State of Vermont
Agency of Human Services
Office of the Secretary
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VERMONT Blueprint for Health
Smart choices. Powerful tools.

Blueprint for Health Follow Up to Questions in House Health Care on April 29, 2026

1. How much of the CHT funding is pass-through versus hiring staff that is then embedded in a practice?

Health Service Area	Administrative Entity who receives payment	Notes on how dollars are distributed
Barre	Central Vermont Medical Center	Pass-through to all non-hospital practices, including Medications for Opioid Use Disorder (MOUD) practices.
Bennington	Southwestern Vermont Medical Center	Pass-through to non-hospital practices and MOUD practices
Brattleboro	Brattleboro Memorial Hospital	Pass-through to all non-hospital practices including MOUD practices
Burlington	University of Vermont Medical Center	Pass through to all non-hospital practices including MOUD and specialty OB/GYN practices.
Middlebury	Porter Medical Center	Pass-through to all non-hospital practices, including MOUD practices
Morrisville	Copley Hospital	Owns no primary care practices. All dollars are passed through to practices
Newport	North Country Hospital	Pass through to non-hospital practices, including MOUD practices.
PPNNE	Planned Parenthood of Northern New England	Only owns all PPNNE practices: no pass-through
Randolph	Gifford Health Care	Pass-through to non-hospital practice and MOUD sites
Rutland	Rutland Regional Medical Center	Owns no primary care practices. Pass-through to FQHC and MOUD

		practices and provides centralized staffing for independent practices.
Springfield	North Star Health	All practices are owned by North Star Health. Pass-through funding only for the MOUD practice.
St. Albans	Northwestern Medical Center	Owns no primary care practices. All dollars are passed through to practices
St. Johnsbury	Northern Vermont Regional Hospital	Pass-through to all non-hospital practices including MOUD practices.

2. How were the performance measures (Resource Utilization Index for practices, and four performance payments per Health Service Area) chosen? What longitudinal data do you have on how the HSAs have done with these measures?

Payment measures came from a consensus-based process to update the payment model in 2016 that coincided with a fiscal appropriation and NCQA PCMH scoring changes. Introducing performance payments rewarded practices for high-quality, high-value care based on measures of resource utilization and quality of care. RUI is a risk adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. This was selected as a payment measure because it serves as an indicator for the over- or underuse of health services, such as preventable ED visits, inappropriate medication use or lab testing, or unwarranted procedures. The quality measures were selected to address the care needs of two conditions presenting significant morbidity and mortality for Vermonters, to balance pediatric (preventative) and adult (chronic disease management) measures, to be in alignment with the payment and reporting measures of existing ACOs at the time, and to attempt to incorporate claims from the Vermont Health Care Uniform Reporting and Evaluation System and clinical data (from data transmitted from EMRs to a Clinical Registry).

The Blueprint receives performance payment measure data annually, in two-year increments. However, over time the data is not necessarily comparable to the most recent data received in 2025 because specifications for how the measures are calculated can change from year to year.

3. What sort of report would be required if we wanted to study universal primary care?

This question may be better suited for Legislative Counsel and is outside the scope of the Blueprint for Health.

4. **Can you present an information graphic about how the funds flow through Blueprint Community Health Teams (CHT)?**

    a. Blueprint directs funds to 13 Administrative Entities (AE) and Planned Parenthood of Northern New England. Funds do not flow through the Blueprint.
    b. Each Administrative Entity works with practices to discuss staffing needs and type of staffing eligible for funding.
    c. Practices and the Blueprint Program Manager work together on the hiring of CHT staff.
    d. The Program Manager sends a quarterly financial report to the Blueprint's central office for accountability and tracking purposes.

5. **What are the concrete dollar amounts that each public/private payer pays?**

Blueprint Payments CY2025		
Program	**Payer**	**Amount**
Patient-Centered Medical Home (PCMH)	Commercial	$4,413,574
	Medicare	$2,331,925
	Medicaid	$5,160,936
	TOTAL	**$11,906,435**
Community Health Team (CHT) Core	Commercial	$3,730,310
	Medicare	$3,131,577
	Medicaid	$3,010,035
CHT Mental Health Integration (MHI)	Medicaid	$5,605,309
CHT Core (Includes MHI)	**TOTAL**	**$15,477,231**
CHT Spoke	**Medicaid**	**$5,956,407**
Pregnancy Intention Initiative (PII) CHT	Medicaid	$730,699
PII Practice One Time	Medicaid	$12,517
PII Practice Payment	Medicaid	$180,424
PII Total	**TOTAL**	**$923,640**
Sum	**TOTAL**	**$34,263,713**

6. **Can you give the committee an example of how the Blueprint uses consumer/patient data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS)?**

   Please see the CAHPS Access Preferences Summary from Feb. 9, 2026.