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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	
Opioid Addiction as defined by the DSM-IV-TR criteria	

Specify the criteria for at risk of developing another chronic condition:
Vermont Medicaid data are consistent with national data that has found this population to be at high risk of having or developing other substance abuse disorders and co-occuring mental health conditions, especially depression and anxiety. Research shows that individuals with a dependency on drugs are much more likely to drink alcohol, and individuals with an alcohol dependency are far more likely than the general population to use other drugs (HHS, NIH, NIAAA. Alcohol Alert 76, 2008). Among opiate dependent patients the lifetime prevalence of affective disorders has been reported to be 85.4% in women and 70.0% in men (Rounsaville. Arch Gen Psychiatry, 1982), with a current prevalence of major depression of 15.8% (Brooner. Arch Gen Psychiatry, 1997). The lifetime prevalence of anxiety disorders was reported to be 13.2% in women and 24.5% in men (Rounsaville. Arch Gen Psychiatry, 1982). Post-traumatic stress disorder (PTSD) is also common, though patients may deny a PTSD history until they feel confident in their treating clinician. Villagomez (Substance Abuse Treatment, 1995) reported a lifetime prevalence of PTSD of 20% in women and 11% in men.

☐ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

(●) **By county**
Specify which counties:
Health Home services will be available statewide.
The effective dates are as follows:

Effective 7/1/13: Addison, Chittenden, Franklin, Grand Isle, Washington, Lamoille, Orange, Windham and Windsor counties.

Effective 1/1/14: Bennington, Rutland, Essex, Orleans, and Caledonia counties.

( ) **By region**
Specify which regions and the make-up of each region:

( ) **By city/municipality**
Specify which cities/municipalities:

( ) **Other geographic area**
Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

( ) **Opt-In to Health Homes provider**
Describe the process used:

(●) **Automatic Assignment with Opt-Out of Health Homes provider**
Describe the process used:
MAT patients are automatically enrolled in Health Homes. All Health Home services are available at all times to enrolled participants. The Health Home Teams at the Hub Designated Provider provides all six Health Home Services and the Spoke RN and Clinician Case Manager teams also provide all six Health Home services. Individual beneficiaries may choose to decline a specific Health Home service based on their individual Plan of Care, but all six services remain available to them at any time these services are desired or needed.

Current MAT patients will be informed about Health Homes services via letter and follow-up

communications, including telephone and face-to-face contact when the beneficiary visits the MAT prescriber's office for treatment or for a prescription refill. Potential Health Home participants will be identified through provider, community partner and judicial referrals, MAT prior authorizations, Vermont Chronic Care Initiative risk stratification, claims and utilization data. The majority will be identified through providers, clinical assessment, the prior authorization process for buprenorphine prescriptions and enrollment in methadone treatment.

☑ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☑ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

The Controlled Substances Act requires that any program dispensing opioid drugs for the treatment of opioid addiction must meet Federal Opioid Treatment standards established by SAMHSA. An OTP must have a current, valid certification from SAMHSA to be qualified to dispense drugs for opioid addiction and meet the federal opioid treatment standards. Highlights of the certification and treatment standards include:

Administrative and organizational structure to ensure quality of patient care and meet all local, state, and federal standards; A program sponsor and a medical director responsible for overseeing all care; A system of continuous quality improvement including annual reviews of program policies and procedures, and patient outcomes; Staff credentials, education, training, and

experience to perform assigned duties and to comply with the credentialing requirements of their respective professions; Initial physical exam performed by a physician; Preparation of a treatment plan and periodic reassessment; Drug abuse testing services; System to ensure that patients are enrolled in only one OTP program at a time; Systems for medication administration, dispensing, and use including dosage ranges, witnessed dosing, protocols for take home medication; Security systems to assure safety of the medications.

The Division of Alcohol and Drug Abuse Programs (ADAP) in Vermont is the single state entity charged with oversight and certification of OTP. The Hubs in the region supported by the SPA have a current, valid certification from SAMHSA, meets the ADAP requirements and is also accredited by CARF as an OTP.

Registered nurses and master's level licensed clinician case managers (e.g., LADC, LCSW, LMHC), overseen by a program director who typically is also a clinician, will primarily be responsible for providing the Health Home services. The Hubs have agreed contractually to provide services in accordance with CMS' standards for the 11 core functional components.

- [ ] **Federally Qualified Health Centers (FQHC)**

  Describe the Provider Qualifications and Standards:

- [ ] **Other (Specify)**

- [x] **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

- [x] **Physicians**

  Describe the Provider Qualifications and Standards:
  Buprenorphine prescribers must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They are required to adhere to Vermont's Buprenorphine Clinical Practice Guidelines and the Vermont Department of Health Medication Assisted Therapy for Opioid Dependence Rules. These are the Spoke physician prescribers.

- [x] **Nurse Care Coordinators**

  Describe the Provider Qualifications and Standards:
  Registered Nurses with expertise in addictions treatment. These professionals will work under the Spoke model, supervised by prescribing physician.

- [ ] **Nutritionists**

  Describe the Provider Qualifications and Standards:

- [x] **Social Workers**

  Describe the Provider Qualifications and Standards:
  Licensed master's level social workers with experience in addictions treatment. These professionals will work under the Spoke model, supervised by prescribing physician.

- [x] **Behavioral Health Professionals**

  Describe the Provider Qualifications and Standards:
  The Health Home behavioral health professionals in this proposed SPA include the professionals currently credentialed as licensed providers in Vermont's Medicaid program. These are: Licensed Alcohol and Drug Abuse Counselors, Licensed Clinical Social Workers, Licensed Mental Health Counselors, Licensed Psychologists, and Licensed Marriage and Family Therapists. These professionals will work under the Spoke model, supervised by prescribing physician.

- [ ] **Other (Specify)**

- [ ] **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

- [ ] **Medical Specialists**

  Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes 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. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
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 or 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 provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report 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.**

Description:

Current OTPs and OBOTs are supported in transforming into Hub and Spoke 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 and the Blueprint. Three types of learning collaboratives are planned or in progress: regional OBOT collaboratives, a state-wide Hub program collaborative, and a state-wide Spoke Staff learning community. Participation in the collaboratives is voluntary. The collaborative content is planned by clinical and scientific leaders in Vermont familiar with current programming and national practice standards. Led by a team from Dartmouth-Hitchcock Medical Center with expertise in addictions treatment, each meeting includes didactic learning, reports on quality performance measures, description of PDSA cycles undertaken to improve performance and lessons learned. Two regional OBOT collaboratives are underway and the statewide Hub and Spoke staff collaboratives are also underway.
The State is providing the Health Home providers with the same HIT architecture as is used among all Primary Care Patient-Centered Medical Homes. An opioid treatment measures set is being developed as an addition to Vermont's central clinical registry, Covisint DocSite, 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 substance abuse and mental health treatment providers. Health Home staff will document their clinical work with patients in the EMR used by each host program site to promote consistent access and documentation.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

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 OBOT with buprenorphine prescribed by specially licensed physicians in their offices. In contrast, methadone treatment is highly regulated and can only be provided through specialty OTPs that offer comprehensive addictions services. Methadone OTPs and physicians prescribing buprenorphine in OBOTs have worked in relative isolation from each other and with limited interface with the primary health and mental health care systems.

Vermont's new integrated MAT system of care, referred to as the Hub and Spoke, will provide Health Home services to MAT patients. It builds on strengths of the specialty OTPs, OBOT buprenorphine prescribing physicians, and the local Blueprint PCMH and CHT infrastructure. The Hub (OTP) is a regional specialty addictions treatment center that provides methadone MAT, buprenorphine for clinically complex patients, and addictions consultation. Spokes are buprenorphine prescribers supported by RN and Master's level clinician case managers who assist MAT patients with care coordination, counseling, enhanced self-management, education, and care transitions. Spoke staff are administratively managed by the administrative agent (AA) in each HSA that oversees the Blueprint CHTs. Enhanced Hub and Spoke staffing provide Health Home services specifically to Medicaid beneficiaries receiving MAT. Under this approach, each patient undergoing MAT will have a physician-led medical home and CHT, a single MAT prescriber, a pharmacy home, and access to Hub or Spoke Health Home nurses and clinicians.

The administrative agent for each of the 14 HSAs that oversees Spoke staff also provides the following services: administers the payment processes for CHTs and PCMH provider PMPMs; plans and operates the CHTs (hires, supervises or subcontracts for the CHT staff); recruits primary care providers to the Blueprint and supports work to become NCQA recognized as patient-centered medical homes; convenes the working teams to assure the exchange of health information from practice-based EMRs through the Health Information Exchange to the Blueprint Central Clinical Registry (DocSite); convenes and supports learning health system activities, including development and dissemination of performance reports, learning collaboratives, and training events, and; plans and implements initiatives including the health homes.

The lead AAs are health care organizations with strong fiduciary and administrative capabilities, are Medicaid enrolled providers, and are recognized health care leaders in their communities. Examples include hospitals, FQHCs, and/or community mental health centers. The Department of Vermont Health Access /Blueprint executes performance-based contracts with each lead AA for these services. The AAs do not provide any Health Home services.

Each HUB and Spoke system has its own RNs and licensed clinicians. HUB staff is employed by the HUB. Spoke staff employed by the lead administrative agents in each HSA as are members of the Blueprint Community Health Teams (CHTs). Health Home staff of HUBs and Spokes are planned and deployed in concert with local CHTs and participate in regional learning activities to build integration and coordination of care among PCMHs, addictions providers and community services providers.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

As the sole entity providing methadone treatment, the Hub must fulfill all federal requirements as an Opioid Treatment Program (OTP). It also must serve as the regional consultant/subject matter expert to Spoke providers on opioid dependence and treatment, and must provide buprenorphine to clinically complex patients. The Hubs will work under a performance-based contract with the State of Vermont that was developed to be consistent with the 11 required components for delivering Health Home services.

Spoke buprenorphine prescribers must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They are required to adhere to Vermont's Buprenorphine Clinical Practice Guidelines. Spoke RN care managers and clinician case managers are hired by the local Blueprint administrative agent (AA) that oversees the other CHT staff within the same Health Services Area. Nurse care managers are licensed nurses with experience working with individuals with substance abuse and/or mental health conditions. Clinician case managers are licensed in a behavioral health field (e.g., LADC, LCSW, LMHC). The AAs work under performance-based contracts with the State of Vermont that include the 11 required components for delivering Health Home services. The AAs will be responsible for establishing and monitoring staff performance expectations that also include the 11 required components.

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

- ☐ **Fee for Service**
- ☐ **PCCM**
  - ○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**
  - ○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

    The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:
    - ☐ **Fee for Service**
    - ☐ **Alternative Model of Payment (describe in Payment Methodology section)**
    - ☐ **Other**

      Description:

    - ☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

      If yes, describe how requirements will be different:

- ☐ **Risk Based Managed Care**
  - ○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**
    - ☐ **The current capitation rate will be reduced.**
    - ☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

      Provide a summary of the contract language for the additional requirements:

    - ☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**
☐ **Alternative Model of Payment (describe in Payment Methodology section)**
☐ **Other**

Description:

☑ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:
Spoke RNs and clinicians are part of a team of health care professionals. Payment for Spoke Health Home services will be made to the administrative agents (AAs) that oversee the Blueprint Community Health Teams (CHTs) so they can hire and support 1 RN care manager and 1 clinician case manager for every 100 buprenorphine patients served within the Health Services Area (HSA). Payments are based on the average monthly number of unique patients for which Medicaid paid a buprenorphine pharmacy claim during the most recent 3-month period. Payments will be added to DVHA's existing monthly payment to the AA for CHT services, which are covered by contracts the Blueprint already executes with the AAs to cover Blueprint administration and CHT payments. The additional CHT Spoke staff will provide the Health Home services and will be fully funded by DVHA. Spoke staff resources will be deployed to the prescribing practices proportionate to the number of patients served by each practice. Spoke physicians will continue to bill fee-for-service for all typical treatment services currently reimbursed by DVHA.

Hubs are designated providers. Hub payments will be a single monthly rate per patient, with a percentage of the total payment linked directly to provision of Health Home services. The Hubs may initiate a claim through the MMIS on behalf of a patient for whom it can document 2 services during that month: 1 face-to-face typical treatment encounter (e.g. assessment, counseling, observed dosing), and 1 Health Home service. Only the HH service (30% of the total) will be paid using the enhanced funding match.

☑ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☐ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☐ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☑ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☑ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

The funding methodology for Hub & Spokes is based on staff costs to provide health home services. The Hub methodology is based on the cost to employ key health professionals (salary and fringe benefits) to provide the Health Home services. The staffing enhancements are based on a model of 6 FTEs for every 400 MAT patients served. The enhanced staffing model represents a 43% increase over the current average rate for methadone treatment as usual.

The agency's fee schedule rate was set as of July 1, 2013, is effective for services provided on or after that date, and are the same for both private and public providers. All rates for both Hub and Spoke payments are published on the DVHA website: http://dvha.vermont.gov/for-providers/claims-processing-1.

The Hub payment is a monthly, bundled rate per patient. The Hub program makes a monthly claim with a Health Home modifier for each Medicaid Health Home member who receives at least one Health Home service in the month. The Health Home service is documented in the clinical chart of the Hub program. This documentation is auditable. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of addictions treatment services for patients receiving Medication Assisted Therapy (MAT).

Payment for Spoke Health Home services is based on the costs to employ 1 FTE RN and 1 FTE licensed clinician case manager for every 100 MAT patients across multiple providers. The patient count to determine the Spoke payment is 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 are deployed to the prescribing practices proportionate to the number of patients served by each practice. Payments will be made to the lead Blueprint administrative agent in each HSA when staff provides at least one Health Home service per month to each Medicaid beneficiary on the Spoke Health Home caseload. Health Home services are documented in the clinical record of the prescribing physician's practice. This documentation is auditable.

The State will review service utilization rates annually to ensure that rates are economic and efficient based on analysis of care management costs and services provided by the team of health care professionals and its components for both the Hub and the Spoke programs.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

The Hub program and the Spoke program make a monthly claim with a Health Home modifier for each Medicaid Health Home member who receives at least one Health Home service in the month.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
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, developing QI activities to improve care, and linkages with long term care services and supports.

Health Home Staff providing Comprehensive Care Management: Spoke Nurse and Spoke Clinician Care Manager; Hub Health Home Program Director, Hub supervising MD, Hub RN Supervisor, Hub Consulting Psychiatrist.
Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Treatment information will be documented in the EMR and communicated through the central clinical registry Covisint DocSite, which contains clinical information as well as documentation and tracking of self management goals and action plans. If Covisint DocSite usage is not yet operational, Covisint ProviderLink may be used to transmit patient information. Covisint ProviderLink 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.
Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**
- ☑ **Behavioral Health Professionals or Specialists**
  Description
  The Hub Health Home Program Director, who typically is also a clinician, is involved in these activities, especially in developing the overall plan of care (POC). Hub and Spoke Master's level clinician case managers, who frequently are behavioral health professionals, are involved in developing and implementing comprehensive care management activities.
- ☑ **Nurse Care Coordinators**

Description
Spoke RN care coordinators will be involved in developing and monitoring these activities.

- [ ] **Nurses**
  Description
- [ ] **Medical Specialists**
  Description
- [x] **Physicians**
  Description
  Hub supervising physicians, consulting psychiatrists and Spoke prescribing physicians are actively involved in comprehensive care management activities and provide oversight and monitoring of the plan of care. PCPs also are involved in developing the plan of care, as needed.
- [ ] **Physicians' Assistants**
  Description
- [ ] **Pharmacists**
  Description
- [x] **Social Workers**
  Description
  Licensed master's level social workers may be Spoke clinician case managers and as such, will be involved in developing and implementing comprehensive care management activities.
- [ ] **Doctors of Chiropractic**
  Description
- [ ] **Licensed Complementary and Alternative Medicine Practitioners**
  Description
- [ ] **Dieticians**
  Description
- [ ] **Nutritionists**
  Description
- [ ] **Other (specify):**
  Name
  Description

Care Coordination

Definition:
Care coordination activities involve implementing the Plan of Care through appropriate linkages, referrals, coordination and follow-up across treatment and human services settings and providers (medical, social, mental health and substance use, long-term care, corrections, education, and vocational).

The Spoke Nurses and clinician care managers share responsibility for all Health Home services and the staffing ratio for providing all Health Home services in the Spokes is 2 FTE for every 100 MAT members. The Health Home Care Coordination functions are shared across four Health Home staff at the Hubs (the supervising MD, the consulting psychiatrist, the addictions counselors, and the clinician case managers).

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Information will be shared through the central clinical registry Covisint DocSite as well as through existing information sharing technologies and Electronic Medical Records (EMRs). DocSite is a web-based registry that receives feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, 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.

Scope of benefit/service

- [x] **The benefit/service can only be provided by certain provider types.**
  - [x] **Behavioral Health Professionals or Specialists**
    Description
    HUB Clinician case managers, who often are behavioral health professionals, are key staff in providing care coordination services.
  - [x] **Nurse Care Coordinators**
    Description
    Spoke RN care coordinators are key staff in providing these services.
  - [ ] **Nurses**
    Description
  - [ ] **Medical Specialists**
    Description
  - [x] **Physicians**
    Description
    Hub supervising physicians, consulting psychiatrists and Spoke prescribing physicians are actively involved in comprehensive care management activities and provide oversight and monitoring of the plan of care. PCPs also are involved in developing the plan of care, as needed.
  - [ ] **Physicians' Assistants**
    Description
  - [ ] **Pharmacists**
    Description

☑ **Social Workers**

Description

Licensed master's level social workers may be Hub clinician case managers and would be key staff in providing care coordination services.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Promotion

Definition:

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; development of 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, and increased physical activities; support for developing skills for emotional regulation and parenting; and support for improving social networks.

Health Home staffs providing Health Promotion Activities are the Spoke Nurse and Spoke Clinician Care Manager, and the Hub MA Addictions Counselors and the MA Clinician Case Managers.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

Information will be shared through the central clinical registry Covisint DocSite as well as through existing information sharing technologies and Electronic Medical Records (EMRs). DocSite is a web-based registry that receives feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, 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.
Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Hub MA Addictions Counselors and the HUB and Spoke MA Clinician Case Managers are particularly involved with health education specific to opioid dependence and treatment, other substance issues, and with related behavioral interventions.

☑ **Nurse Care Coordinators**

Description
Spoke RN nurse care coordinators are involved with health promotion regarding all health issues, particularly with health education regarding other chronic conditions and promoting healthy lifestyle interventions such as nutritional counseling, obesity reduction, and increased physical activities.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
HUB social workers are particularly involved with education and promotion of behavioral techniques and support for developing skills for emotional regulation, parenting, and improving social networks.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description

Spoke nutritionists are involved in education regarding healthy diets, weight reduction, and specific cooccurring chronic conditions (such as diabetes).

☐ **Other (specify):**

Name

Description

Health Homes Services (2 of 2)

Category of Individuals

CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:

Comprehensive transitional care 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, long-term care, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance abuse treatment services. Care managers work with discharge planners to schedule follow-up appointments with primary or specialty care providers within seven days of discharge, and work with patients to help ensure attendance at scheduled appointments.

Spoke Nurse, the Hub Health Home Director, the Hub Supervising MD, the Hub RN Supervisor, and the Hub MA Clinician Case Managers will be involved with transitional care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

Concurrent review of hospital stays requires that Vermont Medicaid 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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

Especially involved in care transitions from inpatient stays for behavioral health issues, residential treatment programs, primary care and specialty mental health and substance abuse treatment services.

- [x] **Nurse Care Coordinators**

Description

Especially involved in transitions involving hospital settings and nursing facilities. Activities include developing collaborative relations between Health Home providers and hospital ERs and discharge planners to schedule follow up appointments with primary or specialty care providers and work with patients to ensure attendance at scheduled appointments.

- [ ] **Nurses**

Description

- [ ] **Medical Specialists**

Description

- [x] **Physicians**

Description

Specifically assists with patient education about health conditions and recommended treatments and facilitating ongoing revisions to individual plans of care.

- [ ] **Physicians' Assistants**

Description

- [ ] **Pharmacists**

Description

- [x] **Social Workers**

Description

Especially involved in transitions involving corrections, probation and parole staff, and establishing supports and services in the community to facilitate successful transitions.

- [ ] **Doctors of Chiropractic**

Description

- [ ] **Licensed Complementary and Alternative Medicine Practitioners**

Description

- [ ] **Dieticians**

Description

- [ ] **Nutritionists**

Description

- [ ] **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:
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.

Spoke Registered Nurse, Spoke Licensed Clinician Case Manager, the Hub Supervising MD, the Hub MA Addictions Counselors, and the Hub MA Clinician Case Managers will be involved with individual and family support.
Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Covisint DocSite can make specific information related to a patient's care available for reference in Individual and Family Support Services.
Scope of benefit/service

- [x] **The benefit/service can only be provided by certain provider types.**
  - [x] **Behavioral Health Professionals or Specialists**
    Description
    Especially involved with assessing individual and family strengths and needs,and linking individuals and families with appropriate supports and services.
  - [x] **Nurse Care Coordinators**
    Description
    Especially involved with providing information and education to family and other support persons on ways they can support the patient in establishing healthy behaviors, particularly around chronic health conditions.
  - [ ] **Nurses**
    Description
  - [ ] **Medical Specialists**
    Description
  - [x] **Physicians**
    Description
    Especially involved with advocacy, assessing individual and family strengths and needs, providing information about services and assistance with navigating the health and human services systems, and providing support and outreach to key caregivers.
  - [ ] **Physicians' Assistants**
    Description
  - [ ] **Pharmacists**
    Description

☑ **Social Workers**

Description

Especially involved with advocacy, assessing individual and family strengths and needs, providing information about services and assistance with navigating the health and human services systems, and providing support and outreach to key caregivers.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:

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).

The Spoke Registered Nurse and Spoke Licensed Clinician Case Manager will be responsible for appropriate referrals to community and social support services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

Covisint ProviderLink secure electronic fax functions may be used with all providers, including community and social support service agencies, to transmit and share appropriate patient information.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

Licensed clinician case managers, including behavioral health professionals, are the primary Health Home staff providing these services.

☑ **Nurse Care Coordinators**

Description
RN Care Coordinators are involved with identifying and coordinating with community services, especially those pertaining to chronic health conditions and healthy behaviors.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Licensed clinician case managers, including licensed master's level social workers, are the primary Health Home staff providing these services, especially with helping clients obtain supports and entitlement for which they are eligible.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
Members who are treated with buprenorphine can receive care in either a Spoke or Hub. The decision about which site is the most appropriate is a clinical one. In general, the Hub setting provides more intensive
structure and has the capacity to see members on a daily basis. Typical Spoke OBOT providers see patients twice a month and as frequently as three times a week but can rarely sustain daily contact over time. Therefore, a patient receiving buprenorphine care that is relatively stable can be well supported in a Spoke. If the patient is experiencing relapse or acute exacerbation of other mental health or health conditions, they can be
treated in a Hub. The Hub and Spoke Health Home supports movement of members
based on clinical needs between both types of providers.

By federal regulation, any member receiving methadone for the management of opioid dependence can only be served in an OTP Hub program.

☑ **Medically Needy eligibility groups**

- ◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

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Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement 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.

Data Source: Claims

Numerator: Number of hospital stays with a readmission within 30 days.

Denominator: Number of hospital stays.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Vermont will annually assess cost savings using a pre/post comparison approach adapted from the Blueprint cost modeling framework. DVHA identified annual Medicaid total costs of care across major health care categories (health, mental health, and substance abuse treatment) for beneficiaries who received treatment for opioid dependence during state fiscal years 2010, 2011 and 2012 to establish a projected cost trend for subsequent years (without Health Homes) that is adjusted for projected inflation rates provided by Vermont's Department of Financial Regulation. Actual costs after Health Homes implementation for the same population and health care categories will be compared with the projected costs in the absence of Health Homes for SFY 2013 and subsequent post-implementation SFYs. Savings will be the difference between projected and actual costs in each post-implementation year net of new Health Home investments [cost of Health Home staffing at Hubs (30%) and Spokes (100%)].
Data source: claims.
Measure: Total Medicaid expenditures in the selected cost categories for the target population.

Describe how the State will use health information technology in providing Health Homes services and to improve service 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).
The Hub & Spoke system will build on the Blueprint's Health Information architecture, which includes a central clinical registry (Covisint DocSite), use of the Vermont Health Information Exchange, and a communication tool (ProviderLink) that facilitates the secure transmission of clinical information between health providers. This health information architecture supports guideline-based preventive healthcare, coordinated health services, an integrated health record across services and organizations, and flexible reporting. The Hub & Spoke initiative will be the first expansion of this capacity to specialty addictions treatment providers. An opioid treatment measures set is being developed for DocSite for visit planning and documentation. Hub and Spoke Health Home staff will document directly in the practice EMR. The goal is to have information on day-to-day provisions of care documented in practice EMRs, hospital data systems, and practice management systems and then transmitted via interfaces to the Health Information Exchange (VHIE) and then into the Covisint DocSite Clinical Registry. DocSite is web-based and receives data feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and direct data entry. To facilitate concurrent review of hospital stays for better transitional care planning, the State is developing automated procedures with hospial ERs and inpatient discharge planners, as well as CHTs, to receive daily feeds on Medicaid patients. Residential substance abuse service providers also will be included in the procedures developed.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Admissions per 1000 member months for any diagnosis among Hub/Spoke clients.

Measure Specification, including a description of the numerator and denominator.
Numerator: All Hub & Spoke enrollees in the geographic area with a hosptial stay during the measurement year.
Denominator: All Hub & Spoke enrollees in the geographic area during the measurement year.
Data Sources:
Claims
Note: Claims are continuously collected. Admission rates will be calculated annually.
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

ER visits per 1000 member months for any diagnosis among Hub/Spoke clients.

Measure Specification, including a description of the numerator and denominator.
Numerator: All Hub & Spoke enrollees in the geographic area with an ER visit during the measurement year.
Denominator: All Hub & Spoke enrollees in the geographic area during the measurement year.
Data Sources:
Claims
Note: Claims are collected continuously but ER rates will be calculated annually.
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:

Admissions per 1000 member months for any diagnosis among Hub/Spoke clients.

Measure Specification, including a description of the numerator and denominator.
Numerator: All Hub & Spoke enrollees in the geographic area with a skilled nursing facility admission during the measurement year.
Denominator: All Hub & Spoke enrollees in the geographic area during the measurement year.
Data Sources:
Claims.
Note: Claims are collected continuously but ER rates will be calculated annually.
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the 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 pre/post Health Homes implementation as well as 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 of payment reforms and Patient-Centered Medical Homes supported by Community Health Teams. 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. The analyses establish a basis for tracking change over time. The Hubs/Spokes initiative will build upon the resources available through the Blueprint. In addition, Vermont's Medicaid Chronic Care Initiative targets a variety of chronic diseases at both the population and individual levels and evaluates evidence-based care and health outcomes.
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, Hub or Spoke nurses and clinicians, and access to CHTs, if appropriate, 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 and will share coordination protocols already established by the CHTs. The CHT measures sets maintained in Covisint DocSite (Vermont's clinical registry) already provide the ability to track the number and type of referrals to community and social services. Providers who do not yet have access to Covisint DocSite will receive information through Covisint ProviderLink, 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 Hub/Spoke Health Homes staff and participating providers. Hubs and Blueprint administrative agents that oversee CHT staff, including new Spoke Health Home staff, work under performance-based contracts that will be monitored for fulfilling contract requirements. The requirements include the 11 CMS elements for Health Home performance. Efforts have begun to develop a consistent consumer survey to evaluate patient satisfaction.

Processes and Lessons Learned
The State regularly elicits feedback from providers and patients to understand any operational barriers to implementing Hub/Spoke Health Homes services. This is be especially important as it will inform implementation statewide. The Blueprint Assistant Director and other staff meet regularly with both Hub and Spoke service providers.
Assessment of Quality Improvements and Clinical Outcomes
The State will utilize quality process and outcome measures to assess quality improvements and clinical outcomes. As the Hubs/Spokes Health Homes program progresses, Vermont anticipates implementing additional quality improvement and clinical outcome measures for patients receiving MAT, including but not limited to:
- 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 health care categories such as pharmacy, inpatient hospitalization, emergency room, lab, and residential treatment

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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PRA Disclosure Statement