

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

Public Notice	
Whether Comment is Solicited (Indicate whether public comment was solicited. Public Notice is required for new Health Homes programs and for changes to payment methodologies.)	Public Notice was solicited from December XX, 2012, through December 21, 2012
Method of Public Comment (Indicate how public comment was solicited, such as newspaper, publication in state administrative record, website notice, and public hearing. For each method, indicate date and location of notice.)	
Tribal Input	
Whether Input is Solicited (Indicate whether tribal input was solicited. Tribal input is required if the State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.)	N/A
Organization Consulted for Tribal Input (Indicate which organizations were consulted for tribal input)	N/A
Method of Tribal Input (For each organization consulted, indicate the date, method, and location of consultation)	N/A

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

Health Home Population Criteria and Enrollment	
Geographic Area (Describe whether statewide or targeted. If targeted, describe if targeted by county, city, region, or other)	Northwestern region of Vermont, which includes Addison, Chittenden, Franklin, and Grand Isle counties.
Population Criteria (Indicate if State will be using 2 or more chronic conditions, 1 and being at risk for another or 1 serious and persistent mental illness and include the targeted chronic conditions list.)	<p>One (1) chronic condition and at risk of developing another. Beneficiaries targeted are those with the chronic condition of opioid dependence as defined by the DSM-IV-TR criteria for Diagnosis of Opioid Dependence and receiving Medication Assisted Therapy (MAT) for this condition. A diagnosis of opioid dependence requires an individual to meet three (3) or more of the following criteria: tolerance; withdrawal; taken in larger amounts or over longer time periods than intended; persistent desire or unsuccessful efforts to control use; great deal of time spent in activities to obtain, use, or recover from effects of the substance; interferes with social, occupational, or recreational activities; continued use despite knowledge it is causing or exacerbating a persistent or recurrent physical or psychological problem. [Source: American Psychiatric Association: <i>Diagnostic and Statistical Manual of Mental Disorders</i>, 4th ed., Text Revision. Washington, DC: American Psychiatric Association, 2000].</p> <p>This population has been found to be at high risk of having or developing co-occurring mental health (especially depression and anxiety) and other substance abuse disorders.</p>
Enrollment of Participants (Describe how the individuals will be assigned to the health home, including whether eligible individuals can opt-in to a Health Home or are auto-assigned with an option to opt-out):	<p>Health Home participants receiving Medication Assisted Therapy (MAT) for opioid dependence will be identified via provider or other community partner referrals, MAT prior authorizations, Vermont Chronic Care Initiative (VCCI) risk stratification, claims and utilization data, judicial referrals, and outreach to patients lost to contact. The majority will be identified through provider referrals, clinical assessment, and the prior authorization process for buprenorphine prescriptions. Physicians, other providers, treatment centers, and criminal justice system professionals who may refer patients will be made aware of the integrated MAT system and referral process through a variety of means, including banner pages and other notices, Grand Rounds, community meetings, and provider agreements. Current MAT patients will be informed about the availability of enhanced Health Home services via letter and follow-up communications, including telephone and face-to-face contact, which will be conducted when the beneficiary visits the MAT prescriber’s office for treatment or for a prescription refill. Consistent with the Patient-Centered Medical Home model, beneficiaries will be able to agree or decline to receive specific Health Home services during their participation in developing the individualized Plan of Care. Declining Health Home service or services will have no effect on their regular Medicaid benefits.</p> <p>Only one <i>Hub</i> Health Home (see below) is available within this geographic region so beneficiaries will not be able to select an alternative <i>Hub</i> provider until Health Homes are implemented statewide. Beneficiaries served through a <i>Spoke</i> (see below) may elect to be served by an alternative <i>Spoke</i> provider within this geographic region. The Health Home will notify other treatment providers about the goals and types of available Health Home services and involve them in Health Home activities for shared patients. Individuals receiving services in a hospital ED or as an inpatient who may be eligible for Health Home services will be notified about their availability and referred based on geographic location.</p>
Health Home Provider Requirements	

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

Provider Infrastructure

(Indicate whether designated providers, team of health care professionals or health team)

Background:

Vermont will establish Medicaid Health Homes for beneficiaries receiving Medication Assisted Therapy (MAT) for opioid dependence as determined by meeting the DSM-IV criteria for this condition. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Effective MAT programs also provide services such as physical and mental health care, case management, life skills training, employment support, integrated family support, and recovery support services. Health Home services build on existing MAT resources and the infrastructure created by Vermont’s *Blueprint for Health Patient-Centered Medical Home* and Community Health Team model.

The two primary pharmacological treatments for opioid dependence, methadone and buprenorphine, are governed by separate federal regulations that have resulted in two distinct provider types, programs, and funding streams. The majority of Vermont MAT patients receive Office-Based Opioid Treatment (OBOT) using buprenorphine prescribed by specially licensed physicians in their offices; these physicians typically have no direct access to addictions or mental health services and limited coordinated access to other health, rehabilitation or recovery services. In contrast, methadone treatment is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTPs), which have provided comprehensive addictions services but with little integration into the broader health care or mental health treatment systems. Methadone OTPs and physicians prescribing buprenorphine in OBOTs have worked in relative isolation from each other and with limited interface with the primary care health care and mental health systems.

To address these issues, Vermont is implementing a comprehensive integrated treatment system for all Medicaid patients requiring MAT for opioid dependence, referred to as the *Hub and Spoke* system of care. This model builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in OBOTs, and the local *Blueprint for Health (Blueprint)* patient-centered medical home (PCMH) and Community Health Team (CHT) infrastructure. *Blueprint* primary care practices deliver care consistent with the National Committee for Quality Assurance (NCQA) standards for a Patient Centered Medical Homes (the PPC-PCMH standards). The *Blueprint* supports multi-disciplinary, locally-based Community Health Teams (CHTs) that work closely with the medical home setting. The CHT effectively expands the capacity of the medical home by providing patients with direct access to enhanced services and more individualized follow-up care. Multidisciplinary CHTs are comprised of nurse coordinators, clinician case managers, social workers, counselors, health educators and other professionals as determined by community needs that assist patients and families with care coordination, counseling, enhanced self management, education, and transitions of care. CHTs are supported through funding provided by all Vermont’s insurers, including Medicaid and Medicare, and are administratively managed by one administrative agent (AA) for each Health Service Area.

This SPA applies to one (1) *Hub* regional specialty addictions treatment center and the buprenorphine *Spoke* providers within the four counties that comprise the defined geographic region, which includes three Health Service Areas (HSAs). Enhanced *Hub* and CHT staffing will provide Health Home services to Medicaid beneficiaries receiving MAT for opioid dependence. Under this approach, each patient undergoing MAT will have an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing *Blueprint* Community Health Teams, and access to *Hub* or *Spoke* Health Home nurses and clinicians.

Designated Providers:

The *Hub* is a *Designated Provider* as described in Section 1945(h)(5). The *Hub* builds upon the existing OTP system by developing into a regional specialty treatment center that provides the six (6) Health Home services in addition to the traditional comprehensive methadone addictions treatment it currently provides. The *Hub* serves as the regional consultant and subject matter expert on opioid dependence and treatment, and as the OTP, is the only entity providing methadone treatment. In addition, the *Hub* will provide care to a subset of clinically complex buprenorphine patients. Core *Hub* Health Home team members include the Health Home Program Director, supervising physician, consulting psychiatrist, and registered nurses and clinician case managers. The *Hub* will need approximately six (6)

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

	<p>additional FTE staff per 400 patients served to ensure the provision of Health Home services. <i>Enhanced funding is requested <u>only</u> for the provision of Health Home services. Current opioid treatment services will continue to be matched at the regular state rate.</i></p> <p><u>Team of Health Care Professionals:</u> The <i>Spoke</i> system serves MAT patients who do not require methadone and are not as clinically complex as <i>Hub</i> patients receiving buprenorphine. A <i>Spoke</i> is a <i>Team of Health Care Professionals</i> providing ongoing care for patients receiving buprenorphine. A <i>Spoke</i> is comprised of a <i>Designated Provider</i> who is the prescribing OBOT physician and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. <i>Spokes</i> are supported in providing Health Home services through the addition to existing CHTs of one registered nurse care manager and one licensed clinician case manager for every 100 MAT patients served by a <i>Spoke</i>. <i>These staff resources are the primary providers of the six Health Home services and enhanced funding is sought for 100% of their cost.</i> Core <i>Spoke</i> Health Home team members include the RN care manager, licensed clinician case manager, buprenorphine prescribing physician and primary care provider.</p>
<p>Types of Providers (Indicate the types of providers to be included, such as those listed in Section 1945(a)(5), 1945(a)(6), and 1945(a)(7). For each type, indicate provider qualifications and standards.)</p>	<p>Core <i>Hub</i> Health Home team members and roles:</p> <ul style="list-style-type: none"> - <i>Program Director:</i> A licensed clinician primarily involved with comprehensive care management, including identifying potential MAT patients, conducting outreach, assessing preliminary service needs, establishing a comprehensive care plan, developing an individualized Plan of Care with goals set in conjunction with the patient, assigning Health Home team roles and responsibilities, developing treatment guidelines and protocols, monitoring health status and treatment progress, and developing QI activities to improve care. - <i>Supervising MD:</i> Primarily involved with comprehensive care management, care transitions, and care coordination with health and mental health care provider and coordination of all medications. - <i>RN Supervisor/Care Manager:</i> Involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services. - <i>Licensed clinicians/counselors:</i> Involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services. - <i>Consulting Psychiatrist:</i> Primarily involved with comprehensive care management and transitions of care. <p>Core <i>Spoke</i> Health Home team members and roles:</p> <ul style="list-style-type: none"> - <i>Primary Care Provider:</i> Primarily involved with comprehensive care management, care transitions, and care coordination to address health and mental health conditions, and oversee medication management. - <i>Buprenorphine Prescribing Physician:</i> The Designated Provider who primarily oversees comprehensive care management and transitions of care. - <i>Registered Nurse Care Manager:</i> Involved in providing all aspects of Health Home services, particularly those focused on medical management, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services. - <i>Licensed Clinician Case Manager:</i> Involved in providing all aspects of Health Home services, particularly those focused on community and social support services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

<p>Supports for Providers (Describe the methods by which the State will support health homes providers in meeting requirements for the service)</p>	<p>Current OTPs and OBOTs are supported in transforming into <i>Hub</i> and <i>Spoke</i> Health Homes through participation in regional and statewide learning activities, including learning collaboratives and trainings sponsored by the Department of Health, Division of Alcohol and Drug Abuse Programs, that are designed to provide education and support for providing Health Home services and care using a whole person approach that integrates behavioral health, primary care and other needed services and supports.</p> <p>An opioid treatment measures set and activity tracker is being developed as an addition to Vermont’s central clinical registry, <i>Covisint DocSite</i>, which ultimately will be developed into an integrated health record for use by both health care and Health Home teams. The registry will contain consistent assessment criteria, protocols, treatment plans, and continuity of care mechanisms across the health care system, including among substance abuse and mental health treatment providers.</p>
<p>Provider Standards (Describe the State's minimum requirements and expectations for Health Homes providers)</p>	<p><i>Hubs</i> must fulfill all federal requirements as Opioid Treatment Programs (OTPs). OBOT buprenorphine prescribers must have completed the federally required training and hold the appropriate X-DEA license.</p> <p>Through performance-based contracts with <i>Hubs</i> and with the administrative agents overseeing Community Health Teams, <i>Hub</i> and <i>Spoke</i> Health Home providers must achieve the following standards:</p> <ol style="list-style-type: none"> 1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services; 2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; 3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; 4. Coordinate and provide access to mental health and substance abuse services; 5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings; 6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; 7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; 8. Coordinate and provide access to long-term care supports and services; 9. Develop a person-centered care plan for each individual that coordinates and integrates all of his/her clinical and non-clinical health-care related needs and services; 10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and providing feedback to practices, as feasible and appropriate; and 11. Establish a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. 12. Develop treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; 13. Monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines; 14. Develop and disseminate reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs. 15. Participate in and provide requested data to inform all program evaluations.
<p>Health Home Service Delivery System</p>	

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

<p>Type of Service Delivery System (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another service delivery system)</p>	<p>Traditional opioid treatment services continue to be provided Fee for Service. The reimbursable unit for Health Home services is the provision of at least one Health Home service per month provided by the Health Home staff at the <i>Hub</i> or by the Blueprint Community Health Team <i>Spoke</i> staff. There are essentially two rates: one for the <i>Hub</i> and one for the <i>Spokes</i>. The monthly <i>Spoke</i> capacity payment is based on the costs to deploy 2 FTE clinical staff for every 100 patients receiving buprenorphine treatment. The monthly <i>Hub</i> payment is based on the costs of the Health Home staffing enhancements to the traditional OTP programs and is a PMPM payment.</p>
<p>PCCM Information (Indicate whether duplicate payments are provided to PCCM and health homes and, if so, describe the payment methodology for PCCM health homes)</p>	<p>N/A</p>
<p>Risk-Based Managed Care Information (Summarize contract language regarding health home services and indicate whether health homes are paid as part of the capitation rate. If not, describe the payment methodologies for health homes in risk-based managed care.)</p>	<p>N/A</p>
<p>Payment Methodology</p>	
<p>Type of Payment Methodology (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another model)</p>	<p>Both the <i>Hubs</i> and <i>Spokes</i> will combine services currently reimbursed in Vermont’s State Medicaid Plan with the new Health Home services. Vermont seeks 90-10 matching funds only for the <i>Hub</i> and <i>Spoke</i> costs directly linked to providing the Health Home services. The remaining services will be matched at the current state match rate. There are two payment streams: one for <i>Hubs</i> and one for <i>Spokes</i>.</p> <p><i>Hub</i>. The methodology to develop costs for the <i>Hub</i> Health Home enhancements is based on the cost to employ key health professionals (salary and fringe benefits) who will provide the Health Home services. The staffing enhancements are based on a model of 6.15 FTEs for every 400 MAT patients served. The <i>Hub</i> payment is a monthly, bundled rate per patient. The <i>Hub</i> provider initiates a claim for the monthly rate, using an existing procedure code for traditional opioid treatment and a modifier for the Health Home services. The provider may make a monthly claim using the modifier on behalf of a patient for whom the provider can document the following two services in that month: (1) one face-to-face typical treatment service encounter (e.g., nursing or physician assessment, individual or</p>

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

	<p>group counseling, observed dosing), and; (2) one Health Home service. If the provider did not provide a Health Home service in the month, then they may only bill the existing procedure code without the Health Home modifier for the current rate.</p> <p><i>Spoke</i>. Payment for <i>Spoke</i> Health Home services are based on the costs to deploy 1 FTE Registered Nurse and 1 FTE licensed clinician case manager for every 100 MAT patients across multiple providers. <i>Spoke</i> payments are based on the average monthly number of unique patients in each Health Services Area (HSA) for whom Medicaid paid a buprenorphine pharmacy claim during the most recent three-month period in increments of 25 patients. <i>Spoke</i> staff resources are deployed to the prescribing practices proportionate to the number of patients served by each practice. Payments will be made to the lead administrative agent in each Blueprint Health Service Area as part of the existing Medicaid Community Health Team payment. Since the <i>Spoke</i> RNs and licensed clinicians are added to the CHTs specifically to provide Health Home services, 90-10 match is requested for their entire cost. <i>Spoke</i> MAT providers will continue to bill fee-for-service for all typical treatment services currently reimbursed by the Department of Vermont Health Access (DVHA) at the regular state match.</p>		
<p>Will payment methodology be tiered? If yes, provide methodology for tiering the payments, such as severity of a person’s condition; provider capabilities; or use of incentive payments).</p>	<p>No</p>		
<p>Health Home Services</p>			
<p>Comprehensive Care Management</p>	<p style="text-align: center;">Service Definition</p> <p>Activities involve identifying patients for MAT, conducting initial assessments, and formulating individual plans of care. Specific activities include: identifying potential MAT patients and conducting outreach, assessing preliminary service needs, treatment plan development and goal setting in conjunction with the patient, assigning Health Home team roles and responsibilities, developing treatment guidelines and protocols, monitoring the patient’s health status and treatment progress, and developing QI activities to improve care.</p>	<p style="text-align: center;">Ways HIT Will Link</p> <p>Patient information will be communicated through the clinical registry <i>Covisint DocSite</i>, which contains clinical information as well as documentation and tracking of self management goals and action plans. If <i>Covisint DocSite</i> usage is not yet operational, <i>Covisint ProviderLink</i> can be used. <i>Covisint ProviderLink</i> is an electronic provider communication tool that supports case management by enabling providers to securely transmit and receive information directly to their EMR system or directly through their fax line.</p>	<p style="text-align: center;">Provider Types Furnishing the Service</p> <p>The Health Home Program Director, RNs and licensed clinician case managers will be involved in these activities, with active involvement and oversight by the Hub supervising physician and consulting psychiatrist or the Spoke prescribing physician.</p>
<p>Care Coordination and Health Promotion</p>	<p style="text-align: center;">Service Definition</p> <p>Care coordination activities involve implementing the Plan of Care through appropriate linkages, referrals, coordination and follow-up across</p>	<p style="text-align: center;">Ways HIT Will Link</p> <p>Information will be shared through the central clinical registry <i>Covisint DocSite</i> as well as through existing</p>	<p style="text-align: center;">Provider Types Furnishing the Service</p> <p>Health Home RN and clinician case managers will primarily directly provide or coordinate these services.</p>

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

	<p>treatment and human services settings and providers (medical, social, mental health and substance use, corrections, education, and vocational). Health promotion activities promote patient activation and empowerment and support healthy behaviors and self management of health, mental health, and substance abuse conditions. They include health education specific to opioid dependence and treatment, health education regarding a patient’s other chronic conditions, developing self-management plans, behavioral techniques (e.g., motivational interviewing) to engage patients in healthy lifestyles, supports for managing chronic pain, smoking cessation and reduction in use of alcohol and other drugs, promoting healthy lifestyle interventions such as nutritional counseling, obesity reduction, increased physical activities, support for developing skills for emotional regulation and parenting skills, and support for improving social networks.</p>	<p>information sharing technologies. This web-based registry receives feeds of guideline-based data elements from practices and hospitals. Data sources include Electronic Medical Record (EMR) systems, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont’s Health Information Exchange infrastructure run by Vermont Information Technology Leaders (VITL). In addition to patient care and population management, the registry supports flexible performance reporting with measures derived from national guidelines on health care quality and outcomes.</p>	
<p>Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)</p>	<p>Service Definition</p> <p>Focuses on streamlining movement of patients from one treatment setting to another, between levels of care, and between health, substance abuse and mental health service providers. These activities include developing collaborative relations between Health Home providers and hospital ERs, discharge planners, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance abuse treatment services.</p>	<p>Ways HIT Will Link</p> <p>Concurrent reviews of hospital stays requires Vermont Medicaid to be notified when admissions occur. The State is developing automated procedures with hospital emergency departments and inpatient discharge planners, as well as CHTs, to receive daily feeds on Medicaid patients. Residential substance abuse providers also will be included in the procedures developed. Care managers will work with discharge planners to schedule follow up appointments with primary or specialty care providers within 30 days of discharge, and will work with the patient to ensure attendance at the scheduled appointment.</p>	<p>Provider Types Furnishing the Service</p> <p>Health Home RNs and licensed clinician case managers, with involvement and oversight by supervising and prescribing physicians.</p>

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

Individual and Family Support Services	Service Definition	Ways HIT Will Link	Provider Types Furnishing the Service
	These services promote recovery by supporting participation in treatment, reducing barriers to access to care, and supporting age and gender appropriate adult role functioning. Activities include advocacy, assessing individual and family strengths and needs, providing information about services and education about health conditions, assistance with navigating the health and human services systems, support and outreach to key caregivers, and assistance with adhering to treatment plans.	<i>Covisint DocSite</i> can make specific information related to a patient’s care available for reference in Individual and Family Support Services. Vermont’s Agency of Human Services is also pursuing a new Case Management system which will further support these services.	Provided or frequently coordinated primarily by the Health Home RN and licensed clinician case managers working closely with the Health Home supervising and prescribing physicians.
Referral to Community and Social Support Services	Service Definition	Ways HIT Will Link	Provider Types Furnishing the Service
	Activities include developing information about formal and informal resources including peer and community based programs, assistance with accessing resources based on patient needs and goals, and supporting patients in obtaining supports and entitlements for which they are eligible (e.g., income, housing, food assistance, vocational and employment services to promote self-sufficiency).	Vermont’s clinical registry, <i>Covisint DocSite</i> , already provides the ability to track the number and type of referrals to community and social services. <i>Covisint DocSite</i> can make specific information related to a patient’s care available for Referral Services, and Vermont’s Agency of Human Services is also pursuing a new Case Management system which will further support these services.	Health Home Program Directors, RN and licensed clinician case managers
Use of Health Information Technology to Link Services	<p style="text-align: center;">Service Definition</p> Information will be shared through the central clinical registry <i>Covisint DocSite</i> as well as through existing information sharing technologies. All Blueprint NCQA patient-centered medical homes use <i>Covisint DocSite</i> . This web-based centralized clinical registry receives feeds of guideline-based data elements from practices and hospitals. Data sources include Electronic Medical Record (EMR) systems, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont’s Health Information Exchange infrastructure and run by Vermont Information Technology Leaders (VITL). In addition to patient care and population management, the registry supports flexible performance reporting with measures derived from national guidelines on health care quality and outcomes. Sites that are transmitting data can use registry reporting to track performance and guide their quality improvement activities. The registry also can be used to track changes in the health of populations, and the		Provider Types Furnishing the Service

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

	<p>relationship between health and the quality of health services.</p> <p>The <i>Covisint DocSite</i> clinical registry is available statewide and the conditions it supports continue to expand, including the addition of a measures set for opioid treatment and an activity tracker for system services. Vermont is building on this registry to develop an integrated health record for use by both health care and Health Home teams. The State has identified the need to develop and adopt consistent assessment criteria, protocols, treatment plans, and continuity of care mechanisms across the health care system, including among substance abuse and mental health treatment providers.</p> <p>In addition, Vermont is piloting <i>Covisint ProviderLink</i>, a communication tool that facilitates the transmission of clinical information across care settings. A longer term plan is to implement a common case management system across the Vermont Agency of Human Services, CHTs, and community agencies and service providers</p>	
<p>Health Homes Patient Flow (Describe the patient flow through the State's Health Homes system. The state must submit flow-charts of the typical process an individual would encounter)</p>	<p>Currently under development</p>	
Assurances		
<p>The State provides assurance that eligible individuals will be given a free choice of health homes providers.</p>	<p>Only one <i>Hub</i> Health Home (see below) is available within this geographic region so beneficiaries will not be able to select an alternative <i>Hub</i> provider until Health Homes are implemented statewide. Beneficiaries served through a <i>Spoke</i> (see below) may elect to be served by an alternative <i>Spoke</i> provider within this geographic region.</p>	
<p>The States provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving health homes services.</p>	<p>Vermont provides this assurance that individuals dually eligible for Medicare and Medicaid and also meet the population criteria are eligible to receive Health Home services.</p>	
<p>The State assures that hospitals participating in the State plan or waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department</p>	<p>Vermont provides this assurance. The Department of Vermont Health Access is requiring Health Home providers collaborate with hospitals to develop these procedures.</p>	

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

to designated providers.		
The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.	The State consulted with SAMHSA on March 8, 2012.	
The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.	These systems are in place. Health Home enrollees will be flagged in Vermont’s Medicaid data system to ensure no individual receives the enhanced FMAP for longer than one 8-quarter period.	
The State will report to CMS information submitted by health home providers to inform the evaluation and Report to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.	Vermont will provide the requested information to CMS.	
Monitoring		
Describe the State’s methodology for tracking avoidable hospital readmissions to include data sources and measure specifications.	Data Sources Claims	Measures Specifications
	Vermont will use the HEDIS method to calculate the number of inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.	<i>Numerator:</i> Number of hospital stays with a readmission within 30 days. <i>Denominator:</i> Number of hospital stays
Describe the State’s methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measures specifications.	Data Sources Claims	Measures Specifications
	Overall, health care costs are approximately three times higher among Medication Assisted Therapy (MAT) patients than within the general Medicaid population. In addition to the costs directly associated with MAT, these individuals have high rates of co-occurring mental health and other health issues and are high users of emergency rooms, pharmacy benefits, and other health care services. Vermont will annually assess cost savings using a pre/post-period comparison. The assessment will include total Medicaid savings for the	Developing formula

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

	<p>intervention group. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditures.</p>	
<p>Describe the State’s proposal for using health information technology in providing health home services under this program and improving services delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).</p>	<p>Information will be shared through the central clinical registry <i>Covisint DocSite</i> as well as through existing information sharing technologies. All Blueprint NCQA patient-centered medical homes use <i>Covisint DocSite</i>. This web-based centralized clinical registry receives feeds of guideline-based data elements from practices and hospitals. Data sources include Electronic Medical Record (EMR) systems, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont’s Health Information Exchange infrastructure and run by Vermont Information Technology Leaders (VITL). In addition to patient care and population management, the registry supports flexible performance reporting with measures derived from national guidelines on health care quality and outcomes. Sites that are transmitting data can use registry reporting to track performance and guide their quality improvement activities. The registry also can be used to track changes in the health of populations, and the relationship between health and the quality of health services.</p> <p>The <i>Covisint DocSite</i> clinical registry is available statewide and the conditions it supports continue to expand, including the addition of a measures set for opioid treatment and an activity tracker for system services. Vermont is building on this registry to develop an integrated health record for use by both health care and Health Home teams. The State has identified the need to develop and adopt consistent assessment criteria, protocols, treatment plans, and continuity of care mechanisms across the health care system, including among substance abuse and mental health treatment providers.</p> <p>In addition, Vermont is piloting <i>Covisint ProviderLink</i>, a communication tool that facilitates the transmission of clinical information across care settings. A longer term plan is to implement a common case management system across the Vermont Agency of Human Services, CHTs, and community agencies and service providers.</p>	

Evaluations – Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing:				
Hospital Admissions	<p>Description Admission per 1000 member months for any diagnosis among Hub/Spoke clients</p>	<p>Measure Specification, including numerator and denominator <i>Numerator:</i> All Hub and Spoke enrollees with a hospital stay during the measurement year <i>Denominator:</i> All Hub and Spoke enrollees during the measurement year</p>	<p>Data Source claims</p>	<p>Frequency of Data Collection Annual</p>
Emergency Room Visits	<p>Description ER visits per 1000 member months for any diagnosis among Hub/Spoke clients</p>	<p>Measure Specification, including numerator and denominator <i>Numerator:</i> All Hub and Spoke enrollees with an ER visit during the measurement year <i>Denominator:</i> All Hub and Spoke enrollees during the measurement year</p>	<p>Data Source claims</p>	<p>Frequency of Data Collection Annual</p>

TITLE XIX
State: Vermont
Health Home SPA Template – Effective 1/1/2013

Skilled Nursing Facility Admissions	Description Admission per 1000 member months for any diagnosis among Hub/Spoke clients	Measure Specification, including numerator and denominator <i>Numerator:</i> All Hub and Spoke enrollees with a skilled nursing facility admission during the measurement year <i>Denominator:</i> All Hub and Spoke enrollees during the measurement year	Data Source claims	Frequency of Data Collection Annual
Evaluations - Describe how the state will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program as it pertains to the following:				
Hospital Admission Rates	This information is available through analysis of Vermont’s Medicaid claims data. Hospital admissions rates for Health Home enrollees in the implementation region can be compared with rates for the opioid dependent population in regions where Health Homes have not yet been implemented.			
Chronic Disease Management	The Vermont Department of Health (VDH) maintains a number of databases and registries that can be used for modeling patterns at a population level and tracking change over time. The Blueprint team has worked closely with the VDH Center for Health Statistics to assemble an array of measures from these data sources that can be used to track changes in Vermont that may be influenced by the Blueprint Integrated Health Services model and the development of Community Systems of Health. Data sources for these measures include Vermont’s Uniform Hospital Discharge Data Set, the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), the Adult Tobacco Survey, the Vermont Physician Survey, and United States Census Data. The VDH team has used these disparate data sources to construct integrated views on patterns of health, hospital based healthcare, and risk factors in the state. Results are presented for common chronic conditions and each Health Service Area. These complex analyses provide important information that can be used for planning operations in a transformed environment where advanced primary care practices and CHTs work together as part of an integrated Community System of Health. The analyses also establish a basis for tracking change over time to determine whether the Blueprint’s Integrated Health Services approach is associated with changes in risk factors and health at a population level. The <i>Hubs/Spokes</i> initiative will build upon the resources available through the Blueprint.			
Coordination of Care for Individuals with Chronic Conditions	Each Health Home enrollee will have an established medical home, a single MAT prescriber, a pharmacy home, access to the existing CHTs (and Vermont Chronic Care Initiative care coordinators), and access to the <i>Hub</i> or <i>Spoke</i> nurses and clinicians, all of which will be documented in the Plan of Care to ensure coordination and follow up among team members and with the patient. Existing Vermont CHTs already have established relationships and extensive experience coordinating with a wide range of community supports and services. The Hub and Spoke nurse and clinician case managers will become members of these existing CHTs, who will share their established coordination protocols. The CHT measures sets maintained in <i>Covisint DocSite</i> (Vermont’s clinical registry) already provides the ability to track the number and type of referrals to community and social services. Providers who do not yet have access to <i>Covisint DocSite</i> will receive information through <i>Covisint ProviderLink</i> , an electronic provider communication tool that supports case management by enabling providers to receive information to their electronic medical record or directly through their fax line. Vermont will use claims, encounter, and clinical registry data to collect information on patients’ coordination of care, including post-inpatient discharge continuation of care.			
Assessment of Program Implementation	Vermont will monitor implementation in several ways. The State will meet with personnel and provider representatives on a regular basis to assess implementation status and develop work groups, as necessary. Data and reports about progress will be shared with <i>Hubs/Spokes</i> Health Homes staff and participating providers.			
Processes and Lessons Learned	The State will develop tools to elicit feedback from providers and patients to understand any operational barriers of implementing <i>Hubs/Spokes</i> Health Homes services. This will be especially important as it will inform implementation statewide.			

TITLE XIX

State: Vermont

Health Home SPA Template – Effective 1/1/2013

Assessment of Quality Improvements and Clinical Outcomes	<p>The State will utilize the quality process and outcome measures to assess quality improvements and clinical outcomes. As the <i>Hubs/Spokes</i> Health Homes program progresses, Vermont anticipates implementing additional quality improvement and clinical outcome measures for patients receiving MAT, including but not limited to:</p> <ul style="list-style-type: none">– Reducing rates of arrest and incarceration– Increasing rates of employment/wages earned– Increasing housing stability– Reducing rates of positive urine drug screenings– Engaging patients in Community Self-Management Programs– Engaging patients in documenting self-management goals and written self-management plans– Reducing smoking rates– Increasing rates of continuous health insurance– Developing patient experience of care survey instruments– Reducing use of high cost/high use categories such as pharmacy, inpatient hospitalization, emergency room, lab, and residential treatment
Estimates of Cost Savings (if different from the method described under monitoring)	

Quality Measures were moved to an administrative reporting document separate from the State Plan Amendment (SPA) and required after SPA approval

