VERMONT HUB AND SPOKE HEALTH HOMES

PROGRAM AND PAYMENT OVERVIEW

Background

Introduction

Vermont is proposing a Medicaid Health Home program under Section 2703 of the Affordable Care Act to create a coordinated, systemic response to the complex issues of opioid addiction among Vermont's Medicaid population, focusing specifically on medication assisted therapy (MAT) for individuals with opioid dependence. MAT, such as methadone and buprenorphine in combination with counseling, is recognized as the most effective treatment for opioid addiction.

The initiative will be implemented in phases by region through sequential State Plan Amendments beginning January 1, 2013, in the Northwest region of the State.

The Health Home for Vermonters with opioid dependence has two related service provider configurations: *Hubs,* which are regional specialty addictions treatment centers regulated as Opioid Treatment Programs (OTP); and *Spokes,* which are the nearly 200 physicians prescribing buprenorphine in Office Based Opioid Treatment Programs (OBOTs) and the clinical staff deployed to ensure the provision of Health Home services.

Global Commitment to Health 1115 Demonstration

The majority of Vermont's Medicaid program operates under the Global Commitment to Health Demonstration. The Global Commitment (GC) Demonstration was recently renewed to extend until December 31, 2013 with the expectation that it will be continued after that date once the terms are revised to reflect changes under the Affordable Care Act. The GC Demonstration will also provide the foundation for this State Plan Amendment proposal under section 2703 of the Affordable Care Act.

The GC Demonstration operates under a managed care model that is designed to provide flexibility with regard to the financing and delivery of health care in order to promote access, improve quality and control program costs. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) is the entity delegated to operate the managed care model and has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services).

One of the major drivers for entering into the GC waiver was to help bend the curve on the growth of Vermont's Medicaid costs – a goal that has been achieved. Vermont's actual spending over the 8.25 years of the waiver is projected to be $8.4 billion -- $500 million less in expenditures than projected without the waiver (i.e. Demonstration savings). There are a number of ways the GC Demonstration has helped Vermont achieve this success. First, the waiver provides the State with the ability to be more

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flexible in the way it uses its Medicaid resources, which has enabled Vermont to fund creative alternatives to traditional Medicaid services to improve quality of care and control costs. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams, capacity-based payments) rather than fee-for-service, the ability to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation), and investments in programmatic innovations for Medicaid beneficiaries (e.g., the Vermont Blueprint for Health).

Blueprint for Health

The Blueprint for Health is Vermont's state-led reform initially focusing on primary care in Vermont. Originally codified in Vermont statute in 2006, then modified further in 2007, 2008, and finally in 2010 with Vermont Act 128 amending 18 V.S.A Chapter 13 to update the definition of the Blueprint as a *"program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting heath maintenance, prevention, and care coordination and management.*" Under the Blueprint for Health, Vermont's primary care practices are supported to meet the National Committee of Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Standards. In addition, participating practices in collaboration with local community partners plan and develop "community health teams" that provide multi-disciplinary support for PCMHs and their patients. The teams are functionally integrated into the practices and are scaled in size based on the number of patients served by participating practices. The community health teams (CHT), are a core resource available free of barriers (co-pays, fees,) to the patients and the practices. Vermont's patient centered medical home initiative is unique in the nation in that it is state-wide, and it is supported by all of Vermont's large insurance payers. BCBS, Cigna, MVP, VT's large self-insured plans, and Medicaid and Medicare all participate in the Blueprint payment reforms.

Leaving the current fee-for-service payments to providers untouched, the Blueprint adds two key payment reforms:

1. A per Member per Month (*PMPM*) payment made by all payers to primary care providers with a qualifying score on the NCQA PCMH standards. The PMPM amount depends on the actual score on the standards with higher scores resulting in higher payments, so this payment reform incents improvements in quality of care.

2. C*apacity*" payments to support the salaries and expenses of the community health teams. The payment is scaled at $350,000 for every 20,000 patients. Vermont's commercial and public payers all share equally in the cost to support the CHTs. The Medicaid portion of this capacity payment is made monthly to a lead administrative agent in each of 14 health service areas. The payment is based on a quarterly calculation of attributed patients to the participating primary care practices.

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Vermont is part of the national Multi-payer Advanced Primary Care Practice Demonstration, and Medicare and Medicaid fully participate in the Blueprint payment reforms.

The community health teams are designed locally by participating primary care providers and area health and human services partners. Typically the teams are comprised of nurse care managers, health coaches, social workers, and behavioral health clinicians. These multi-disciplinary teams are hired by the Blueprint administrative agents and are deployed to work in the participating primary care practices.

Currently, there are just over 100 primary care practices independently recognized as patient-centered medical homes by the NCQA participating in the Vermont Blueprint for Health. Collectively these practices serve 400,000 Vermonters. Eighty full time equivalent (FTE) community health team staff statewide work in the primary care practices, transforming the scope of primary care. With an onboarding schedule of over 50 additional practices, Vermont will meet its legislative mandate of including all willing primary care providers in the Blueprint payment and practice reforms by October 2013.

The Blueprint is administratively organized into 14 geographically distinct health service areas with a single lead administrative agent in each area that:

- administers the payment processes for community health teams and provider PMPMs;
- plans and operates the community health teams (hires, supervises or subcontracts for the CHT staff);
- recruits new primary care providers to the Blueprint and supports their work to become NCQA recognized as patient-centered medical homes;
- convenes the working teams to assure the exchange of health information from practice-based Electronic Medical Records through the Vermont Health Information Exchange (VHIE) to the Blueprint Central Clinical Registry;
- convenes and supports learning health system activities, including development and dissemination of key performance reports, learning collaboratives, and training events, and;
- plans and implements new initiatives including the *Hub* and *Spoke* activities for this proposed State Plan Amendment.

The lead administrative agents are health care organizations with strong fiduciary and administrative capabilities, are Medicaid enrolled providers, and are recognized health care leaders in their communities. They are hospitals, federally qualified health centers, and/or community mental health centers. The Department of Vermont Health Access / Blueprint executes performance-based contracts with each lead administrative agent for these services.

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The local administrative agents receive monthly *capacity* payments for the community health teams from each of Vermont's commercial and public payers. Specifically, the Vermont Department of Vermont Health Access, through its contracted claims processing agent, currently makes monthly payments to each Blueprint administrative agent for the Medicaid share of the Community Health Team costs. The monthly payment amount is set quarterly based on the number of Vermont resident patients seen by the participating practices in increments of 2,000 patients. Vermont Medicaid, along with Medicare and Vermont's largest commercial insurers share in the cost for these payments. Medicaid, Medicare, BlueCross BlueShield and CIGNA each pay 22.2 % of the CHT costs. MVP pays 11.2% of the costs as it has significantly fewer covered lives in Vermont.

Opioid Dependence

The essential features of substance dependence are a set of cognitive, behavioral and physiological symptoms in which a person continues to use the substance despite significant substance-related problems. The repeated use of opioids results in patterns of tolerance (requiring increasing doses of the substance to achieve effects), withdrawal (a set of physiological symptoms), and compulsive drug taking due to intense feelings of "craving" for the substance.

Opioid dependence is a chronic, relapsing illness. It is diagnosed by a physician based on the presence of at least three of seven criteria over a 12-month period. Opioid dependence includes compulsive, prolonged, self-administration of opioid substances that are not for a legitimate medical purpose and are used in doses that are greatly in excess of the amount needed for pain relief.

"Medication Assisted Treatment" (MAT) is defined by the Center for Substance Abuse Treatment (CSAT) as "the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders." The two primary medications used to treat opioid dependence are methadone and buprenorphine, and opioid dependent individuals may remain on them indefinitely, akin to insulin use among people with diabetes.

Office Based Opioid Treatment & Opioid Treatment Programs

Although the primary pharmacological treatments for opioid dependence (methadone and buprenorphine) have similar effects, two different federal regulations govern their use, resulting in distinct provider types. In Vermont, typical of many states, this has resulted in separate programs for buprenorphine and methadone. Methadone treatment for opioid dependence is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTP), of which Vermont has only four programs.

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Buprenorphine treatment is allowed under Section 3502 of the Children's Health Act of 2000 (HR 4365), which set forth the *Drug Addiction Treatment Act of 2000* (DATA). This legislation significantly changed medical treatment for opioid dependence by allowing physicians to treat opioid addiction with opioid medication (buprenorphine) in office-based settings. Previous to DATA 2000, all treatment of opioid dependence with medication was provided only in specialty Opioid Treatment Programs (OTP).

Under DATA 2000, a physician with an X-DEA license can prescribe buprenorphine for opioid dependence in a general medical office – called Office Based Opioid Treatment Programs (OBOT). The physician must complete an 8-hour online course to gain the authority to prescribe buprenorphine for opioid dependence. DATA 2000 enables physicians to treat patients for opioid dependence in their office with Schedules III, IV and V narcotic controlled substances specifically approved by the FDA for addiction treatment. Physicians must demonstrate qualifications as defined in the DATA (Public Law 106-310, Titles XXXV, Sections 3501 and 3502) and obtain a waiver from the Substance Abuse and Mental Health Services Administration.

DATA 2000 restricts the number of patients a physician may treat with buprenorphine for opioid dependence. In the first year of obtaining the X-DEA license and waiver a physician may only treat up to 30 patients. In the second year, the physician may request additional authority to treat 100 patients. No physician operating in an office-based treatment setting may prescribe buprenorphine for opioid dependence to more the 100 patients at the same time.

In Vermont nearly 200 physicians prescribe buprenorphine – most prescribe to fewer than 20 Medicaid beneficiaries, some to 20-40, and a smaller number of physicians prescribe to between 50-100 patients. The common practice specialties include family medicine, internal medicine, OB/GYN, and psychiatry. Vermont seeks to build a systematic network of health home services around these highly diffused providers.

Hub & Spoke

The comprehensive treatment system Vermont is proposing to implement for Medicaid patients receiving medication assisted therapy for opioid dependence builds on the strengths of the specialty methadone OTPs, the physicians who prescribe buprenorphine in office-based (OBOT) settings, and the local *Blueprint* Community Health Teams and Medical Home infrastructure. This integrated treatment model is called the "*Hub and Spoke"* initiative. *Hubs* are *Designated Providers* as described in Section 1945(h)(5). *Hubs* build upon the existing OTP system by developing into regional specialty treatment centers that provide the six (6) Health Home services in addition to the traditional comprehensive methadone addictions treatment they currently provide. *Hubs* serve as the regional consultants and subject matter experts on opioid dependence and treatment. As the OTPs, *Hubs* are the only entities

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providing methadone treatment. In addition, *Hubs* provide care to a subset of clinically complex buprenorphine patients and also provide support for tapering off MAT, when indicated.

A *Spoke* is a *Team of Health Care Professionals* providing ongoing care for patients receiving buprenorphine. The *Spoke* system serves MAT patients who do not require methadone and are not as clinically complex as *Hub* patients receiving buprenorphine. A *Spoke* is comprised of a *Designated Provider* who is the prescribing OBOT physician and the *team of collaborating health and addictions professionals* who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. *Spokes* 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 *Spoke*. *These staff resources are the primary providers of the six Health Home services and enhanced funding is sought for 100% of their cost.*

Under the *Hub and Spoke* Health Home approach, each patient undergoing MAT will have an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing Community Health Teams (CHTs), and access to *Hub* or *Spoke* nurses and clinicians. Providers of opioid addiction treatment will have access to resources and support to effectively care for current patients, as well as to support additional care of new patients.

Hubs

Vermont proposes to enhance the methadone treatment programs (OTPs) by adding new staff to provide the six Health Home Services and to offer consultation support on specialized addictions treatment to the network of buprenorphine prescribers. The newly enhanced programs, called *Hubs* will provide methadone treatment, health home services, and limited buprenorphine treatment for a subset of more clinically complex patients. Plans are underway to expand upon the current OTPs to create five (5) regional specialty addictions treatment center *Hubs* in Northwest, Southwest, Southeast, Central and Northeast Vermont. *Hubs* must demonstrate the capacity to either provide directly or to organize comprehensive care and continuity of services over time that will replace episodic care based exclusively on addictions illness with coordinated care for all acute, chronic, and/or preventative conditions in collaboration with primary care providers and CHTs. Enhanced *Hub* Health Home staffing will dedicate slightly more than six FTE clinical staff for every 400 MAT patients (6 FTE for 400 pts).

Spokes

Vermont proposes to enhance the OBOT buprenorphine services by adding new staff to support the MD prescribers and provide the six Health Home Services. The new staff will be hired or subcontracted by the Blueprint lead administrative agent and will be functionally and administratively part of the local

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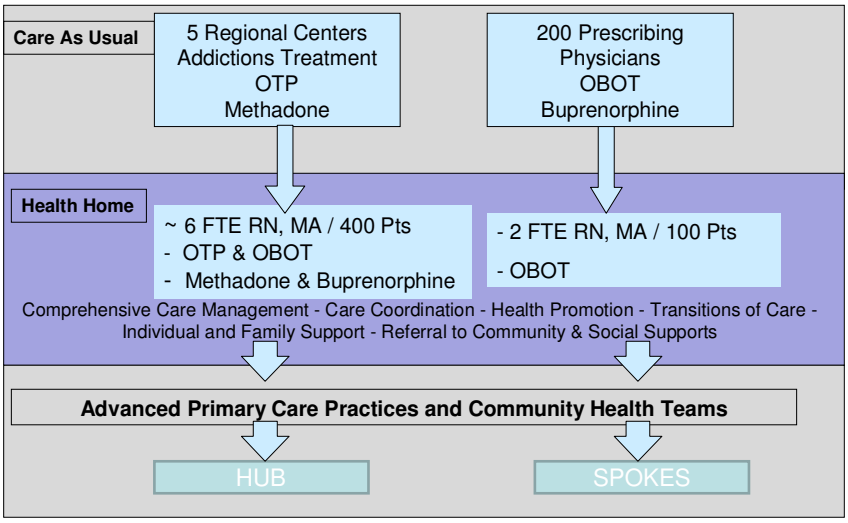
Community Health Team. The combination of the prescribing MD and the new staff are called *Spokes*. The enhanced staffing is modeled at one full time equivalent (FTE) nurse and FTE licensed, clinician case manager for every 100 MAT patients. The *Spoke* Health Home staff (the nurse and clinician case manager) will be deployed directly into the MD practices to provide health home services, monitor adherence to treatment, and provide the six health home services including coordinating access to recovery supports and community services, health promotion, counseling, contingency management, care coordination and case management services. As most MD practices prescribe to fewer than 100 buprenorphine patients, the new *Spoke* staff will be shared across multiple practices in a similar fashion as the community health team staff are shared by participating medical homes.

Vermont Medicaid Health Homes Vision

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

" Hub & Spoke" Health Home for Opiate Dependence



Payment Methodology

Both the *Hubs* and *Spokes* will combine services currently reimbursed in Vermont's State Medicaid Plan with the new Health Home services. Under the terms of the 2703 State Plan Amendment, Vermont will seek 90-10 matching funds **only** for the *Hub* & *Spoke* costs directly linked to providing the Health Home services. The remaining services will be matched at the current state match rate.

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There will be two payment streams: one for *Hubs* and one for *Spokes*.

Hub Health Home Cost Methodology

The methodology to develop cost for the Hub health home enhancements is based on the costs to employ key health professionals (salary and fringe benefits) who will provide the health home services. The staffing enhancements for the Health Homes were developed in collaboration with current methadone providers (OTP) and are based on a model of 400 MAT patients served at a regional treatment center. The resulting Health Home enhanced staffing model represents, on average, a 30% increase from Vermont's current statewide average rate for methadone treatment as usual (statewide average rate of $4,553 per patient per year). The Health Home *Hub* staff and annual costs for 400 patients are shown below.

HUB Health Home Scale Model: (400 patients)	
Staffing	**Annual FTE costs**
Health Home Director (1FTE)	$65,000
Health Home Nurse (1FTE)	$85,000
MA Clinician Case Managers (2 FTEs)	$110,000
MD (15% FTE)	$ 21,000
Psychiatry (20% FTE)	$28,000
MA Addictions Counselors (30% 6 FTEs)	$99,000
Total Salary	**$408,000**
Fringe benefits @ 35% of salary	$142,800
Total Hub Health Home Staffing Costs	**$550,800**
Annual Health Home per patient cost	**$1,377**
Per Patient Per Month	**$114.75**

The Health Home staffing enhancement to the *Hub* OTP programs is $1,377 per patient per year. The Health Home services combined with the traditional OTP results in an average annual statewide rate of $5,930 per patient.

OTP Statewide Average Methadone Rate	**Health Home Staff Enhancement Statewide Average**	***Hub* Rate (Health Home + OTP Statewide Average)**
$4,553/year	$1,377/year	$5,930/year
$379.42/month	$114.75/month	$494.17/month

Hub Payments

The Hub payment is a monthly, bundled rate per patient. The *Hub* provider initiates a claim for the monthly rate, using an existing procedure code 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:

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- ✓ One face-to-face typical treatment service encounter (e.g., nursing or physician assessment, individual or group counseling, observed dosing); and
- ✓ One Health Home service (comprehensive care management, care coordination, health promotion, transitions of care, individual and family support, referral to community services).

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 average rate of $379.42 per month.

Under the terms of the 2703 State Plan Amendment, Vermont will seek 90-10 matching funds for *only* the Health Home Enhancements.

Vermont's single state Methadone Treatment Authority is the Division of Alcohol and Drug Abuse Programs (ADAP) of the Vermont Department of Health. ADAP executes performance-based contracts with the OTP providers. These contracts are revised to reflect the Health Home services and increased coordination with the Blueprint for Health participating primary care practices and the local Community Health Teams. The monthly payment process for the *Hubs* is administered by the Department of Vermont Health Access as described above.

Spoke Health Home Cost Methodology

Payment for *Spoke* Health Home services will be based on the costs to deploy 1 FTE Nurse and 1 FTE licensed clinician case manager for every 100 patients across multiple providers and their offices. The costs are modeled for 100 buprenorphine patients as follows:

Spoke Staffing Scale Model: (100 patients)		
Staffing	**Annual FTE cost**	
1 FTE RN Care Manager	$85,000	$85,000
1 FTE Clinician Case Manager	$55,000	$55,000
	Total Annual Salary	**$140,000**
	35% fringe benefits	$49,000
	Total Annual Personnel Costs	**$189,000**
	Operating	**$ 7,500**
	Total Estimated Annual Costs per 100 patients	**$196,500 ($1,965 per patient) $163.75 PPPM**

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Spoke Payments

Spoke 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. *Spoke* staff resources will be 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 Services Area as part of the existing Medicaid Community Health Team payment. The six key Health Home services will be provided by the *Spoke* nurse and licensed clinician case managers acting as an extension of the Blueprint Community Health Teams.

Spoke physicians will continue to bill fee-for-service for all typical treatment services currently reimbursed by the Department of Vermont Health Access (DVHA).

Spoke Provider	Payment Mechanism	Purpose of Payment
Physician	Fee-for-Service payment to physician, under current Medicaid State Plan	Buprenorphine treatment
Nurse + Clinician Case Manager	Capacity payment to Blueprint administrative entity, based on numbers of unique Medicaid beneficiaries receiving buprenorphine	Care management, care coordination, transitions of care, health promotion, individual and family support, and referral to community services

Payment Process

The monthly *Spoke* payment amount for each HSA is revised on a quarterly basis based on the average monthly number of unique patients for whom Medicaid paid a pharmacy claim for buprenorphine, during the most recent three-month period (see below for more details on Caseload Determination).

The Blueprint provides the revised monthly *Spoke* payment amount for each HSA to DVHA's fiscal agent at the beginning of each quarter for processing. The *Spoke* payments are added to DVHA's monthly payment for the Blueprint Community Health Teams, resulting in one combined monthly payment by DVHA to each Blueprint HSA administrative agent for core CHT and *Spoke* services.

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Caseload Determination

Each month, the DVHA clinical unit creates a report reflecting the number of unique Medicaid patients with at least one paid buprenorphine (i.e. Subutex®, Suboxone®) claim, by prescribing physician. The HSA's caseload is calculated based on the average number of unique patients with a paid pharmacy claim in the most recent three consecutive months for all prescribers in the HSA. For payment purposes, the average monthly caseload for each HSA is rounded up to the next 25 beneficiaries. Rounding builds *Spoke* staffing in increments roughly equivalent to a 50% FTE position and helps assure adequate staffing for caseload growth in a quarter. This rounded, average monthly caseload number is then multiplied by the per patient per month Spoke cost to arrive at the monthly Spoke payment amount.

The Blueprint maintains a roster of local buprenorphine prescribers in each Health Service Area. The *Spoke* staff resources are deployed by the Blueprint administrative agent as part of the Community Health Teams in each HSA to the prescribing practices proportionate to the number of patients served by each practice.

Prospective Caseload Adjustments

A Blueprint Health Service Area may request a prospective adjustment for an upcoming quarter if:

- ✓ a current physician plans to enlarge his/her buprenorphine practice by at least 25 patients;
- ✓ a new buprenorphine practice of at least 25 patients is planned.

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Vermont Health Home Draft SPA – Informal Questions from CMS 11-19-12

Payment Methodology

1. Please note that public notice will be required to conform to 42 CFR 447.205.

   Public Notice will be provided in conformance with 42 CFR 447.208

2. Please describe the rate methodology used to calculate the PMPM. Please include descriptions of cost considerations or salary information used in the calculation.

The costs (rate methodology) for Spoke capacity payments and Hub PMPM payments for Health Home Enhancements are as follows:

HUB Health Home Scale Model: (400 patients)	
Staffing	**Annual FTE costs**
Health Home Director (1FTE)	$65,000
Health Home Nurse (1FTE)	$85,000
MA Clinician Case Managers (2 FTEs)	$110,000
MD (15% FTE)	$ 21,000
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Spoke Staffing Scale Model: (100 patients)		
Staffing	**Annual FTE cost**	
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35% fringe benefits		$49,000
Total Annual Personnel Costs		**$189,000**
Operating		**$ 7,500**
Total Estimated Annual Costs per 100 patients		**$196,500 ($1,965 per patient) $163.75 PPPM**

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The salary rates were based on published pay scales for the Northeastern United States based on specific staff credentials for individuals with mid-career experience levels.

3. Regulations at 42 CFR 430.10 require that the State plan be a comprehensive written statement. As currently described, CMS is unable to determine from the proposed reimbursement language the amount that providers would be reimbursed for health home activities through the single statewide rate. Please include the following information in the reimbursement description:
    a. the reimbursable unit of service,

The reimbursable unit of service is the provision of at least one health home service per month provided by the Health Home staff at the regional Hubs or Blueprint Community Health Team Spoke staff. There are essentially two rates: one for the Hub and one for the Spokes.

    b. variation in payment based on team composition or caseload cost assumptions,

The Vermont SPA proposes two payment streams (one each for Hubs and Spokes) based on the staffing compositions described above.

The monthly Spoke capacity payment is based on the costs to deploy 2FTE clinical staff for every 100 patients receiving buprenorphine treatment. The monthly Spoke capacity payment rate is based on $163.75 per patient and is calculated by rounding up to the nearest increment of 25 to assure predictable and adequate staffing capacity across the Health Service Area to provide the health home services.

The monthly Hub payment is based on the costs of the Health Home staffing enhancements to Vermont's OTP programs and is a PMPM payment of $114.75.

    c. the actual fee paid to providers based on the cost assumptions and billed per unit of reimbursable activity.

Please see "b." above and the overview of costs and payment methodology on pages 6-9 of this document.

    d. If the State chooses not to include the fee paid as a case rate, please include the following language in the plan:

"The agency's rates were set as of <u>(insert date here)</u> and are effective for services on or after that date. All rates are published (<u>ex.</u> <u>on the agency's website</u>). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers."

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Vermont will include this language in the State Plan Amendment.

4. Are the hourly assumptions included in the PMPM rate calculation for each individual for every month? Does the State anticipate varied level of service per month?

Vermont does anticipate that individual beneficiaries will have varied levels of services each month based on their individual plan of care. Vermont did not use hourly cost assumptions; rather we used projected annual salary and fringe benefits costs for health home enhanced staffing based on models of 400 patients for Hubs and 100 patients for Spokes.

5. Are the payments tiered based on individual needs or the make-up of the health home provider team?

The payments are based on the annual salary and fringe benefits costs for the Health Home teams at the Hubs and at the Spokes. We developed scale models of 400 patients at the Hubs and 100 patients at the Spokes. Please refer to question #2 above.

   a. The Vermont proposal includes payments for the Hub providers, Spoke providers, and the physicians that provide the pharmaceuticals related to the addiction treatment.

Vermont proposes payments to Hub providers for the enhanced Health Home Services and to Blueprint administrative agents to employ and deploy the health home Spoke staff in physician practices. Vermont does not seek enhanced match for physician services.

   Please include a description of the composition of the rate in relation to the providers that will be providing the services.

Please refer to the response to question # 2 above and the description of the payments and costs provided on pages 6-9 of this document.

   b. Will providers be paid only during months in which they provide the services?

Hub providers may make a claim for enhanced health home payments based on the provision of at least one Health Home service that month. The Spoke capacity payments will be recalculated each quarter to reflect the most recent average monthly number of unique Medicaid beneficiaries served by the provider each month. The provision of at least one Health Home service each month will be documented within the EMR and/or central clinical registry.

   c. Will physicians be reimbursed under the physician benefit? Or will they be reimbursed as members of the health home team? If reimbursed as a member of the health home team, why is their payment not considered as part of the PMPM? Please note that

payments outside of the payment for health home services will not be reimbursed at the 90% match rate.

The physicians providing buprenorphine treatment in the OBOT programs will be reimbursed under the current state plan physician benefits at the regular state match rate. The Spoke Health Home staff (1 FTE nurse and 1 FTE licensed clinician case manager) costs will be supported through the monthly capacity payment at the 90-10 match rate.

Vermont seeks 90-10 matching funds only on the Health Home staff at the Hubs and Spokes.

6. Please clarify whether the composition of the health home team will include public and/or private providers. Will the case rates be the same regardless of whether a team is composed of public or private employees? Please verify that the payment is not only limited to public employees but that any qualified provider may receive payment for health home services.

Vermont confirms that only private employees will provide and receive payment for health home services.

7. Please verify in the SPA that providers are expected to document and bill based on a minimum provision of health home activities per enrolled member per month (i.e. at least one documented activity per individual). Note that health home billable activities do not necessarily require a face-to-face encounter based on State determined coverable activities.

Vermont confirms that health home payments to Hubs and Spokes will be based on at least one health home service per enrolled member per month. The services will be documented in the practice and program EMRs.

8. How frequently will the State review the rate methodology to determine: the cost assumptions, the enrollment figures, the anticipated level of services delivery and the team compositions and projected service hours were correct? Please describe this process in the plan.

Vermont will review enrollment figures for both Hubs and Spokes quarterly. The Spoke staffing numbers will be reported quarterly with the Community Health Team staffing rosters. The level of services delivery will be assessed monthly. For Hubs this will be in the form of a claim for the enhanced health home rate, and for Spokes based on the average of unique beneficiaries served each month for three months.

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9. Will providers submit a claim to the MMIS to receive service payments? If providers are not required to submit a claim, will the State Medicaid agency enter claims into the MMIS on behalf of the provider?

The Hub providers will submit a monthly claim to the MMIS to receive payments for methadone care as usual or with a modifier for the Health Home enhancements. The Spoke payments will be prospective, monthly capacity payments as part of the Blueprint Community Health Team payments based on the number of unique beneficiaries served each month over the most recent past three month period.

10. Is appropriate oversight in place so that the payments could hold-up to an audit process?

The Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) oversees performance-based contracts with reporting requirements for the Hubs. Services are documented in the Hub electronic medical records (EMR). ADAP also conducts site reviews with the Hubs. The Spoke providers will document services in the physician practice EMRs, and DVHA reviews reports for pharmacy and other physician claims.

11. Does the State intend to review the rates to ensure that the rate-setting assumptions were accurate?

Rates for Health Home services will be reviewed annually in the general rate review process employed by DVHA for Medicaid services.

12. How frequently will the rate review occur?

Annually.

13. What factors will the State review in order to understand that the rates are economic and efficient?

The state will review the salary rates and fringe benefit rates and compare these for comparable disciplines in the Northeastern region of the United States.

14. Please clarify if the State intends to pay the Hubs, Spokes and Physicians in separate payment streams or within one payment stream.

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The state proposes two payment streams, one for Hubs and one for Spokes. The cost and payment methodology for both is described in the answers to questions #2-#7 and #9, and also in the descriptive narrative included in this response.

15. If they are paid in separate payment streams, please describe the two distinct sets of activities the Hubs, Spokes and Physicians will be required to provide. How will it impact the beneficiary's experience?

The same health home services are provided by the Health Home staff at the Hubs and Spokes. They are organized into separate provider systems consistent with the federal regulations governing OTP and OBOT services. Beneficiaries receiving methadone or buprenorphine who agree to health home services in their individual plans of care will experience increased attention to coordination of their care with other providers (primary care for instance), increased focus on health promotion activities, referrals to community services and direct support in managing opioid dependence.

16. You indicate that specified percentages of the per member per month will go to the Hubs, Spokes and Physicians. How did the State determine those percentages?

The state consulted providers about the proposed Health Home Services and the staffing complement required to provide these (please see the staffing plan provided in response to question #2). Vermont is seeking 90-10 match only on those staff health home enhancements. Vermont is seeking 90-10 match on the cost for the nurse and clinician case manager hired as part of the Blueprint Community Health teams in the Spokes.

17. The Health Home draft SPA submitted by Vermont included a statement that says: "Funds from this SPA will support the hiring of *Spoke* nurse care managers and clinician case managers." It is acceptable for a provider to use Medicaid payments to hire new employees or expand their practices, but they must first provide a Medicaid service. The language in the draft SPA seems to imply that there are no Spoke providers currently prepared to provide services and that the Spoke payments will be used to hire RNs prior to the actual provision of services. If this is the case, the 90% FFP will not be available if the payments are made without the services being provided.

Vermont will seek 90% FFP only on health home services provided. The Blueprint administrative agents and Hub provider in the region to be covered in this SPA have been actively recruiting and training Spoke and Hub staff throughout this fall.

18. The Health Home draft SPA also states under Spoke payments: "Payments will be made to selected administrative entities with defined geographic areas working in partnership with

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Blueprint Community Health Teams (CHTs). The monthly Spoke payment amount will be revised on a quarterly basis by the *Blueprint* Assistant Director." Payments made to an administrative services organization are not able to be matched at 90% federal funds. Also, please explain why the Assistant Director of *Blueprint* is able to adjust payments related to the Spoke providers. This language is not comprehensive, and the ability to adjust payments outside of the State plan is not comprehensive. The language in the plan would have to be crafted to thoroughly articulate how the PMPMs are calculated and payments could not be adjusted outside of the methodology described.

The Blueprint is administratively organized into 14 geographically distinct health service areas with a single lead administrative agent in each area. The lead administrative agents are health care organizations with strong fiduciary and administrative capabilities, are Medicaid enrolled providers, and are recognized health care leaders in their communities. They are hospitals, federally qualified health centers, and/or community mental health centers. They are not administrative services organizations.

The quarterly adjustment for Spoke capacity payments is reviewed by the Blueprint Assistant Director based on the most recent three month average of Medicaid beneficiaries seen for buprenorphine treatment.

Vermont appreciates guidance on crafting comprehensive language in the state plan amendment.

19. The Hubs payment section indicates that the Hub providers will provide Health Home services in addition to other services and that the Health Home services will be matched at the enhanced rate while the other services will be matched at the normal State plan match rate. What are these other services and are they claimed under a different State plan authority? Please explain.

The current state plan includes the authority to provide methadone consistent with the federal regulations for Opioid Treatment Programs (OTP). This includes assessment for opioid dependence, development of a plan of care to manage addiction, counseling services, observed dosing, and contingency management.

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the State plan for such service.

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1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   No portion of Medicaid payments, including the Federal and State share, are returned to the State, local government entity, or any other intermediary organization.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Note that, if the appropriation is not to the Medicaid agency, the source of the State share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;

   (ii) the operational nature of the entity (state, county, city, other);

   (iii) the total amounts transferred or certified by each entity;

   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,

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(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

The State share funds were appropriated by the Vermont legislature to the Medicaid agency.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   No supplemental or enhanced payments are proposed.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-State government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

   Since the services that will be paid for in this state plan amendment are not clinic or outpatient hospital services, this question does not apply.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   No, there are no public providers impacted by this SPA.