small insurers, out of state Medicaid, VA etc.

Full-time Equivalent Positions on Community Health Teams



In Their Own Words

- *"It's like a good friend checking in and I can tell her what's going on and she can give me resources to handle whatever problems that I'm having."* [Patient Interview]
- *"[CHT] has been a lifesaver for us. Having access to her skills has been invaluable to the peds team."* [Provider Surveys]
- *"I also was able to expand my work to be with children as well, which was as a new therapist, I was curious, figuring out where my specific population to work with would be. And so, it was cool that I was able to dip toes in both the adult primary care and pediatric settings."* [CHT Interview]
- *"It kind of makes it easier to do the caregiving.....it's not as stressful knowing that I can reach out to the social worker and she will back me, really, on anything that I need help with. And if she doesn't know how to do it, then she'll make some phone calls and make sure that she can guide me on how to do certain things or just make sure that my family's needs are met."* [Family & Caregiver Interview]

Thank You!

Blueprint for Health Central Office

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