# PROGRAM OVERVIEW

## 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 chronic condition of opioid addiction among Vermont's Medicaid population; these individuals also are at risk of developing additional chronic conditions including alcohol abuse, depression, and anxiety. The Health Home initiative focuses specifically on enhancing the provision of Medication Assisted Therapy (MAT) for individuals with opioid addiction. MAT, such as methadone and buprenorphine in combination with counseling, is recognized as the most effective treatment for opioid addiction.

The Health Home initiative will be implemented state-wide in three phases by region through sequential State Plan Amendments beginning January 1, 2013, in the Northwest region of the State. Phase Two begins July 1, 2013 in Central and Southeastern Vermont. Phase 3 begins January 1, 2014 in the balance of the state.

Health Homes for Vermonters with opioid addiction have two related service provider configurations: "designated providers" called *Hubs,* and "teams of health care professionals" called *Spokes*. New clinical staff is added to both the *Hubs* and the *Spokes* specifically to provide the six Health Home services.

The *Hubs* are regional specialty addictions treatment centers regulated as Opioid Treatment Programs (OTP) and are operated by community behavioral health agencies. Vermont will develop five *Hubs* to provide regional, specialty Health Home and MAT services. The *Spokes* are teams of health care professionals led by physicians who prescribe buprenorphine in practices regulated as Office-Based Opioid Treatment Programs (OBOT). Vermont will embed teams of health care professionals within each OBOT physician's practice to provide the Health Home services. Payment methodologies, one for *Hubs* and a different one for *Spokes,* are built upon the existing payment infrastructure of their service provider configurations.

## CHRONIC CONDITION OF OPIOID ADDICTION

Substance addiction includes 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) and withdrawal (a set of physiological symptoms) for most people. However, in addition to tolerance and withdrawal, individuals with addiction also exhibit compulsive drug taking due to intense feelings of "craving" for the substance. Opioid addiction

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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.

Opioid addiction is a chronic, relapsing illness diagnosed by a physician based on the presence of at least three of seven criteria over a 12-month period. Medication Assisted Therapy (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 addiction are methadone and buprenorphine. Individuals with opioid addiction may remain on MAT indefinitely, akin to insulin use among people with diabetes.

## BUILDING BLOCKS FOR *HUB* AND *SPOKE* HEALTH HOMES

### *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 extends 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 the 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 Demonstration 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 $8.2 billion -- $650 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 flexible in the way it uses its Medicaid resources, enabling Vermont to fund creative alternatives to traditional Medicaid services that improve quality of care and control costs. Examples of this flexibility include the following: new payment mechanisms (e.g., case rates, capitation, combined funding streams, capacity-based payments)

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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* (Blueprint) 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, Vermont's primary care practices are supported to meet the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Standards. In addition, primary care practices in collaboration with local community partners plan and develop *Community Health Teams* (CHT) that provide multidisciplinary support for PCMHs and their patients. The teams are scaled in size based on the number of patients served by participating practices within a geographic area called a Health Service Area (HSA) at a ratio of five FTE for every 20,000 patients served. CHT members are functionally integrated with the practices in proportion to the number of patients served by each practice. The CHTs are a core resource available to the patients and the practices free of barriers (e.g., co-pays, fees) because they are funded by Vermont's large health insurance payers; BCBSVT, Cigna, MVP, Vermont's large self-insured plans, and Medicaid and Medicare all participate (Vermont is part of the national Multi-Payer Advanced Primary Care Practice Demonstration). This support and the Blueprint's statewide implementation make Vermont's PCMH initiative unique in the nation.

<u>Blueprint Payment Reforms</u>
Leaving the existing provider fee-for-service payments untouched, the Blueprint adds two key payment reforms:

1. A *Per Member Per Month* (*PMPM*) *Quality Payment* made by all payers to primary care providers with a qualifying score on the NCQA PCMH standards. Because the *PMPM Quality Payment* amount increases with higher scores, this payment reform incents improvements in quality of care.

2. A C*apacity Payment* to support the salaries and expenses of the Community Health Team (CHT) staff. This payment is scaled at $350,000 for every 20,000 patients, providing approximately five full time equivalent (FTE) staff for every 20,000 patients.

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Vermont's commercial and public payers all make the *PMPM Quality Payments* to qualifying primary care providers and share equally in the *Capacity Payments* that support the cost of the CHTs. The Medicaid portion of the *Capacity Payment* is made monthly to a *lead administrative agent* in each of Vermont's 14 *Health Service Areas (HSA)*. The *Capacity Payment* is based on a quarterly calculation of attributed patients to the participating primary care practices within an HSA.

Blueprint Community Health Teams and the Vermont Chronic Care Initiative

The *Community Health Teams* (CHT) are designed locally by participating primary care providers along with 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 *lead administrative agents* for each HSA and are deployed to work in the participating primary care practices. The CHTs work with any patient within these practices, including Medicaid beneficiaries. However, the highest risk and highest cost Medicaid beneficiaries are referred to the Vermont Chronic Care Initiative (VCCI) for care management. VCCI nurses and social workers are State of Vermont employees located throughout the state; they are not hired or overseen by the administrative agents that oversee the CHTs. VCCI provides short term (typically three months) intensive case management to this select population. Once patients are stabilized, they are referred back to the CHTs for ongoing support services.

Currently, there are 116 primary care practices independently recognized as patient-centered medical homes by the NCQA that are participating in the Vermont Blueprint for Health. Collectively these practices serve 460,000 Vermonters. Statewide, 114 FTE CHT staff work in the primary care practices, transforming the scope of primary care. Vermont will meet its legislative mandate to include all willing primary care providers in the Blueprint payment and practice reforms by October 2013.

Blueprint Lead Administrative Agents

The Blueprint is administratively organized into 14 geographically distinct Health Service Areas (HSA) with a single *lead administrative agent* in each area. The role of the *administrative agent* is to lead and convene the work involved with creating an integrated health system. These entities perform the following functions:

- Administer the *Capacity Payments* that support the CHTs and the provider *PMPM Quality Payments*;
- Plan and operate the CHTs (hire, supervise or subcontract for CHT staff);
- Recruit new primary care providers to the Blueprint and support their work to become NCQA recognized as PCMHs;

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- Convene working teams that 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;
- Convene and support learning health system activities, including development and dissemination of key performance reports, learning collaboratives, and training events, and;
- Plan and implement new initiatives, including *Hub and Spoke* Health Homes for Vermonters with opioid addiction.

The Department of Vermont Health Access/Blueprint has performance-based contracts with each *lead administrative agent* to provide these administrative services. The *administrative agents* are health care organizations that are enrolled Medicaid providers, have strong fiduciary and administrative capabilities, and are recognized health care leaders in their communities. They include hospitals, federally qualified health centers, and/or community mental health centers, and do not provide Health Home services.

***Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT)***

Methadone and buprenorphine are the primary pharmacological treatments for opioid addiction. Although they 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 methadone and buprenorphine.

Methadone treatment for opioid addiction is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTP), of which Vermont currently has only four. OTPs adhere to specific regulations for providing comprehensive methadone addictions treatment. Before 2000, Medication Assisted Therapy (MAT) for opioid addiction could only be provided in these specialty OTPs. The *Drug Addiction Treatment Act of 2000* (DATA 2000), under section 3502 of the Children's Health Act of 2000 (HR 4365), significantly changed medical treatment for opioid addiction by allowing physicians to prescribe buprenorphine for MAT in a general medical office, referred to as Office-Based Opioid Treatment (OBOT).

A physician must complete a required 8-hour online course, obtain an X-DEA license by demonstrating qualifications as defined in the DATA 2000 (Public Law 106-310, Titles XXXV, Sections 3501 and 3502), and obtain a waiver from the Substance Abuse and Mental Health Services Administration in order to provide MAT for opioid addiction in an OBOT. DATA 2000 enables office-based physicians to treat patients for opioid addiction with Schedules III, IV and V narcotic controlled substances specifically approved by the FDA for addiction treatment.

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DATA 2000 restricts the number of patients a physician may treat with buprenorphine for opioid addiction. 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 at the same time, which is the maximum number of concurrent patients allowed.

During the period May through July, 2013, 115 physicians were prescribing buprenorphine for opioid addiction to Medicaid beneficiaries in Vermont; 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's *Hub and Spoke* Health Home initiative will build a systematic network of Health Home services to support these highly diffused providers and better integrate the services provided by the OTPs and OBOTs.

## HEALTH HOME *HUB AND SPOKE* TREATMENT SYSTEM FOR OPIOID ADDICTION

### *Overview*

The comprehensive, integrated treatment system Vermont is implementing for Medicaid patients receiving Medication Assisted Therapy (MAT) for opioid addiction, called the *Hub and Spoke* initiative, builds on the strengths of the existing provider infrastructure:

- Specialty methadone Opioid Treatment Programs (OTPs);
- Physicians who prescribe buprenorphine in Office-Based Opioid Treatment (OBOT) settings, and;
- Local *Blueprint* Community Health Team (CHT) and Patient-Centered Medical Homes (PCMH).

Under the *Hub and Spoke* Health Home approach, each patient undergoing MAT will have an established physician-led PCMH, a single MAT prescriber, a pharmacy home, access to Community Health Team (CHT) primary care supports, and access to *Hub* or *Spoke* nurses and clinicians with expertise in opioid addiction treatment. Providers of opioid addiction treatment will have access to new staff resources and support to effectively care for current patients, as well as to support additional care of new patients.

### *Hubs*

*Hubs* are *Designated Providers* as described in Section 1945(h)(5). Plans are underway to expand upon the current OTPs to create five (5) regional specialty addictions treatment center

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*Hubs* in Northwest, Southwest, Southeast, Central and Northeast Vermont. *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 addiction and treatment. As the OTPs, *Hubs* are the only entities 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. *Hubs* must demonstrate the capacity to either provide directly or to organize comprehensive care and continuity of services over time to replace episodic care based exclusively on addictions illness. Instead, they will provide coordinated care for all acute, chronic, and/or preventative conditions in collaboration with primary care providers and CHTs. *Hub* funding will be supplemented to augment staffing in order to add the Health Home services to the traditional addictions treatment the *Hubs* already provide. Enhanced *Hub* Health Home staffing will dedicate slightly more than six FTE clinical staff for every 400 MAT patients. *Enhanced funding is sought for a percentage of these costs.*

***Spokes***

A *Spoke* is a *Team of Health Care Professionals* providing ongoing care for patients receiving buprenorphine in OBOTs. The *Spoke* system provides MAT with buprenorphine to patients who are less clinically complex than the patients receiving buprenorphine in the *Hub*s. 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. *Spoke* Health Home services will be provided to Medicaid beneficiaries by registered nurse care managers and licensed clinician case managers with expertise in opioid addiction treatment who are added administratively to existing CHTs. The enhanced staffing is modeled at one FTE nurse and one FTE licensed clinician case manager for every 100 MAT patients. *Since these staff resources are added specifically to provide the six Health Home services, enhanced funding is sought for 100% of their cost.*

The new staff will be hired or subcontracted by the Blueprint *lead administrative agent* and will be functionally and administratively part of the local Community Health Team (CHT). As with other CHT staff, the *Spoke* Health Home nurses and clinician case managers will be deployed directly into the OBOT physician practices to provide the six Health Home services. As most physician practices prescribe to fewer than 100 buprenorphine patients, the new *Spoke* staff will be shared across multiple practices in the same way current CHT staff is shared among participating PCMHs.

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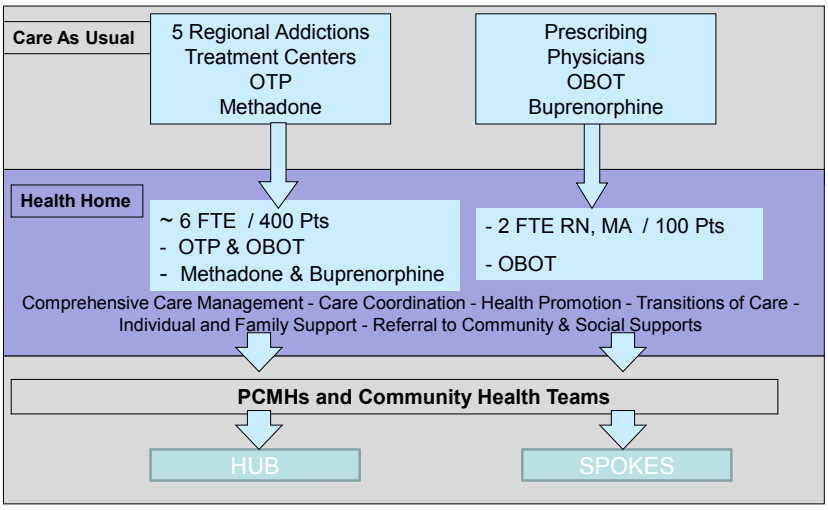
## *Vermont Medicaid Health Homes Vision*

VERMONT
Department of Vermont Health Access

VERMONT Blueprint for Health
Smart choices. Powerful tools.

" Hub & Spoke" Health Home for Opioid Addiction




## HUB AND SPOKE HEALTH HOME SERVICES

The *Hub and Spoke* Health Home initiative adds new health care staff to both the *Hub designated providers* and the *Spoke teams of health care professionals* to provide Health Home services for Vermonters with opioid addiction, and links both types of addictions treatment systems with the Blueprint primary care PCMH and CHT infrastructure to functionally integrate care across the health and addictions treatment systems. The Health Home staff at the *designated Hub* behavioral health agencies and the *Spoke teams of health care professionals* will assure integrated and holistic care across the health, human services, long term, recovery, and community support systems of care through the provision of Health Home services.

### *Comprehensive Care Management*

Comprehensive care management includes activities undertaken to identify patients for MAT, conduct initial assessments, formulate individual plans of care, and manage patient care across the health, substance abuse and mental health, social services and long term systems of care.

Identification: MAT patients are identified via a variety of methods, including but not limited to:

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- Provider referrals
- Prior authorization for buprenorphine claims and utilization data
- Vermont Chronic Care Initiative

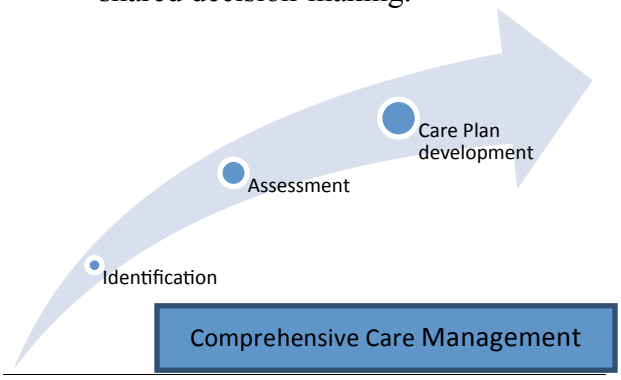
Eligibility Determination: Only a licensed physician can make a clinical diagnosis of opioid addiction and ultimately decide upon the choice of medications (methadone or buprenorphine). Physicians are responsible for documenting that the patient:

- Meets the DSM-IV diagnostic criteria for opioid addiction;
- Is screened as appropriate for MAT.

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) develops decision support tools to aid in the process of determining whether a patient is more appropriate for treatment provided in a *Hub* or a *Spoke*.

Assessment and Care Plan Development: All eligible beneficiaries receive a comprehensive biopsychosocial assessment (e.g., addiction severity index, PHQ, American Society of Addiction Medicine placement criteria) of their health care needs upon entry into either a *Hub* or *Spoke*. Based upon the initial assessment, an individualized plan of care is developed.

- The physicians (*Hub* Medical Director, *Hub* Psychiatrist, *Spoke* buprenorphine prescriber) are responsible for the initial diagnosis and determination of clinical needs.
- The RNs and licensed clinician case managers in both *Hubs* and *Spokes* are engaged from the beginning to assure the patient's medical and non-medical needs are coordinated (social and personal health needs required to embrace recovery).
- Patients and families are actively engaged in developing the care plan and participate in shared decision-making.



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## *Care Coordination and Referral to Community and Support Services*

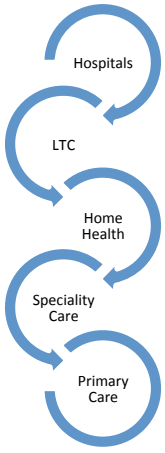
Once an individualized plan of care is developed, the Health Home RNs and licensed clinician case managers are primarily responsible for monitoring its implementation (with patient engagement) through appropriate coordination, referrals, and follow up of services and supports across treatment and human services providers.

- The RNs monitor medical treatment progress, including medication adherence. Physicians provide care coordination services related to prescribed medication (medication management).
- The RNs and licensed clinician case managers play a key role in assuring continued patient participation in the individualized care plans.
- The RNs and licensed clinician case managers assure appropriate linkages are made with the Vermont's Agency of Human Services field directors for social services (e.g., child welfare, housing, corrections, and employment) and with the existing Community Health Teams, which have established relationships with the primary care community.
- The RNs and licensed clinician case managers develop and maintain up to date information about resources beyond those covered in the Medicaid service package, including community and peer based programs.

## *Care Transitions*

Care transitions focus on streamlining the movement of patients from one treatment setting to another, between levels of care, and between health, specialty mental health and substance abuse, and long term care providers.

- RNs and licensed clinician case managers are primarily responsible for developing collaborative relationships among health home providers and hospital ERs, discharge planners, long term care services and support providers, primary care providers, specialty mental health and substance abuse treatment services.



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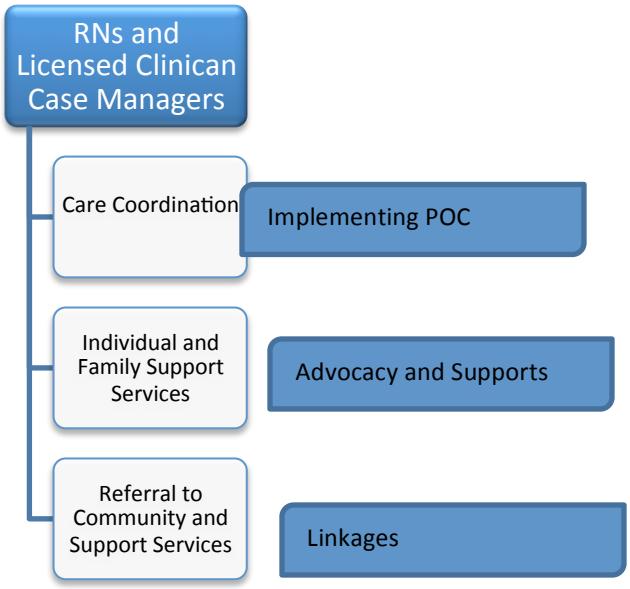
### *Individual and Family Supports*

The RNs and licensed clinician case managers are primarily responsible for supporting the resilience of patients and their families through various activities, including but not limited to: advocacy, assessments of individual family strengths and needs, education about the Agency of Human Services resource systems, and facilitating participation in the ongoing development and revision of care plans.




### *Health Promotion*

Health promotion activities are part of every plan of care and include activities that promote patient activation and empowerment for shared decision-making in treatment, healthy behaviors, and self-management of health, mental health, and substance abuse conditions. Depending on the needs of the individual, the patient may elect to engage in one-on-one activities or group educational health promotion programs.

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- Health promotion activities may be conducted by any member of the health home team but the RNs and licensed clinician case managers are the primary practitioners responsible for coordinating activities.
- Physicians will need to order/prescribe new interventions (e.g., nutritional counseling, NRT therapy, etc.).


## PAYMENT METHODOLOGIES FOR *HUB AND SPOKE* HEALTH HOME SERVICES

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 ACA Section 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.

There are two payment methodologies and two payment streams: one for *Hubs* and one for *Spokes*.

### *Hub Health Home Payment Methodology*

*Hub* Health Home Staffing and Cost Model

The methodology to develop costs 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 Health Homes were developed in collaboration with current methadone providers (OTP) and are based on a model of 400 MAT patients served

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at a regional treatment center. The resulting Health Home enhanced staffing model represents, on average, a 43% increase from Vermont's current statewide average rate for methadone treatment as usual (statewide average rate of $4,144 per patient per year). *Hub* Health Home services represent 30% of the total *Hub* costs.

The Health Home *Hub* staff and their approximate annual costs for 400 patients are shown below:

| ***Hub* Health Home Scale Model: (400 patients)** | |
|---|---|
| **Staffing** | **Annual FTE costs** |
| Health Home Director (1FTE) | $95,000 |
| Health Home Nurse (1FTE) | $90,000 |
| MA Clinician Case Managers (2 FTEs) | $120,000 |
| MD (15% FTE) | $ 45,400 |
| Psychiatry (20% FTE) | $70,000 |
| MA Addictions Counselors (30% 6 FTEs) | $106,000 |
| **Total Salary** | **$526,400** |
| Fringe benefits @ 35% of salary | $184,000 |
| **Total Hub Health Home Staffing Costs** | **$710,400** |
| **Annual Health Home per patient cost** | **$1,776** |
| **Per Patient Per Month** | **$148.01** |

The cost of Health Home staffing enhancements to the *Hub* OTP programs equals $1,776 per patient per year. The Health Home services combined with the traditional OTP services result in an average annual statewide rate of $5,920 per patient.

| **OTP Statewide Average Methadone Rate without Health Homes** | **Health Home Staff Enhancement Statewide Average** | ***Hub* Rate (Health Home + OTP Statewide Average)** |
|---|---|---|
| $4,144/year | $1,776/year | $5,920/year |
| $345.36/month | $148.01/month | $493.37/month |

<u>*Hub* Health Home Payments</u>

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

- One face-to-face typical treatment service encounter (e.g., nursing or physician assessment, individual or group counseling, observed dosing); and,

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- 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 $345.36 per month.

Under the terms of the ACA Section 2703 State Plan Amendment, Vermont will seek 90-10 matching funds for *only* the Health Home enhancements, or 30% of the total *Hub* costs per Medicaid patient.

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 Payment Methodology***

<u>*Spoke* Health Home Staffing and Cost Model</u>
Payment for *Spoke* Health Home services will be based on the costs to deploy one FTE RN and one FTE licensed clinician case manager for every 100 patients across multiple providers within a Health Service Area. 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)**<br>**$163.75 PPPM** |

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*Spoke* Health Home Payments

*Spoke* payments are based on the average monthly number of unique patients in each Health Service Area (HSA) for whom Medicaid paid a buprenorphine pharmacy claim during the most recent three-month period in increments of 25 patients. Building on the existing Community Health Team infrastructure, new *Spoke* staff are supported through *Capacity Payments*.
For administrative efficiency, *Spoke* 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.

Buprenorphine pharmacy claims are not affected and *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 |

*Spoke* Caseload Determination

Each month, the DVHA clinical unit creates a report reflecting the unique Medicaid beneficiaries with at least one paid buprenorphine (e.g., Subutex®, Suboxone®) claim, linked with the prescribing physician. The caseload within each Health Service Area (HSA) is then 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. 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 HSA. The *Spoke* staff resources are deployed by the Blueprint *lead administrative agent* to the prescribing practices proportionate to the number of patients served by each practice.

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*Spoke* Prospective Caseload Adjustments

A Blueprint HSA 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.

*Spoke* 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.

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. For administrative ease, the *Spoke* payments are added to DVHA's monthly payment for the Blueprint Community Health Teams (CHT), resulting in one combined monthly payment by DVHA to each Blueprint HSA *lead administrative agent* for costs associated with both core CHT and *Spoke* Health Home services.