



State of Vermont  
Agency of Administration  
Health Care Reform  
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Montpelier, Vermont 05609

REPORT TO THE VERMONT LEGISLATURE

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## **Report on Integration of Substance Abuse Payment and Care Coordination with Physical and Mental Health**

**In accordance with Act 179 of 2014, Section E.306.2(b)(1)**

*Submitted to*  
*Joint Fiscal Committee*  
*House Committee on Appropriations*  
*House Committee on Human Services*  
*Senate Committee on Appropriations*  
*Senate Committee on Health and Welfare*

*Submitted by*  
*Justin Johnson, Secretary*  
*Agency of Administration*  
*and*  
*Lawrence Miller, Chief of Health Care Reform*  
*Governor's Office*

*January 15, 2016*

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## Summary:

Section E.306.2(b)(1) requires the Secretary of Administration and the Chief of Health Care Reform to submit a report on “current and additional strategies to achieve a more comprehensive health care service and delivery system based on a greater integration of substance abuse payment and care coordination with physical and mental health.” This report fulfills this requirement and summarizes activities underway to align substance abuse services and the larger system of care.

There are four major initiatives underway that address integration of substance abuse care with physical and mental health. They are:

1. The **Care Alliance for Opiate Addictions (Hub & Spoke) Initiative**, a comprehensive, regional system of treatment for opioid addiction in Vermont built upon the foundation of the existing specialty treatment programs linked with services through the Blueprint for Health. This initiative includes payment and delivery system reforms.
2. The **Screening, Brief Intervention and Referral to Treatment (SBIRT) Initiative**, designed to prevent substance dependence through early identification and provision of services to people at risk before more severe symptoms occur. This is a primary care-based service.
3. The **Substance Abuse Treatment Coordination Workgroup/Agency of Human Services**, with representatives from each AHS Department, has developed a policy and protocols to guide an approach to screening and coordinating referral for substance abuse services for AHS clients who are in need of specialty treatment. This builds on the SBIRT Substance Abuse Treatment Initiatives and extends those principles across the Agency.
4. **Integration of Mental Health and Substance Abuse Delivery System through Vermont’s State Innovation Models (SIM) grant** from the federal Centers for Medicare & Medicaid Innovation (CMMI), the SIM Core Team has allocated funds to support payment and delivery reform design and readiness activities specifically for Designated Agencies and private providers of mental health and substance abuse services.

### **Care Alliance for Opiate Addictions (Hub & Spoke)**

Through the development of the Care Alliance for Opiate Addiction (Hub & Spoke) Initiative, the Departments of Health and of Vermont Health Access have made considerable progress toward integrating addiction treatment with the physical health system. In the development of this network that includes specialty Opiate Treatment Centers (OTP) and Office-Based Opiate Treatment (OBOT) by primary care physicians, the departments built upon the foundation developed by the Designated Agencies/Preferred Providers who are delivering an array of mental health and substance abuse services, and Vermont's patient-centered medical home initiative (the Blueprint for Health<sup>i</sup>).

The majority of Vermont's Medicaid program operates under the Global Commitment to Health Demonstration Waiver. The Global Commitment to Health Demonstration Waiver (GC) 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).

The GC 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) 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).

The Affordable Care Act offered an opportunity to expand Vermont's Blueprint for Health to encompass substance abuse treatment services through the Health Home model. Health Homes are a Medicaid State Plan Option under Section 2703 of the Affordable Care Act which offers states enhanced federal reimbursement for qualifying "Health Home services" for a limited period of time.<sup>ii</sup> In 2013, Hub and Spoke was formalized as a new initiative that would take advantage of this enhanced funding while seeking to form a more integrated service network and better address substance use disorders within a comprehensive Health Home framework. Hub and Spoke is a joint initiative of the Vermont Blueprint for Health, the Clinical Operations unit of the Department of Vermont Health Access (DVHA), and the Vermont Department of Health Division of Alcohol and Drug Abuse Programs, and works in collaboration with local health, addictions, and mental health providers.

The initiative was designed to establish a comprehensive, regional system of treatment for opioid addiction in Vermont by building on the infrastructures of existing provider

configurations, namely a) the specialty OTPs established initially to provide highly regulated methadone treatment; b) the authorized physicians prescribing buprenorphine in OBOT settings; and c) Vermont’s patient-centered medical homes (PCMHs) supported by Community Health Teams (CHTs) that is grounded in Vermont’s Blueprint for Health framework for health care reform and the Health Home concept in the Federal Affordable Care Act. New creative payment methodologies were also built upon the existing infrastructure of their service provider configurations. At the center of the approach is the implementation of what has become known as the Hub & Spoke Health Home Model to ensure that each person’s care is effective, coordinated, and supported.

Key Success Factors

a. **Expanding the use of buprenorphine in the OTPs (also known as Hubs).** Previously, OTPs were exclusively specialty methadone treatment clinics. Now, OTPs as Hubs are also authorized to prescribe buprenorphine (as well as naltrexone), as are OBOTs. This has significantly expanded the availability of buprenorphine therapy (as shown in Figure 1 below).

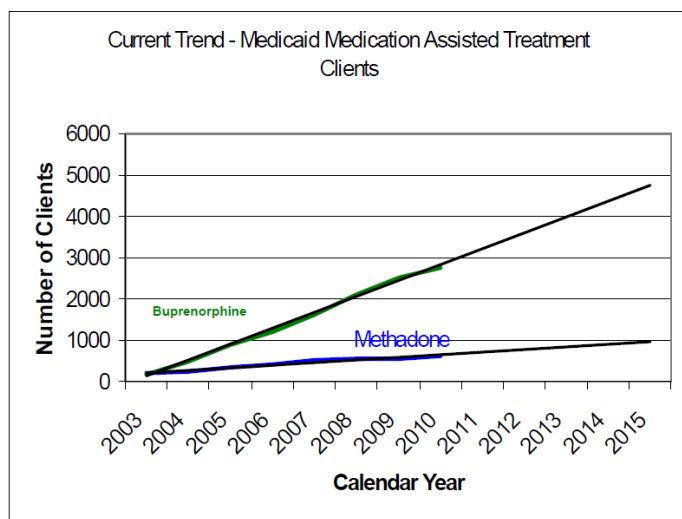


Figure 1

The number of Medication Assisted Treatment (MAT) patients receiving buprenorphine in a Hub or as prescribed by a physician in a medical office, has far exceeded the number of MAT patients receiving Methadone, the highly regulated treatment provided in specialty clinics.

By expanding the use of buprenorphine in the Hubs, Hub physicians can for the first time determine the appropriate medication instead of automatically having to place the patient on methadone.<sup>iii</sup> Patients treated in Hubs with buprenorphine who might be sufficiently stabilized now have the opportunity to be transferred as patients to OBOTs (also known as Spokes) for continued buprenorphine treatment, as clinically indicated, by a qualified physician in their local community.

Buprenorphine is more expensive than methadone. The Hub & Spoke Initiative delivers this high cost medication within a cost structure to foster integrated care. The aim of this program is to achieve improved patient care and reduce overall costs for the state's health system. The objective is that patient outcomes will further improve as they move out to Spokes, which include office-based care. Patients will move from the Hubs, which cost more, to the Spokes, which are less expensive and more convenient for the patient encouraging compliance. This will result in a reduction of some health care costs. At present, approximately 1/3 of all patients on a statewide basis move from Hubs to Spokes once stabilized. Additional cost savings are also expected to be realized from reduction in other unnecessary and even higher cost health care expenditures (e.g. medically unnecessary emergency room visits and hospital visits) and social/legal costs associated with opioid addictions simply for having a system alternative to absorb these individuals. The Hub & Spoke Initiative focuses on breaking the cycle of addiction.

**b. Ensuring consistent protocols for the transfer of patients between Hubs and Spokes by reliable and efficient referrals.** Establishing a smooth, efficient, and reliable means of transferring patients between care modalities is a significant challenge for the Hub & Spoke Initiative. First, this involved developing a process for care management between Hubs and Spokes, supported by case rates and staff provided through the Blueprint for Health patient-centered medical home structure, to replace the fee-for-services incentive to keep clients in the clinic and maintain financial stability. Ideally, a patient who clinically qualifies for treatment in a Hub would stabilize on buprenorphine within the Hub and then, if appropriate, transfer to an office-based physician practice where medication is less controlled by the clinician. Should the patient destabilize, they may be referred back to the Hub for re-stabilization. This requires a sophisticated referral process and protocols for bi-directional movement between the Hubs and Spokes. The first regional Hub & Spoke learning collaborative, which the Department of Vermont Health Access has undertaken through a contract with the Geisel School of Medicine of Dartmouth College, seeks to operationalize the Hub to Spoke transfer process within the Blueprint's Health Service Areas (HSA).<sup>iv</sup>

**c. Adopting a creative payment methodology that allowed the use of Health Home money to expand capacity within Hubs to support "service enhancements" while building staffing infrastructure within the Spokes.** The Hub "service enhancements" include federally-defined Health Home services which link primary care with community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and specialists prescribing buprenorphine. In addition, the funding for Spoke infrastructure embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in physician practices that prescribe buprenorphine through the Blueprint CHTs to provide Health Home services, including the clinical and care coordination supports to individuals receiving buprenorphine. To date, approximately 40 FTE nurses and addictions counselors have been hired and deployed to over sixty different practices.<sup>v</sup>

Vermont's managed care model through Global Commitment is designed to provide significant flexibility with regard to the financing and delivery of health care to promote better access, improve quality, and control program costs.

Hub Payments. 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 federally-defined Health Home<sup>1</sup> 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,
- One federally-defined 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 resulting in a lower reimbursement rate.

Spoke Payments. Payment for Spoke services are 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. Embedding staff directly in the prescribing practices allows for more direct access to mental health and addiction services, promotes continuity of care, and supports the provision of multi-disciplinary team care. As with the Blueprint CHTs, Spoke staff (a nurse and clinician case manager) are provided free of cost to patients receiving MAT, essentially serving as a “utility” to the practices and patients.

Spoke payments are based on the average monthly number of unique patients in each Health Service Area for whom Medicaid paid a buprenorphine pharmacy claim during the most recent three-month period, in increments of 25 patients. Building on the existing CHT infrastructure, new Spoke staff are supported through Capacity Payments. For administrative efficiency, Spoke payments are made to the lead administrative agent in each Blueprint Health Service Area as part of the existing Medicaid CHT payment.

Third Party Payers. While the majority of medication assisted treatment (MAT) is funded by the state through Medicaid payments, CHT, and financial support for uninsured patients in Hubs, some patients have third party insurance through Blue Cross Blue Shield, MVP, Cigna, and Tri-Care. Medicare does not pay for MAT provided by specialty treatment providers such as the Hubs, but it will pay for Spoke services provided in physician’s offices. Insurers have consistently paid for direct medical care through the Spokes as well as buprenorphine dispensed in pharmacies. Third party payers also contribute funds for the Blueprint CHTs, but commercial payer payment methodologies did not originally fully support the Hub component of the payment. Recently, Hub providers have made significant progress in negotiating payments for the Hub services for patients with private insurance.

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<sup>1</sup> The federal designation of Health Home provided additional federal resources for the first eight quarters of the program.

## Conclusions

By combining a new payment structure to support the delivery of medication and therapy in an integrated way, Vermont's Hub & Spoke Initiative for the provision of MAT for individuals with opioid addictions aims to achieve improved patient care at reduced costs for the state's health system. This model also builds a base upon which additional substance abuse services can be added or linked for improved care management. The connection to the Blueprint providers and CHTs began an approach which can be further developed to improve the integration of mental health and substance use disorder treatment with the Hub & Spoke network.

First, the Hub and Spoke initiative has significantly increased access to care as measured by increases in the number of Hubs, number of Spokes, number of patients in both Hubs and Spokes, and numbers of patients receiving MAT per 10,000 Vermonters.

Second, Vermont has made widespread investments to ensure improved quality of care, including focusing on expanding MAT for the treatment of opioid addictions. Other efforts to improve quality of care include adopting and/or establishing new and higher standards of care, supporting better collaboration and innovation for more effective medication delivery and better care coordination to meet the needs of this very high risk, complex, and sometimes hard to reach, population. Data shows excellent results to date, demonstrating improvements in quality of care as seen by producing very high satisfaction ratings among patients in Hubs and holding waitlists level despite growing numbers with opioid dependence.

Finally, while too early to demonstrate definitively, there is strong indication that the system design will indeed produce greater cost effectiveness. Significant cost savings are already being realized by avoiding unnecessary, higher cost health care expenditures and social/legal impacts associated with opioid misuse and dependence, and treatment strategies in absence of the Hub & Spoke model.

While growing demand resulting from the opioid crisis still outweighs system expansion efforts, early data shows positive results in increased access to care, improved quality of care, and indications of greater cost effectiveness. Additional cost efficiencies are expected to be demonstrated as the system continues to reduce other unnecessary and even higher cost health care expenditures including medically unnecessary emergency room visits and hospital visits, as well as social consequences and legal costs often associated with opioid and other addictions.

## **Screening, Brief Intervention and Referral to Treatment (SBIRT)**

The Screening, Brief Intervention and Referral to Treatment (SBIRT) Initiative is designed to prevent substance dependence through early identification and delivery of services to people at risk before more severe symptoms occur. As of 2013, the U.S. Preventive Services Task Force recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs has developed relationships with fifteen providers including hospital emergency departments, federally qualified health centers, primary care practices, and a university health center to train providers to screen and intervene with patients who demonstrate a certain level of risk for substance misuse. Approximately 34,000 Vermonters have been screened since the start of the project two and a half years ago. Any patients screened who demonstrated risk factors received appropriate counseling and/or referral to specialty treatment.

The Department of Health received a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012 to develop and implement evidence-based screening and brief intervention services in ten primary care practices and emergency departments. These funds have enabled the Department to train 325 practitioners and support them to embed screening and brief intervention. To date, 34,000 Vermonters have been screened in medical settings. The goal is for these practices and others to continue the screening protocols that they have learned to implement after the grant has ended.

Medicaid currently reimburses for SBIRT and the Department of Health is beginning a project with Blue Cross/Blue Shield to pilot embedding the practice in five locations. Screening for alcohol and drug misuse can easily be embedded into the medical questionnaires and follow up discussions that take place in primary care. A general health visit or a specialty code can be billed for these services. They would also fit into a bundled payment model as we explore new opportunities for payment.

### **Conclusions**

First, by embedding early screening and brief interventions into emergency department and primary health care settings, we aim to prevent the development of substance use disorders. Brief interventions delivered by health professionals have been shown to be effective in helping people to reduce risky drinking patterns. These interventions are most effective when delivered on-site during the delivery of routine or emergency health care services.

Second, training health care professionals to ask about alcohol and drug use and providing them with the tools and support to intervene supports the principle of providing preventive care. Preventive approaches can save money by avoiding more complex services necessary when a condition has progressed to a more serious phase.



Third, with the seriousness of the alcohol and drug problems in Vermont it is essential that the health care system become more knowledgeable and skilled in working with patients who are at risk of developing serious addictive disorders. Using the SBIRT approach is a way to embed important, proven protocols into strategic locations within the health care environment.

### **Substance Abuse Treatment Coordination Workgroup (SATC)**

The Agency of Human Services' Substance Abuse Treatment Coordination Workgroup (SATC), with representatives from each AHS Department, has developed a policy to guide a coordinated approach to screening and coordinating substance abuse services for AHS clients who need them. Each department developed protocols that specify which types of clients will be screened and how that screening will be incorporated into department workflow. State staff who provide services to AHS clients are in the process of receiving training to prepare them to conduct the screenings. We will develop a region-specific process for implementing their plan for improved care coordination for clients with substance use treatment needs. We have begun to gather data that will document numbers of clients screened and referred, and eventually the number who went on to treatment and received coordinated care.

### **Conclusions**

This initiative begins to link AHS protocols in a structured way with the health care system. AHS clients have typically arrived at the door of specialty treatment as a result of a crisis, whether it be through the Department for Children and Families, Corrections, or another Department. By training appropriate staff to understand the effects of addiction, its signs and symptoms, our aim is to intervene earlier to prevent the development of more serious substance use disorders. This initiative builds upon the evidence of the SBIRT model, described above. It creates the opportunity for a more seamless approach to identifying and helping people on the path to addiction.

## **Integration of Mental Health and Substance Abuse Delivery System through Vermont's State Innovation Models (SIM) Grant**

Finally, as a part of Performance Periods 2 and 3 of the State Innovation Models (SIM) Testing Grant, the SIM Core Team has allocated funds to support payment and delivery reform design and readiness activities specifically for Designated Agencies and private providers of mental health and substance abuse services. This project will produce an implementation plan by the end of CY 2016 that proposes significant delivery and payment reforms for mental health and substance abuse services. The group will focus efforts so that they are aligned with All-Payer Model development and build off of work already initiated for the Integrated Family Services pilot project.

The Departments of Vermont Health Access, of Mental Health, of Health, of Disabilities, Aging and Independent Living, and the Secretary's Office of the Agency of Human Services, along with the Agency of Administration, Designated Agencies, Specialized Service Agencies and private Substance Abuse providers are partnering to determine how best to serve Vermonters through a more integrated continuum of mental health and substance abuse services. The group is focused on care delivery and payment reform, and is charged to create an implementation plan by the end of CY 2016. The work will address provider readiness, state readiness, alternative payment models, practice transformation and quality improvement, quality measurement, and evaluation.

These efforts will be focused on payment and delivery system models that are most able to align with and build on the success of current health reform efforts under way in Vermont. This includes building on the Integrated Family Services (IFS) pilot project and design work currently underway around the All-Payer Model. IFS is an AHS initiative that provides practice transformation support within communities and alternative payment models to support providers engaged in the care of Vermont's children, youth and families.

This public/private group will work to understand the intricacies of current payment models in order to support the development of value-based payments for these services. The group will also work to identify potential impacts on provider service delivery and potential unintended consequences of reforms, as well as assessing financial risks being assumed by payers and/or providers. The group will also perform detailed provider readiness assessments to determine the ability of these providers to take on increased financial risk, which will enable the State to provide specific practice transformation supports to providers participating in the alternative payment structure.

### **Conclusions**

Vermont's payment and delivery system reform goals are to achieve the Triple Aim: Better Health, Better Quality, and Lower Cost. These reforms use a combination of practice transformation activities, provision of health information to providers, and modifications in payment methods to support different care delivery systems. By pursuing all of these areas

simultaneously, we seek to achieve better value in health care, driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.

The activities of this group will enable us to develop an alternative payment methodology that supports better integration, higher quality care, and aims to balance financial incentives for providers against financial risk.

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<sup>i</sup> The Blueprint for Health (Blueprint) is Vermont’s state-led, nationally recognized initiative transforming the way primary care and comprehensive health services are delivered and paid for. Originally established through Vermont statute in 2006, the Blueprint was codified in 2010 with Act 128 (amending 18 V.S. A. Chapter 13) defining it 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 health maintenance, prevention, and care coordination and management.” Subsequently, the Blueprint for Health set out a system under the Vermont Chronic Care Initiative (VCCI) whereby the highest risk and highest cost Medicaid beneficiaries are referred for care management. The Blueprint for Health operates under the Department of Vermont Health Access, Vermont’s state publically funded health insurance programs. Substance abuse, including opioid addiction, was defined as a chronic condition, and brought under the Blueprint’s Chronic Care Initiative, allowing for more creative funding to test various treatment system modalities.

<sup>ii</sup> For more information on the Health Home Medicaid State Plan Option, visit: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.

<sup>iii</sup> Hub Buprenorphine Details:

- Buprenorphine could now be prescribed just like methadone within the HUBS
- More flexibility with take homes
- Offered every other day or every third day dosing
- Introduced the use of Med-O-Wheels for securing take homes of bup tablets
- Required all patients to FULLY DISSOLVE and ABSORB sublingually both forms of buprenorphine-films and tablets-in a 5 minute observation period
- Prior Authorization process put in place by Medicaid for mono buprenorphine and all doses over 16 mg
- Required checking of VT Prescription Monitoring System (VPMS) at intake (to eliminate the risk of OBOT treatment overlaps).
- Recommended checking VPMS every 3 months and for cause (unexpected drug screen result-presence or absence of substance prescribed or not)
- Essential Hub Services
  - Intake/ Physical exams
  - Screening for STDs, TB, HIV, Hep A,B,C and education and referral
  - Onsite urine screening and breathalyzer
  - Medical and psychological evaluation and screening
  - Pregnancy screening and birth control information
  - Vaccines for Hep A/B, TDAP, pneumovax, influenza
  - Daily medication dosing and management and tapers
  - Drug and alcohol counseling group and individual
  - Case management service
  - Orientation to treatment and recovery
  - Gender specific issues-abuse, supportive services, pregnancy, parenthood
  - Discharge planning and referral
  - Care coordination and consultation with primary and specialty and hospital services

<sup>iv</sup> Other topics of focus for the learning collaboratives include:

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- Each entity had specific measures to report on at each session to measure progress toward goals such as:
  - waiting list reductions
  - retention in treatment
  - responses to drug using behaviors
  - psychological assessments
  - reducing diversion
  - assessing dose adequacy
  - care coordination

<sup>v</sup> <http://legislature.vermont.gov/assets/Legislative-Reports/Opioid-system-effectiveness-1.14.15.pdf>, p.7.