State of Vermont
Agency of Human Services
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VERMONT Blueprint for Health
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Blueprint for Health's responses to questions Tuesday March 31, 2026 testimony

Q: Did you look at types of Emergency Department (ED) visits or are those any ED visit?

A: The graphs on Slides 21 & 22 are for any claim from an ED, whether or not that visit was related to Mental Health/Substance Use Disorder (MH/SUD).

Q: Are these people with mental health (MH) issue as primary diagnosis?

A: Yes. Individuals are categorized as MH/SUD if they have at least two outpatient claims with a MH/SUD primary diagnosis or one or more inpatient claim with a MH/SUD primary diagnosis.

Q: Is population on slide 21 same as 22, "people with mental health claims...," and "people with MH/SUD needs..."?

A: No. The population on slide 22 is Medicaid patients with MH/SUD diagnoses (as above) with an additional restriction to only including patients that had annual primary care claims at a Blueprint (conversely non-Blueprint) provider and not a single claim (of any kind, at any point) at the other type of provider. This population is much smaller, since the comparison was much more specific.

The population on slide 21 is all-payer, and the selection criteria did not require annual visits or no claims at the other type of provider.

Q: What interventions do you credit with the ED visit declines (after 2023)? What system components? i.e. MHUC, rapid response.

A: MH-Urgent Care was available for both populations, so while it likely played a factor, it is unlikely to be the sole driver of change. Causation is always difficult due to the variety of factors. A difference-in-difference study attempts to explore this by comparing populations that had access to all the same system components except for one. The one that was singled out between the Blueprint and Non-Blueprint patients in this timeframe was the Blueprint's Mental Health Integration (MHI) Initiative. Patients who were seen at Blueprint practices had access to this initiative while those who were not seen at Blueprint practices did not.

Q: Do you have total patient numbers/charts (not proportion of members)?

A: Provided below. However, it is *extremely* important to realize that values may decrease even while proportions increase as total base population changes from year to year. For example, in the all-payer population from Vermont Health Care Unified Reporting and Evaluation System (VHCURES), the overall number of MH/SUD-categorized individuals with ED visits went down for all populations because the denominators went down from year to year. Only the Blueprint practices showed a decrease in the proportion of people visiting. Proportions are used to compare impact of interventions because a relative value is the only way to compare populations of different sizes.

Table 1 (Slide 21)

	Blueprint	Blueprint	Blueprint	Non-Blueprint	Non-Blueprint	Non-Blueprint
	Distinct Members	**Count of Emergency Department Visits**	**Number of Patients with Any Emergency Department Visit**	**Distinct Members**	**Count of Emergency Department Visits**	**Number of Patients with Any Emergency Department Visit**
2020	296,102	51,119	20,510	159,489	27,229	11,135
2021	297,990	60,535	25,063	161,748	30,334	13,093
2022	293,018	64,526	26,482	176,467	38,448	15,724
2023	294,587	65,715	26,872	182,346	40,992	16,835
2024	288,607	63,785	26,183	176,547	41,878	16,742

Table 2 (Slide 22)

year	Blueprint_n_MH	Blueprint_n_MH_highED	NonBlueprint n_MH	nonBlueprint n_MH_highED
2019	7182	881	1737	233
2020	7599	767	1868	177
2021	8250	950	2048	245
2022	9239	1273	2288	312
2023	9875	1458	2355	337
2024	9913	1390	2298	342

Q: Can you please share the budget for the $16M investment in mental health integration?

A: Please see the table below.

Appropriation (Act 78 of 2023)	$ 20,317,382.00
Hub Expansion (VDH)	$ 4,595,448.00
Blueprint MHI initiative	**$ 15,721,934.00**
Evaluation (Quantitative & Qualitative)	$ 679,717.00
Training for CHT members, Providers, & QI facilitators	$ 124,100.00
VDH MOU for DULCE administrative costs	$ 850,160.00
CHT staffing	$ 14,067,957.00

Q: What is the process for a practice to be recognized as a Patient-Centered Medical Home (PCMH)?

The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) program defines nationally accepted standards around the following concepts of the Medical Home Model:

- Team-Based Care and Practice Organization
- Knowing and Managing Your Patients
- Patient-Centered Access and Continuity
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

PCMH Recognition involves virtual reviews by reviewers from NCQA where practices present evidence of implementation and “tell the story” of their PCMH transformation. A practice first is recognized as a PCMH when it is evaluated to meet 39 core PCMH criteria and 25 credits in elective criteria across five of six concepts.

A practice maintains recognition as a PCMH through annual reporting. Each year, the practice shows NCQA that its ongoing activities are consistent with the PCMH model of care. To sustain Recognition, the practice annually attests that it continues to adhere to policies and procedures and submits additional data to NCQA as evidence.

The typical timeline for transformation to achieve initial PCMH recognition is about 9–12 months from initial engagement to submission.

Early phases focus on assessment, workflow redesign, and building core capabilities like care coordination and population health management. The middle phase involves implementing changes, tracking performance, and refining processes to meet NCQA standards. The final phase is dedicated to documentation, gap closure, and preparing for submission.

Most practices begin actively focusing on PCMH annual reporting about six months before their NCQA recognition anniversary date. This window allows enough time to review current workflows, update documentation, close gaps in required standards, and ensure performance data are current and complete.

Direct NCQA Costs

Fees are calculated on a clinician basis and are available in full detail here:

- Initial recognition is higher and calculated per clinician, with different ranges dependent on the number of clinicians in the practice
- Fees for annual reporting are lower
- Multi-site organizations have a lower per-clinician fee
- HRSA covers the cost of initial recognition and annual reporting for FQHCs and FQHC look-alikes through approval of a Notice of Intent
- Newly transforming practices in Vermont are eligible for a 20% discount

Example:

An independent primary care practice with 8 eligible clinicians (MD, DO, ND, APRN, or PA) would pay an initial fee of $546 per clinician and annual reporting fee of $180 per clinician. A practice's total cost payable to NCQA for initial recognition is $4,368. Ongoing annual reporting costs are $1,440 per year.

A practice of this size typically shows an attribution of around 9,000 patients. With a base payment of $3.00 per-member-per month, the practice receives $27,000 per month in Blueprint payments. This totals $324,000 per year, providing sufficient funding to support the costs and clinician and staff time needed to assemble required records for recognition.

Recognition Supports Offered to Practices

Quality Improvement Facilitators (QIs) work directly with primary care practices to guide them through achieving PCMH recognition by aligning workflows with NCQA standards. They provide hands-on support with quality improvement processes, data tracking, and documentation required for accreditation. Facilitators help practices implement care

coordination, population health management, and team-based care models that meet PCMH expectations. They also coach practices on sustaining these changes over time, ensuring standards are not just met but effectively operationalized in daily care delivery. These services are provided at no cost to the practice.

Beginning the PCMH recognition process signals that a primary care practice is actively aligning with Blueprint and NCQA standards, which is the foundational requirement for participation in the program. Once a practice commits to this pathway, it becomes eligible to receive Blueprint support services which are tied to payment. This initiation effectively serves as the trigger for payment flow, allowing resources to begin reaching the practice while they work toward full PCMH recognition. In this way, payments are structured to enable transformation, not just reward completion, supporting practices throughout the process rather than only after certification is achieved.

Q: What is the caseload of Quality Improvement Facilitators?

Blueprint for Health quality improvement facilitators typically support no fewer than eight and no more than 15 Blueprint practices and at least one community collaborative. They meet with practices on a regular basis (weekly, bi-weekly, or monthly depending on practice needs and preferences). The full potential scope of services a Quality Improvement Facilitator may offer to practices are outlined in Appendix 7 of the Blueprint for Health Manual.

Q: What do they measure?

Quality Improvement Facilitators support the practice to identify, understand, and improve upon how they deliver coordinated, high-quality care and where they can approve. Measures may include:

1. Process measures
    a. Workflow efficiency
    b. Medical home functioning
2. Clinical quality measures
    a. Outcomes for chronic conditions like diabetes, hypertension, and asthma
    b. Preventive care rates (screenings, immunizations)
3. Utilization and cost-related measures
    a. ED visits
    b. Hospital admissions and readmissions
    c. Overall patterns of care use
4. Patient experience measures

Quality Improvement Facilitators use the measures required by the various external requirements for payment or reporting, which can vary based on the type of practice (e.g. Federally Qualified Health Centers [FQHCs], organizational affiliation [hospital or network-affiliated], and participation in various programs [NCQA PCMH, Accountable Care Organizations, Insurer Value-Based Payments].) A sample of the various measures a practice may have to meet are here (2026 update in progress). The Blueprint for Health also evaluates participating practices on numerous quality measures calculated from claims and clinical data, including measures in domains required by statute.

Q: What proportion of MOUD services are provided by practices owned by private-equity firms?

A: The Blueprint does not track ownership type for practices in the State.