Best Practices for Designing and Implementing Substance Use Disorder (SUD)-Focused Health Homes

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Purpose

This document provides a description of some best practices for designing and implementing a Substance Use Disorder (SUD)-focused health home state plan amendment (SPA) based on the experiences of states with approved SUD-focused health home programs as required per section 1006(a)(2) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271).

Executive Summary

To date, five states – Maine, Maryland, Michigan, Rhode Island, and Vermont – have approved health home SPAs, authorized under section 1945 of the Social Security Act (the Act), and have implemented Medicaid health home SUD programs that specifically address opioid use disorder (OUD). Based on their experiences, best practices for designing and implementing health homes have been identified for other states to consider. In the design phase, the following practices were identified:

- Collaborating with the Centers for Medicare & Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other state partners while developing health home SPAs;
- Viewing health home development as a delivery system change initiative;
- Emphasizing provider and consumer engagement during model development to ensure ongoing support; and
- Offering to increase technical support during onboarding of health homes and providers.

Once states moved into the implementation phase, the following best practices were identified:

- Routinely assessing the model from various perspectives can lead to refinements in services provided, the payment model, and to the approach to care management and staffing;
- Incorporating Medicaid managed care organizations (MCOs) into the model, as applicable, up front or after implementation can enhance care coordination delivery and access to resources;
- Commissioning an independent evaluation to assess the health home model's impact on patient experience, access to treatment and for independent living in the community as well as impact on health care and cost related outcomes;
- Continuing technical assistance to health homes and providers to enhance participation
- Coordinating health home model implementation with broader, state SUD-focused initiatives to more fully incorporate into state policy both the patients' and providers' experiences; and
- Reporting annually on the health home core set of quality measures and SUD-specific quality measure will help states analyze the effectiveness of the health homes program.

Introduction

As of 2018, an estimated 20.3 million people in the United States have at least one SUD diagnosis.[1] Specifically, an estimated 2 million people in the United States have an OUD,[2] and states are on the frontline of combating this epidemic. In 2017, state Medicaid programs provided care for nearly four in ten non-elderly adults with OUD.[3] One vehicle states are using to deliver opioid treatment services is the Medicaid health home state plan optional benefit. Authorized under section 1945 of the Social Security Act (the Act), health home services are designed to promote access to and coordination of physical and behavioral health services and long-term services and supports for individuals enrolled in Medicaid who have two or more chronic conditions, have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition. States can use Medicaid health home authority to serve individuals with chronic physical or mental health conditions, including those with SUD and co-occurring SUD and mental health conditions.[4] States may choose to narrow the focus of their health home programs to include only individuals with OUD or to focus specifically on certain geographic areas of the state.

Figure 1: Health Home Services
Health homes must provide six core services: • Comprehensive care management; • Care coordination and health promotion; • Comprehensive transitional care/follow-up from inpatient to other settings; • Patient and family support; • Referral to community and social support services; and • Use of health information technology to link services, as feasible and appropriate.

Health home providers integrate and coordinate all primary, acute, behavioral health and long-term services and supports by using a whole person approach to care, to address all clinical and non-clinical needs of an individual. Health home providers work to establish prevention strategies; educate the individual about their condition; support the individual in maintaining wellness; and improve overall health care quality. Health home providers are responsible for providing six core health home services (noted in Figure 1). States receive an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent during the first eight quarters in which the program is in effect. After the first eight quarters, states receive their regular service match rate. However, as authorized under section 1006(a) of the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act "SUPPORT for Patients and Communities Act, which amended section 1945(c) of the Act, states with an SUD-focused health home SPA approved after October 1, 2018, may request to receive two additional quarters of the enhanced FMAP, for a total of ten fiscal year quarters.[5] To date, one state, Michigan, has been eligible for and requested the two additional quarters of enhanced FMAP.

In 2015, CMS issued a brief, "*Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States,*" which described key features of opioid health home models in three states – Maryland, Rhode Island, and Vermont – and identified early lessons for states in the development of opioid-focused health homes.[6] These early lessons indicated that states should:

- Leverage the requirements of opioid treatment programs (OTP) to encompass key health home components;

- Invest in multi-agency collaboration to develop opioid treatment health homes;

- Support providers as they transform into effective opioid treatment health homes; and

- Encourage information sharing between providers.[7]

This document describes some of the best practices identified by states, for designing and implementing opioid health home programs in Maine, Maryland, Michigan, Rhode Island, and Vermont. These five states use different models and have a variety of staffing and reimbursement structures (see Appendix A: *Features of Approved Medicaid Health Home Models for Opioid Use Disorder).* Also described are the early evaluation results of these states' efforts and highlights from several program innovations and early implementation successes and challenges.

Although some states include SUD as a targeted condition, their models are not SUD-focused because their programs include a variety of other non-SUD chronic conditions, so they are not discussed here. The featured five states focused their SUD programs specifically on the opioid crisis. The programs for these states are based primarily around designated opioid treatment providers that provide both health home services and medication-assisted treatment (MAT) services. MAT services include medications approved by the Food and Drug Administration (FDA) – including methadone, buprenorphine or naltrexone – in combination with counseling and behavioral therapies to provide a whole person approach in the treatment of SUD in order to help sustain recovery. MAT is available through opioid treatment programs (OTPs) or office based opioid treatment (OBOT) settings. OTPs are certified by the SAMHSA and accredited by a SAMHSA-approved accrediting body to provide MAT, including methadone. OBOT settings refer to providers in general medical practices who are also authorized to prescribe buprenorphine or naltrexone. Methadone is only available through OTPs and not authorized to be prescribed by OBOTs. In some states, opioid health home models receive a bundled payment for both the health home service rate and MAT service rate. However, the MAT services, which include the use of approved medications, counseling, and behavioral therapies, are not reimbursed under the health home authority and do not receive the enhanced match rate.

Design Considerations for Opioid Health Homes

Medicaid health homes integrate primary, acute and behavioral health care services and improve care coordination for beneficiaries with multiple chronic conditions. Health homes tailored to individuals with OUD also provide office-based administration of opioid agonist medications, such as buprenorphine or methadone, and psychological counseling and connection to community-based social supports. The following are key design considerations for the development of opioid health homes:

- **Collaborate with CMS/SAMHSA.** Early collaboration with CMS and SAMHSA to develop health home core services and provider requirements, especially with health homes planning to focus on persons with mental and/or substance use disorder diagnosis, will help to ensure that a state's needs and program goals are met, as well as ensure that the proposed health home model is aligned with existing systems and requirements such as quality reporting, licensing, and accreditation standards. The state plan approval process requires states to clearly define services and roles, which can facilitate implementation at the provider level (i.e., clear delineation of who on the care team can provide care management services). It is important to note that the consultation and collaboration with SAMHSA is a requirement for state plan development and approval by CMS.

- **View Health Home Development as a System Change Initiative.** As the health care delivery system evolves to be more patient centered, SUD treatment through a whole person approach is also gaining traction. For example, in an effort to address the wider range of needs of a patient, doctors may be more willing to consider providing SUD treatment and/or become more engaged in the overall process. States adopting the opioid health home model should consider the need for transformation on multiple levels, including the delivery system, at the organizational level, and at the provider and clinical level. For instance, states may wish to initiate efforts to encourage more health care providers to obtain waivers to prescribe buprenorphine.

- **Emphasize Provider Engagement.** Engaging providers early in the model development and implementation process ensures buy-in and ongoing support for the program. For example, Vermont noted that taking a collaborative approach to developing processes for data sharing and coordination to align with the Hub and Spoke model(see *Structure of Vermont's Opioid Health Home Model* above for a description of Hubs and Spokes), and leveraging providers' knowledge and expertise, was critical to the success of its program. Providers may need to be educated about the potential value and goals of health homes.

- **Incorporate Consumer Engagement.** The model focuses on systems change to make the system more person-centered. It is important to include consumers and their supporters early in model development to understand how consumers see the model working most effectively for them, and to gain their buy-in to new, more holistic approaches. Consumer support and engagement can result in greater success in the number of people who receive and maintain treatment.

- **Leveraging Health Information Technology (IT)**. The appropriate and effective of use of health information technology (health IT) is an important component of a state's health home strategy. Accordingly, the SPA template includes a number of places where states may describe how they will incorporate health IT tools to achieve the objectives of their state's health home program. States should think through key areas of SUD/OUD treatment that have health IT implications such as electronic consent, closed loop e-referrals to ensure warm handoffs, and enhanced integration between SUD providers, behavioral health providers, and an individual's health team.

- **Offer Ongoing Technical Support.** For many providers, the office-based administration of opioid medications (buprenorphine and naltrexone) is a new approach. Providing ongoing guidance and support, especially early on in implementation, will improve care delivery and outcomes, and provide a forum for providers to navigate challenges. States can consider forming advisory boards or a learning collaborative for sharing information via a peer-to-peer format. Some states have developed regular provider-led in person sessions, and also offer technical assistance to opioid health home providers and practices though webinars and videoconferences. Maryland maintains a help-desk email channel to address provider-specific reporting questions, among others, which was critical during the early days of implementation and remains critical for communication and technical assistance with providers.   Both CMS and SAMHSA may, in some

cases, be able to offer technical support as well. (See e.g., https://attcnetwork.org/), https://pcssnow.org/).

Overview of Opioid Health Home Programs

Maine

Health homes are a key component of Maine's Value-Based Purchasing strategy, a multi-pronged MaineCare initiative, designed to: (1) strengthen the health care system; (2) improve population health; and (3) reduce costs. Currently, Maine has three different health home programs. In 2013, the state began enrolling MaineCare members with chronic physical health conditions (and some less serious mental health conditions) in health homes, which consisted of partnerships between an enhanced primary care practice and one of ten Community Care Teams operating across the state. A year later the state began a health home program for individuals with severe mental illness or serious emotional disturbance. In April 2017, MaineCare was appropriated $3,000,000 in state funding to create an opioid health home (OHH) to address OUD among the MaineCare population, as well as the uninsured.[8]

The goal of the OHH is to increase the number of individuals receiving SUD treatment, as well as to improve the quality of care that they receive. MaineCare members diagnosed with OUD and who have a second chronic condition or are at risk for having a second chronic condition are eligible for OHH services. The multidisciplinary opioid health home team includes a clinical team lead, a MAT prescriber, a nurse care manager, an OUD clinical counselor, patient navigator and a peer recovery coach. The state's emphasis in embedding a MAT prescriber in the care team was done intentionally to support office-based MAT.

Maine uses a tiered reimbursement methodology for the OHH. Each of the three tiers is based on acuity level and the OHH team's approach to addressing an individual's needs. Reimbursement levels are:

Tier 1 - $394.40 Per Member Per Month (PMPM) for lower acuity,
Tier 2 - $409.40 PMPM for medium acuity, and
Tier 3 - $534.49 PMPM for individuals with the highest acuity.

Providers gave positive feedback about their participation in MaineCare's value-based purchasing models, and the state expects to continue working with providers to fine tune the OHH model in future months. Maine provides considerable technical assistance to the health home providers. For example, Maine health home programs participate in data-focused learning collaboratives where providers work on improving their performance on specific quality measures through both face-to-face and virtual peer-to-peer learning opportunities. There are also four designated provider relations specialists who work directly with health home providers on operational issues including billing, attestations, staffing requirements, and workflow challenges.

Maryland

In 2013, Maryland developed a statewide health home to augment its broader efforts to integrate physical and behavioral health services with a goal to improve health outcomes and reduce avoidable hospital encounters. Thus, the state chose to design a health home model to serve individuals with

serious persistent mental illness and serious emotional disturbance, and those with SUDs determined to be at risk for additional chronic conditions.

The state wanted to allow a variety of interested providers to be able to enroll in the health home both to ensure broad access and to support health home services being available to members where they currently seek the majority of their care. Several provider types are eligible to enroll as health homes, including psychiatric rehabilitation programs, mobile treatment service providers, and OTPs. The state model includes a team consisting of a health home director, nurse care manager, physician, or nurse practitioner consultant, and administrative support staff.

Health home services are reimbursed via a monthly payment of $110.19 based upon the delivery of a minimum of two health home services being provided in the month. In addition, the state acknowledged the necessary up-front work of the team to assess members and also provides a one-time payment of $110.19 for each member's initial intake assessment.

Michigan

Michigan has three distinct health home models. In 2014, the state began a health home program for individuals with serious mental illness in two counties. In 2016, the state began enrolling Medicaid members with chronic physical health conditions into their "MI Care Team" health home model, available in 21 counties. Two years later, in October 2018, the state created an OHH as part of its response to the opioid crisis. This is the first and only state approved to receive 10 quarters of enhanced match at the time of this report.

The broad goals of Michigan's OHH program are to: 1) improve care management of beneficiaries with OUD and comorbid chronic conditions, including MAT; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Medicaid recipients with OUD who also have or are at risk of developing another chronic condition are eligible for OHH services. The multidisciplinary health home team includes: a primary care provider, a clinical case manager, a nurse case manager, a certified peer recovery coach, a community health worker, a health home coordinator, and a health home director.

In Michigan, behavioral health is carved out of the managed care delivery system. Mental health care is managed by Prepaid Inpatient Health Plan (PIHP) – a specialty mental health managed care entity – and this organization also serves as the lead health home entity. Supporting entities that contract with the PIHP are utilized in both the managed care and PIHP delivery systems to support patient's care management needs.

In acknowledgement of the up-front investment providers make to engage beneficiaries in developing their initial recovery action plan, the state pays a one-time action plan payment during the first month of beneficiary enrollment. This recovery action plan payment is $398.91 and $417.80 respectively for OBOT and OTP providers. For ongoing care management, providers are paid a per participant per month rate of $246.32 and $255.76 (after the first month of enrollment) respectively for OBOT and OTP providers. Michigan implemented its OHH after federal legislation increased the enhanced FMAP

availability to 10 quarters for health homes. Thus, Michigan will receive 90 percent FMAP for its OHH model through the end of April 2021.

Rhode Island

Rhode Island has three separate health home models. In 2011, the state created a health home model for children and youth with special health care needs as well as a behavioral health home model for adults, both of which were statewide. Building on this experience, the state developed an opioid treatment health home model in 2013 in response to the growing opioid crisis.

Medicaid beneficiaries with an OUD who currently receive or meet qualifying criteria for MAT and are at risk of developing another chronic condition are eligible for the program. The state's 15 OHH are staffed by a team including the supervising physician, registered nurse, health home team leader, case manager/hospital liaison and pharmacist. Also, three positions are shared across all health home sites, including an administrative level coordinator, a health IT coordinator, and a health home training coordinator in order to provide resources across the health homes and staff at full capacity.

In Rhode Island, providers are paid a weekly OHH rate of $53.50. This rate does not include the cost of methadone treatment and is based on the utilization of OTP health home services only.   In 2016, Rhode Island was granted authority to move opioid treatment health home services in-network for Medicaid MCOs in alignment with other policy-related efforts around managed care, which emphasizes the health home model's flexibility in adjusting to changing health policy landscape in a state.

Vermont

In January 2014, Governor Peter Shumlin used his state-of-the-state speech to raise the alarm about the impact of the opioid epidemic in Vermont, declaring a state of emergency. The Governor's announcement made national headlines and spurred Vermont's towns and cities into action. At the same time, the state Medicaid agency began planning its OHH model, which in turn encouraged local communities and agencies to build more infrastructure, create better policies, and analyze the data needed to fashion a more comprehensive approach to OUD.

Vermont's OHH are organized in a "Hub and Spoke" model. The state is divided into six regions, served by a total of nine Hubs – licensed OTPs– that are staffed with addiction specialists who are able to prescribe methadone, naltrexone, and buprenorphine. Each Hub is surrounded by Spokes, which are usually primary care or other specialty practices (e.g., addictions, pain, OB-GYN, etc.), and clinics where providers prescribe Vivitrol® (naltrexone injection) and buprenorphine. The Spokes are supported by a registered nurse and a masters-level counselor.

Both Hubs and Spokes provide initial patient intake and assessment. Hubs also provide treatment for individuals with complex addictions and comorbid mental health conditions. Less clinically complex patients are referred to the Spokes, but patients can move between Hubs and Spokes as their conditions change.

Health home staff in Vermont include a registered nurse, master's level licensed clinician case manager, and program director employed by the Hub. Spokes include physicians, nurse care coordinator, social worker and behavioral health professional. In addition, the existing Blueprint Community Health Team

provides a registered nurse and clinician case manager to the Spoke team. The funding methodology for Hub and Spoke providers is based on staff costs.

The Hub methodology from the Hub and Spokes model, is based on the cost to employ key health professionals (salary and fringe benefits) to provide health home services. The staffing enhancements are based on a model of 6 FTEs for every 400 MAT beneficiaries served. The HUB payment is a monthly, bundled rate per beneficiary. The HUB program submits a monthly claim with a health home modifier for each Medicaid health home beneficiary who received at least one health home service in the month.

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 beneficiary across multiple providers. Payments will be made to the Blueprint administrative agent in each Health Service Area (HSA) when staff provide at least one Health Home service per month to each beneficiary on the Spoke Health Home caseload. For providing health home services, Hub providers receive $151 bundled PMPM and Spoke providers receive $163.75 monthly for direct health home services (fee-for-service (FFS)).

The OHH program continues to be a catalyst for action. In May 2017, Governor Phil Scott issued an executive order creating the Opioid Coordination Council, a 22-member task force representing state and local governments, service providers, people who have experienced opioid addiction personally and their families, law enforcement, and emergency responders. The Council's first report, issued in January 2018, [9]makes recommendations in four areas: (1) prevention; (2) treatment; (3) recovery; and (4) law enforcement. The report specifically mentions the value of the state's Hub and Spoke treatment approach to OUD, calling for additional support, evaluation and expansion, if necessary.

Update on the Early Adopter Opioid Health Home Programs since Implementation

The OHH programs in Maryland, Rhode Island, and Vermont were all implemented in 2013. Since that time, these states have made relatively few changes in their program structure. The programs continue to operate statewide, target the same populations, have the same provider team structure, and use roughly the same payment models with a few exceptions (see Appendix A: *Features of Approved Medicaid Health Home Models for Opioid Use Disorder*). However, each state has made policy and operational changes in response to their program experience to date, stakeholder feedback, or the new guidelines issued by the Centers for Disease Control and Prevention (CDC) on prescribing opioids for chronic pain.[10]

Expanding Covered Medications. Vermont changed the medications available through its OHH to give providers the flexibility to select the medication best suited to patients' needs. When the program originally started, its Hubs, which are the certified OTP's in the state, dispensed either methadone or buprenorphine to prevent patient relapse after opioid detoxification (see *Structure of Vermont's Opioid Health Home Model* above for a description of Hubs and Spokes). In 2015, the state added Vivitrol® (extended-release, injectable naltrexone) so that all three FDA-approved medications for OUD could be offered to patients.

Rethinking the Payment Model. Maryland's health home payment model consists of two components: (1) a one-time, up-front payment to the health home for an initial patient assessment, and (2) monthly payments for ongoing health home services. The payment rate has been revised for each component

with the initial payment for each reimbursed at $98.83; this was then revised various times with the latest update effective July 1, 2019 to $110.19 for each component.[11] Providers can receive the monthly payment if they provide at least two health home services per enrollee per month.[12]

Maryland's OTPs are reimbursed for MAT services (outside of the health home bundle), which include managing the plan of care; providing medications; nursing services; counseling services and drug testing; and coordinating other clinically indicated services. However, in May 2017, Maryland modified the structure of this OTP bundled payment by carving out counseling services, which are now reimbursed on a FFS basis. Given the critical role that counseling plays in the success of opioid treatment, the state wanted to better understand the intensity of the counseling services that were being provided as well as collect and monitor claims data, which could not be determined when counseling was included in the OTP bundled payment.

Developing a More Sophisticated Approach to Care Management and Staffing. By January 2014, Rhode Island found that, due to the rising rates of opioid use and changes in Medicaid eligibility requirements, the number of individuals eligible for its health home program had nearly doubled. The OTP leadership determined a more efficient system was needed to: (1) guide patient care while making best use of various skill levels and expertise of the health home team; and (2) help health home leadership determine when additional personnel are needed for care coordination activities. To address this challenge, a three-level patient acuity triage model was developed to serve as a guideline in determining how best to meet the needs of the patient:

- Level I: Patients at low to moderate risk;
- Level II: Patients at high risk; and
- Level III: Patients known to have chronic conditions.

On a weekly basis, each team reviews patient profiles to determine the necessary level of service, understanding that there is flexibility between the levels in order to allow for prompt care when necessary. Risk is defined fairly broad and the guideline incorporates assessment of clinical and psychosocial factors as well as patient engagement markers. The percentage of patients within each level varies depending on patient enrollment and the geographic location of the health home program. In Rhode Island, the patient acuity guidelines serve as a guide to address the needs of the patient population and health homes are paid the same PMPM rate regardless of a patient's acuity level. This is a flexibility left up to each state in its health home model design. Rhode Island's OTP health home weekly rate is set at $53.50. This rate does not include the cost of methadone treatment and is based on the utilization of OTP health home services across all lines of business.

The implementation of the patient acuity model also guides health homes to staff themselves more efficiently. As originally developed, Rhode Island's health home model was structured to provide one full care team (i.e., physician, a master's level care coordinator, two care managers, a full-time registered nurse, and a part-time pharmacist) for every 125 patients. With the patient acuity stratification model in place, a single care team can serve 150-160 people, with a mix of acuity levels. The stratification model also helps the health home leadership plan for the hiring of staff, including the requisite licensure and skill set. For example, as the model evolved, the OTP leadership determined that the health home team needed to provide more hours of medical care to meet enrollees' health care needs due in part to better understanding the magnitude of enrollees' chronic conditions. If the team physician did not have

additional time available, the health home was allowed to hire nurse practitioners, in addition to the team physician, to serve in the clinical role.

Adapting Health Homes to a Managed Care Model. Beginning in July 2016, Rhode Island received approval from CMS to move opioid treatment health home services into the benefit package provided by Medicaid MCOs. By incorporating OTP health homes into managed care, OTP providers would receive additional support for reporting and additional assistance in identifying eligible members in need of OTP health homes services. This required careful planning by the state, plans, and providers. About a year before health home services were to be covered by managed care, opioid health home leadership, the MCOs medical directors, and other staff started working to align their care models to ensure patients would receive continuity of care when MCOs were added to the existing opioid health home workflow and structure. At the state level, Medicaid staff identified potential changes to health home team composition and requirements, rates, and the structure of reimbursement. On the administrative side, changes were made to MCO contracts to include support for identifying and providing care coordination to health home enrollees. In addition, the state submitted an additional SPA to address the inclusion of the MCOs in the health homes' workflow.[13]

Lessons in Opioid Health Home Implementation

With nearly six years of experience operating OHH, state Medicaid staff in Maryland, Rhode Island, and Vermont are able to assess where their programs have been successful and where there has been room for improvement. Although Maine and Michigan implemented their OHH more recently, Medicaid staff in both states, were able to compare the launch of the OHH with other health home programs already in operation.

Continue Technical Assistance to Health Homes and Providers to Support Ongoing Participation

When Maryland began its OHH program in 2013, just five OTP providers participated. The state believes that providers' initial reluctance to participate in health homes was likely due to several factors. Providers noted concerns about the potential administrative burdens of becoming accredited as a health home and documenting the health homes' services they provided every month in Maryland's e-Medicaid system. At that time, providers were also anticipating an impending removal ("carve out") of SUD services from the benefits covered by managed care organizations to a FFS model. This was a major change for providers, and many were initially reluctant to initiate the administrative changes needed to become a health home while they transitioned out of managed care.

Over the last five years, the state has performed considerable outreach and offered technical assistance to OTPs interested in becoming health homes providers. At the same time, participating providers have become program champions and promoted participation to other OTPs. Maryland also now requires all OTPs to be accredited under either the Commission on Accreditation of Rehabilitation Facilities' health homes standards or the Joint Commission's behavioral health homes certification. Once providers have achieved that milestone, seeking the additional accreditation they need to become a health home is not as daunting a task. Finally, the state completed the move of SUD services from managed care to a FFS model, and providers have adjusted to those changes. These efforts appear to have paid off – OTPs are increasing with 17 now participating in the health home program.

Coordinate Health Home Implementation with Other Initiatives

Maine is undertaking a variety of initiatives to address OUD. For example, like nearly every other state, Maine has a prescription drug monitoring program (PDMP). State health home staff knew they needed to ensure that OHH requirements aligned with the recent updates to the law surrounding primary medical provider requirements and rules governing the prescription of opioids in order to have consistency across the two initiatives.[14] This alignment made it less burdensome for new providers signing up for the OHH who had not previously prescribed buprenorphine to comply with both the updates to the law as well as meet the health home provider requirements.

Innovative Management Strategy Improves Beneficiary Access and Experience of Care

Vermont's OHH have been very innovative in their efforts to actively manage patient waiting lists in order to get people into treatment more rapidly. Spoke MAT teams work directly with Hub intake coordinators and other providers to set up a triage system. This allows them to see which individuals are seeking treatment, what their needs are and which treatment sites are the best match for their needs. The state reported that its health home program significantly expanded access to MAT in Vermont, and, as of 2017, waiting lists at Hubs and Spokes were nearly eliminated and most individuals could access treatment within a 30- to 45-minute drive.

Spokes are also able to "frontload" their staffing in anticipation of additional enrollment. When a Spoke practice knows that it will expand its caseload, it can receive funding from the state in advance to hire the Spoke staff (i.e., a registered nurse and counselor) to help meet anticipated program needs, rather than creating a waiting list.

Patients and Families Experience Meaningful Benefits from Opioid Health Home Enrollment

Rhode Island's Medicaid staff shared the following stories to illustrate the impact of opioid health home enrollment and how the care coordination they provide can address the needs of the whole person:

- **Asking the Right Questions.** One patient, in his 40s, was morbidly obese and had multiple chronic conditions including diabetes and joint pain. The treatments his primary care physician (PCP) suggested (e.g., referral to nutritional counseling, medications) had not helped him to lose weight. The health home care coordinator instead asked the patient what *he wanted* to do. After learning that he wanted to swim, the health home team consulted the PCP and then found the patient transportation to the local YMCA's pool. He lost over 100 pounds in a year. Health home support and wraparound services were key to connecting him with community resources to reach his goal.
- **Making Critical Connections.** Another client, a young man in his 20s, was not eating correctly due to multiple dental problems and was making frequent emergency department visits for severe pain and constant infection. The health home team connected him to dental providers and found funding to pay for dentures. His nutrition and health improved, and he subsequently was able to find a job.

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Patients and Families Experience Meaningful Benefits from Opioid Health Home Enrollment

Vermont's 2017 Hub and Spoke evaluation included interviews not only with clients but also their families. Families were appreciative of the services available in Vermont for individuals with Opioid Use Disorder (OUD).

- Eleven of the 12 participants expressed praise and gratitude for the Vermont program and the care provided for their family member.
- "It was a nightmare when she got arrested, but I was able to help her find treatment in less than 24 hours."[15]

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Maximizing System Interoperability Eases Burden on Providers

Maryland acknowledges that a lack of information systems interoperability has caused a burden for providers in its OHH program. To meet the state's reporting requirements providers must use e-Medicaid, the state's system for eligibility verification, online FFS billing, and payment information. The e-Medicaid system also has a separate portal for the health home program where providers must record the health home services they provide each month and document outcome measures. For their own patient care and record keeping purposes, health home providers must also enter this information into their own electronic health record systems that do not interface with e-Medicaid. Interoperability within these systems would reduce provider burden but requires a significant technological investment. Other health homes have benefited from pre-existing requirement of system interoperability among providers. The District of Columbia health home models leveraged existing health IT initiatives as the health homes were being developed and incorporated health IT use into routine health home practices.

Further, state Medicaid programs have reporting requirements that they use to monitor their health home programs, many of which are based off of the data they receive from providers. Interoperability at the provider level can impact how robustly the states are able to report this information to CMS.[16]

Health Home "Success" Can Have Unintended Effects

Vermont considers its OHH to be very successful; however, state staff realized that the program has had two unintended effects. The first effect is on the provider workforce. In Vermont's Hub and Spoke model, the Spoke setting is typically a general health care setting with primary care providers,[17] while the Hubs require an extensive staff of addictions-trained doctors, nurses and counselors. The salary range that the state set for Spoke staff was on par with the salaries of staff in general medical office settings, but higher than in community mental health centers or addictions treatment centers. As a result, the Spokes ended up recruiting staff from addiction treatment settings. In retrospect, the state realized that it should have sought more support from academic institutions or other training organizations to help prepare for these workforce changes. State staff believe that, ultimately, the OHH program will promote better pay in the field overall and bring more people into the workforce.

Another unintended effect of the OHH program has been an increase in Vermont's Medicaid non-emergency medical transportation (NEMT) costs. When an opioid health home enrollee initiates MAT, he or she must travel to the Hub location seven days a week for administration of medications—14

NEMT trips per week—perhaps for a duration of several months before stabilizing and making still frequent, but likely fewer, visits. Patient NEMT to the Hub and Spoke providers has become the biggest cost to the overall Medicaid transportation budget. This demand has also overwhelmed the supply of transportation providers, and the system is still trying to catch up. The state's experience suggests the importance of coordination between OHH and transportation authorities.

Providers Need to Support MAT

A common misconception related to MAT is that it substitutes dependency on one drug for dependency on another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body.[18] Some providers also believe that patients just come in to get their medication then leave, when MAT programs actually provide both medication and intensive counseling to help patients address underlying mental health issues and other social determinants that may contribute to their SUD. SAMHSA's Treatment Improvement Protocol 63: *Medications for Opioid Use Disorder* emphasizes the importance of MAT as a standard of care[19]

In Vermont, the leaders of a large medical center were skeptical of MAT's efficacy and were initially reluctant to commit to a health home model with MAT at its core. At the request of the Governor, the organization convened a planning group that included the mayor and police chief of Burlington, as well as the state attorney general who were tasked with eliminating wait lists for MAT treatment in two months. The tide turned when this group learned more about the impacts of MAT in the lives of patients when a patient receiving MAT shared their personal experiences, and the organization is now an enthusiastic proponent of MAT.

Vermont state staff suggested that the guidelines and templates that CMS has provided through the state plan process helped them shape their thinking about how to approach stakeholder engagement. They realized that they needed to think of the implementation of their OHH program as a systems change initiative, and they needed to plan for change at the state level, program level, organizational level, and clinical level. When they changed their approach and put in place policies and procedures that aligned with CMS' expectations, state licensure requirements, and accreditation standards, they were able to get the program off the ground.

Effect of Opioid Health Homes on Patient Outcomes

In May 2017, the Urban Institute, under contract with the Office of Assistant Secretary of Planning and Evaluation in the U.S. Department of Health and Human Services, conducted an evaluation of the earliest health home programs. The report[20] acknowledged that health homes in general, with their focus on integrating physical and behavioral health services and improving care coordination, have the potential to: improve patients' experience, increase access to treatment, and support enrollees with the services they need to live independently in the community.[21] The opioid health homes in Maryland, Rhode Island, and Vermont were not included due to the timing of the evaluation, but the findings may still be applicable to the more specialized OHH. However, Maryland, Rhode Island and Vermont have commissioned their own independent evaluations as mentioned below.[22]

Maryland. In June 2017, Maryland released an evaluation of its health home program that serves patients with serious mental illness, children with serious emotional disturbance, and individual's with

OUD.[23] The evaluation analyzed data from 2013-2015 and found that the health home programs connected their enrollees to primary care and social services and improved access to preventive care. Participation in a health home increased the likelihood of having an emergency department visit, but decreased the likelihood of an inpatient stay. Overall, the authors indicated that there appeared to be incremental progress towards achieving the desired goal of improving health outcomes while reducing costs through this comparison group analysis. They suggest that additional years of data are needed to detect meaningful and sustained differences in long-term health outcomes. The state plans to release another evaluation at a later point.

Rhode Island. In 2016, the Substance Use and Mental Health Leadership Council of Rhode Island surveyed Rhode Island's OHH enrollees to assess their experience of care, satisfaction, and engagement with the program.[24] Results indicate enrollees found support and value in the OHH services they received. Nearly 95 percent of respondents felt the health home staff listened to and respected them, and over 93 percent were satisfied with the assistance provided in connecting them with primary care, mental health, or specialty health services. Further, over 90 percent believed that they were learning skills to more effectively address problems in their daily lives.[25]

Rhode Island also reported findings from OHH focus groups conducted in early 2015:[26]
- The humanizing and personalized approach of the OHH helped participants establish a connection to health care;
- Mutual trust and relationships were critical elements for increasing participants' motivation to take better care of their health;
- The OHH environment was safe, caring, supportive and most of all transformative in that it helped participants develop empowering behaviors;
- The program fostered hope in participants, which they identified to be a key in supporting their recovery; and
- Staff helped the participants understand their problems and how to address them while honoring their values, preferences, and expressed needs.

Participants' suggestions for improvement included: (1) members should not be put on hold when they telephone the health home without first asking members' permission to do so; (2) health home hours of operation could be expanded; and (3) a Patient Advisory Committee should be added.

Vermont: During 2014 testimony to the state legislature, staff from the Vermont Department of Health Access estimated that the Hub and Spoke program had saved $6.7 million for the over 2,100 enrolled patients. Subsequently, the health home program was expanded statewide.[27]

A December 2017 evaluation entitled *Vermont Hub-and-Spoke Model of Care for Opioid Use Disorders: An Evaluation* reported the following results:

- There was an 89 percent decrease in emergency department visits for 80 participants with six continuous months of health home enrollment, although other measures of service utilization did not show a significant change.[28]

- The following changes were also observed among participants after admittance to the program:
    - a 96 percent drop in opioid use,
    - a 92 percent decrease in injection use, and
    - a 90 percent drop in both illegal activities and police stops/arrests.

- Participants reported more satisfaction with their lives and a decrease in family conflict, feelings of depression, anxiety and anger.

Data from another report shows that the health home program significantly expanded access to MAT in Vermont, and, as of 2017, waiting lists at Hubs and Spokes were nearly eliminated and most individuals could access treatment within a 30- to 45-minute drive.[29]

Conclusion

It is important to note that states have the flexibility to scale their health home models over time by adding eligible chronic conditions and expanding the geographic area covered, which helps them to tailor their models to fit available state funding. The enhanced federal match (up to 10 quarters for SUD-focused health homes) also allows states to build program-sustaining resources for after their return to the regular match rate. Overall, the states interviewed consider the health home model to be a successful mechanism for coordinating whole person care for individuals with SUD.

All five states included in this report consider their programs to be successful based on state reporting, program evaluation, and participant and provider feedback. Maine, Maryland, Rhode Island, and Vermont have all secured an increased commitment of state funds from the legislature to support these programs beyond the enhanced match period. They are encouraged by preliminary evaluation data and will continue to collect data, report on quality measures, and refine their programs. Michigan is still in the first 10 quarters of implementation for the OHH and will have more programmatic data with more programmatic experience. Additional states can look to the health home models in these states as they consider designing their own health home models to address OUD in their Medicaid populations to improve health outcomes while reducing costs. There are resources for states on Medicaid.gov found here: https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html. The chart below represents the Best Practices:

Best Practices in SUD Health Home Design and Implementation
In the design phase: • Collaborate with CMS/SAMHSA, state partners, consumer groups, and others while developing the health home model; • View health home development as a system change initiative; • Emphasize provider engagement during model development to ensure ongoing support; and • Offer ramp-up technical support during onboarding of health homes and providers. In the implementation phase: • The momentum built during health home development can be a catalyst for action in other SUD-related efforts; • Routine assessment of the model from various perspectives can lead to refinements in services provided, the payment model, and to the approach to care management and staffing;

- Medicaid MCOs can be incorporated into the model up front or after implementation to enhance care coordination delivery and access to resources;
- Consider commissioning an independent evaluation to assess the health home model's impact on patient experience, access to treatment and for living independently in the community as well as impact on health and cost related outcomes;
- Continue technical assistance to health homes and providers to enhance participation;
- Coordinate health home implementation with broader, related initiatives to more fully incorporate into state policy and the patient/provider experience; and
- Reporting on core set and SUD-specific quality measures annually.

[1] Substance Abuse and Mental Health Services Administration. "Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Available at https://www.samhsa.gov/data/Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

[2] Substance Abuse and Mental Health Services Administration. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health" (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2017. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

[3] Kaiser Family Foundation. "Medicaid's Role in Addressing the Opioid Epidemic." February 2018. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2018/02/medicaid_s-role-in-addressing-the-opioid-epidemic-feb-2018-update.png

[4] In addition to the opioid-focused health home models operating in Maine, Maryland, Rhode Island, and Vermont, 13 of the health home models in other states (one of which is Maine's chronic condition model) enroll individuals with some type of substance use disorder.

[5] Section 1006(a) of the SUPPORT for Patients and Communities Act, by adding the new section 1945(c)(4)(A) to the Social Security Act, provides for ten quarters of the 90% federal match for substance use disorder focused health home programs.

[6] https://www.medicaid.gov/sites/default/files/2020-02/hh-irc-health-homes-opiod-dependency.pdf

[7] Moses, K. and Klebonis, J. "Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States." Health Home Information Resource Center, January 2015. Available at: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-irc-health-homes-opioid-dependency.pdf

[8] Opioid health home services for the uninsured are paid for with state-only funds and do not receive the 90% enhanced federal match.

[9] Opioid Coordination Council report. Avalible at: http://www.healthvermont.gov/response/alcohol-drugs/governors-opioid-coordination-council

[10] Centers for Disease Control and Prevention. "CDC Opioid Prescribing Guideline for Pain." 2016. Available at: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

[11] Maryland Health Home State Plan Amendment, effective July 1, 2019. Available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MD/MD-19-0009.pdf

[12] For a description of the six core health home services see: Centers for Medicare & Medicaid Services. State Medicaid Director Letter # 10-024. November 16, 2010. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[13] Rhode Island Health Home SPA. Available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/RI/RI-16-006.pdf

[14] Maine Board of Pharmacy. 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications. August 2017. Available at: http://www.maine.gov/pfr/professionallicensing/professions/pharmacy/pdf/rule_governing_controlled_substances_mbop_august_3_2017.pdf

[15] Rawson, R. "Vermont Hub-and-Spoke Model of Care for Opioid Use Disorders: An Evaluation." Vermont Center on Behavior and Health, December 2017. Available at: http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Hub_and_Spoke_Evaluation_2017_1.pdf

[16] Section 1945(g) of Social Security Act requires providers to report to the state on quality measures as a condition of payment and when appropriate and feasible, a provider shall use health information technology to provide this information to the state.

[17] Spoke staff include at least one buprenorphine prescribing physician and a MAT team of a registered nurse and a master's level licensed counselor.

[18] Substance Abuse and Mental Health Services Administration. "Medication and Counseling Treatment." September 2015. Available at: https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

[19] SAMHSA treatment improvement 63. Available at: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

[20] Urban Institute and ASPE evaluation of health home programs report. Available at: https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-evaluation-outcomes-selected-health-home-programs-annual-report-year-five#execsum

[21] U.S. Department of Health and Human Services. Office of Assistant Secretary of Planning and Evaluation. "Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Evaluation of Outcomes for Selected Health Home Programs, Annual Report Year Five." May 2017. Available at: https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-evaluation-outcomes-selected-health-home-programs-annual-report-year-five#execsum

[22] Evaluation results are not yet available for Maine's opioid health home program, which began in October 2017.

[23] The Hilltop Institute. "2016 Health Home Evaluation Report." June 2017. Available at: https://mmcp.health.maryland.gov/SiteAssets/SitePages/Health%20Home%20Program%20Evaluation%20and%20Outcomes/health_home_2016_evaluation_report.pdf

[24] Storti, S. "Opioid Health Home Initiative: Patient Satisfaction Report." Substance Use and Mental Health Leadership Council of Rhode Island. March 2017.

[25] Ibid.

[26] Storti, S. "Listening to Those We Don't Often Hear: Enhancing Patient Care and Care Coordination through Rhode Island's Opioid Treatment Program Health Homes." Substance Use and Mental Health Leadership Council of Rhode Island. April 2016.

[27] Chen, H. and VanDonsel, A. "Stopping Vermont's Opioid Problem in Its Tracks: Expansion of the Hub and Spoke Program." Columbia University School of Nursing, 2015. Available at: http://nursing.columbia.edu/sites/default/files/documents/vermont_prescriptiondrugabuse_fall2015.pdf

[28] Rawson, R. "Vermont Hub-and-Spoke Model of Care for Opioid Use Disorders: An Evaluation." Vermont Center on Behavior and Health, December 2017. Available at: http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Hub_and_Spoke_Evaluation_2017_1.pdf

[29] State of Vermont. Department of Vermont Health Access. "Blueprint for Health in 2017: Annual Report." http://blueprintforhealth.vermont.gov/sites/bfh/files/Vermont-Blueprint-for-Health-Annual-Report-2017.pdf

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Appendix A: Features of Approved Medicaid Health Home Models for Opioid Use Disorder

Feature	State				
	Maine	**Maryland**	**Rhode Island**	**Vermont**	**Michigan**
Effective Date	October 2017	October 2013	July 2013	July 2013, expanded statewide January 2014	October 2018
Geographic Location	Statewide	Statewide	Statewide	Statewide	21 counties
Target Population	Medicaid recipients with opioid use disorder (OUD) and have a second chronic condition or are at risk of developing another chronic condition. The state also operates a lookalike program for the uninsured (with state-only funding).	Medicaid recipients with OUD and the risk of developing another chronic condition (current or prior drug, alcohol, or tobacco use); or one or more serious and persistent mental illness (SPMI)	Opioid-dependent Medicaid recipients currently receiving or who meet criteria for Medication Assisted Treatment (MAT) and are at risk of developing another chronic condition	Medicaid recipients with opioid dependence and at risk of developing another SUD and co-occurring mental health condition	Medicaid recipients with OUD who also have or are at risk of developing another chronic condition
Type of Enrollment	Opt-in enrollment	Opt-in enrollment	Auto-assignment, with opt-out	Auto-assignment, with opt-out	Auto-assignment, with opt-out. Providers may also recommend a patient to be considered for eligibility
Enrollment[1]	495	6,478 (4,662 with SPMI and 1,816 with OUD	2,982	6,174 (3,413 in Hubs, 2,761 in Spokes)	270
Types of Providers	The OHH must be a community-based provider and while a substance abuse service license is not required, it is preferred	Designated provider must be one of the following: (1) an opioid treatment program (OTP); and, for the SPMI population, either (2) Psychiatric Rehabilitation Program; or (3) Mobile Treatment Service provider	Designated provider must be OTP licensed by the state as a Behavioral Healthcare Organization	Hub: Designated provider must be a regional specialty OTP Spoke: Team of health care professionals set in office based opioid treatment (OBOT) programs	Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as an (OTP or OBOT)
Providers[2]	19 service locations including federally qualified health centers (FQHCs), substance abuse agencies, and OTP sites.	92 health homes, 17 of which are opioid treatment providers	15 OTP health home sites	Five Hub providers with 9 sites between them; 212 Spoke providers in 83 practices statewide	8 service locations, including FQHCs, behavioral health agencies, and substance use agencies

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[1] As of March 2018
[2] As of March 2018

Feature	State				
	Maine	**Maryland**	**Rhode Island**	**Vermont**	**Michigan**
Key Health Home Team	Multidisciplinary team of providers, including a clinical team lead, MAT prescriber, nurse care manager, OUD clinical counselor, patient navigator and peer recovery coach	Health home director, nurse care manager, physician, or nurse practitioner consultant, and administrative support staff[3]	Supervising physician, registered nurse, health home team leader, case manager / hospital liaison and pharmacist. Also, three shared positions across health home sites: (1) administrative level coordinator; (2) health IT coordinator; and (3) health home training coordinator[4]	Hub: Registered nurse and master's level licensed clinician case manager, and program director employed by the Hub Spoke: Physicians, nurse care coordinator, social worker and behavioral health professional. Registered nurse and clinician case manager employed by Blueprint Community Health Team[5]	Primary Care Provider, Clinical Case Manager, Nurse Case Manager, Certified Peer Recovery Coach, Community Health Worker, Health Home Coordinator, Health Home Director
Payment Model	Maine uses a tiered reimbursement methodology for the opioid health home. Each of the three tiers is based on acuity level and the opioid health home team's approach to addressing an individual's needs. Reimbursement levels are: Tier 1 - $394.40 PMPM for lower acuity, Tier 2 - $409.40 PMPM for medium acuity, and Tier 3 - $534.49 for highest acuity.	**$110.19** monthly payment with a minimum of two health home services provided; and one-time payment of **$110.19** for each member's initial intake assessment	OTP Health Home weekly rate is set at $53.50. This rate does not include the cost of methadone treatment and is based on the utilization of OTP HH services across all lines of business **($214/month)**	Hub* $151 bundled PMPM for Health Home services only. Spoke: $163.75 monthly fee for service payment for direct Health Home services (minimum of one) OTP statewide average rate; $353/month (non-health home) *Total Hub Payment: Health Home ($151) + OTP statewide average ($353) = $504/month[6]	OBOT (initial recovery plan): $398.91 -1 per lifetime OTP (initial recovery plan): $417.80 – 1 per lifetime OBOT (on-going): $246.32 OTP (on-going): $255.76

SOURCE: Health Home Information Resource Center and approved health home SPAs. Health Home Information Resource Center. Health Home State Plan Amendment Matrix. April 2018. Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html;

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[3] Staffing based on a ratio of 125 enrollees per team that equates to slightly more than 1.25 FTEs

[4] Staffing based on a ratio of 125 enrollees per team of 4.35 FTEs

[5] Staffing based on 100 enrollees per team of 2 FTEs

[6] This number shows the total combined payment to Hubs, of which only a portion is funded by health home resources.