

Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States

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Over the last decade, increasing rates of opioid dependency have become a concern for public health officials, state Medicaid agencies, and the federal government. Increased health care service use and higher costs of care have resulted from the significant morbidity and mortality associated with illegal opioid use. In 2010, roughly 600,000 people in the United States used heroin¹ and 12 million used prescription painkillers, including oxycodone and morphine, for nonmedical reasons.² In 2009, nearly half a million emergency department visits were due to people misusing or abusing prescription painkillers. In that same year, health insurers spent \$24 billion on treatment for substance use disorders, of which Medicaid accounted for 21 percent of all spending.³

Individuals who are opioid dependent often have complex social, physical, or behavioral health comorbidities. For example, six out of 10 people with a substance use disorder also suffer from another form of mental illness⁴ and could benefit from increased care management.

According to a recent informational bulletin from the Center for Medicaid and CHIP Services, states can incorporate Medication Assisted Therapy (MAT), an evidence-based practice to address opioid use, into efforts to address substance use disorders.⁵ Clinical guidelines recommend that MAT be offered in combination with behavioral health therapies.⁶ Moreover, to ensure that treatment is coordinated with other needed physical and behavioral health services, many state Medicaid agencies are seeking new mechanisms to promote integrated care for individuals with opioid dependency.

The Medicaid health home state plan option offers states one such mechanism. As of December 2014, three states—Maryland, Rhode Island, and Vermont—have approved state plan amendments (SPAs) to implement Medicaid health home models targeting opioid dependence.⁷ This brief, made

IN BRIEF

Although individuals with opioid dependency represent a small percentage of all Medicaid enrollees, they often have significant physical and behavioral health needs that result in high costs of care. States are looking for innovative, cost-effective ways to integrate and coordinate care for this population. Through the Affordable Care Act (ACA), states can implement health homes to provide enhanced integration and care coordination for people with opioid dependency.

This brief, made possible by the Centers for Medicare & Medicaid Services, highlights key features of approved health home models in Maryland, Rhode Island, and Vermont that are tailored to individuals with opioid dependency. It identifies important considerations in developing opioid dependence-focused health homes, including: (1) leveraging opioid treatment program requirements; (2) promoting collaboration across multiple state agencies; (3) supporting providers in transforming into health homes; and (4) encouraging information sharing.

possible by the Centers for Medicare & Medicaid Services (CMS), shares insights from these three states and outlines key considerations for states in designing an opioid dependence-focused health home.

Comparison of Approved Opioid Health Home Models

Common features across the opioid treatment health home models in Maryland, Rhode Island, and Vermont include: (1) statewide implementation; (2) Opioid Treatment Programs (OTPs)⁸ as a designated provider; and (3) definitions of eligible populations (Exhibit 1). While some program aspects are similar, CMS provides the flexibility for states to tailor programs—within defined requirements and subject to federal approval—to meet the needs of beneficiaries and local providers. Variations across the three state opioid health home models include:

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- Health home provider structure.** Each state has defined providers differently. Vermont’s health home model, for example, refers to its designated providers as “Hubs and Spokes.” Hubs are designated providers (OTP programs) that serve clinically complex members and dispense methadone and buprenorphine in an addictions treatment center. Spokes refer to a team of health care professionals (Office Based Opioid Treatment [OBOT]) that is comprised of physicians licensed to prescribe buprenorphine; nurses; and clinician case managers. (For more information, see sidebar *Spotlight on Vermont’s Health Home Model* page 5.)
 - Type of enrollment.** States must determine if eligible Medicaid beneficiaries will be assigned into the health home with the ability to opt-out, or if beneficiaries must opt-in. Most health home models, including Rhode Island and Vermont, auto-assign beneficiaries, but allow them to opt-out at any time or select among other qualified health homes. Maryland uses the opt-in approach and built beneficiary consent into the opt-in process, ensuring the opportunity to secure the necessary member consent to share critical health care information.
 - Team of health home providers.** Each state defines the health home team differently in terms of: (1) required staff positions; (2) education or training requirements; and (3) the ratio of members to full-time equivalent staff. Rhode Island created a shared statewide administrative-level coordinator role to oversee health home
- implementation at all agencies and act as the liaison to the state agencies supporting health homes. The coordinator strategizes with teams to encourage member participation, identifies potential community partners, addresses implementation challenges, and assists in outcomes evaluation. In Rhode Island, this position is viewed as a trusted advisor to the site-specific health home teams, as well as an excellent resource to the state for ensuring fidelity to the health home model. A key component to this staffing approach is that the state is responsible for hiring the shared administrative coordinator, but funding for the position is shared across all health home sites.
- Approach to payment.** Whereas all three states include some form of bundled payment for health home services, there are three slight variations in payment models: (1) Maryland’s per member per month (PMPM) payment is coupled with a one-time payment for initial intake assessment; (2) Rhode Island uses a weekly bundled payment with the rate based on whether the member is enrolled in fee-for-service or managed care; and (3) Vermont has a monthly bundled rate for Hub providers and a monthly capacity payment for Spoke nurses and clinician case managers. The average monthly payment across these three models ranges from approximately \$100 to \$350 depending on the team’s cost for providing the service, staffing ratios, and what services are included in the rate.

Medication Assisted Therapy

Medication Assisted Therapy (MAT) uses medication (methadone, buprenorphine or naltrexone) in conjunction with counseling and behavioral therapies. MAT is available in two different provider settings: Opioid Treatment Programs (OTPs) or Office Based Opioid Treatment (OBOT) settings. OTPs are specially licensed treatment programs where patients receive dispensed methadone on a daily schedule. Buprenorphine or naltrexone therapy, which has a less rigorous dosing schedule, is also available through an OTP.⁹ OBOT settings refer to certified providers in general medical practices who are also authorized to prescribe buprenorphine or naltrexone.

Exhibit 1: Features of Approved Medicaid Health Home Models for Opioid Dependency

Feature	State		
	Maryland	Rhode Island	Vermont
Effective Date	October 2013	July 2013	July 2013, expanded January 2014
Geographic Location	Statewide	Statewide	Statewide
Target Population	Medicaid recipients with opioid use disorder and the risk of developing another chronic condition; or one or more serious and persistent mental illness (SPMI)	Opioid-dependent Medicaid recipients currently receiving or who meet criteria for MAT	Medicaid recipients with opioid dependence and the risk of developing another substance use disorder and co-occurring mental health condition
Type of Enrollment	Opt-in enrollment	Auto-assignment, with opt-out	Auto-assignment, with opt-out
Enrollment^a	4,553 (4,038 with SPMI and 515 with opioid use disorder)	2,657	4,436 (2,464 in Hubs, 1,972 in Spokes)
Types of Providers	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 OBOT programs
Providers^a	27 agencies with 60 provider sites	Five providers with 12 statewide locations	Five Hub providers; 127 Spoke providers
Key Health Home Team	Health home director, nurse care manager, physician, or nurse practitioner consultant, and administrative support staff ^b	Supervising physician, registered nurse, health home team coordinator, case manager / hospital liaison and pharmacist. Also, three shared positions across health home sites: (1) administrative level coordinator; (2) HIT coordinator; and (3) health home training coordinator ^c	Hub: Registered nurse and master's level licensed clinician case manager, and program director employed by the Hub Spoke: Registered nurse and clinician case manager employed by Blueprint Community Health Team ^d
Payment Model	\$98.87 per member per month (PMPM) payment; and one-time payment of \$98.87 for each member's initial intake assessment	\$87.52 for fee-for-service members and \$52.52 for managed care members structured as a weekly, bundled rate per member	Hub: Monthly bundled rate per member of \$493.37. Note: only 30% of the rate is health-home specific, thus only 30% of the Hub payment is matched at 90% of the federal financial participation rate, or approximately \$148 PMPM. Spoke: \$163.75 PMPM payment

SOURCE: Health Home Information Resource Center and approved health home SPAs.¹⁰

^a As of December 2014.

^b Staffing based on a ratio of 125 enrollees per team that equates to slightly more than 1.25 FTEs.

^c Staffing based on a ratio of 125 enrollees per team of 4.35 FTEs.

^d Staffing based on 100 enrollees per team of 2 FTEs.

Health Homes 101

The Medicaid health home state plan option (ACA Section 2703) promotes access to and coordination of primary and acute physical and behavioral health services and long-term services and supports. Health homes may be virtual or located in primary care or behavioral health providers' offices or other settings that best suit beneficiaries' needs. Health homes must provide six core services, linked as appropriate and feasible by health information technology:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Individual and family support; and
- Referral to community and social support services.

To be eligible for health home services, an individual must be diagnosed with either: (1) two chronic conditions; (2) one chronic condition and at risk for a second; or (3) a serious mental illness. States implementing Medicaid health homes receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home program.

Considerations for Developing Opioid Health Homes

Interviews with representatives from Maryland, Rhode Island, and Vermont provide additional recommendations for the development of opioid dependency-focused health home models. These include:

- 1. Leverage the requirements of OTPs to encompass key health home components.**
OTPs, given their responsibility to provide daily doses of methadone to members, have a “captive audience” that is enviable in Medicaid health homes. Thus, the typically challenging task of identifying and engaging members is not an issue in OTP settings. This opportunity in OTPs for daily member contact with medical and other clinical professionals supports health home goals of ongoing care management, care coordination, and consumer engagement.
- 2. Invest in multi-agency collaboration to develop opioid treatment health homes.**
Overwhelmingly, states cited internal collaboration with other state agencies, such as the Office of Mental Health and the Office of Alcohol and Substance Abuse, as paramount to the success of their opioid health home delivery models. This collaboration requires a significant amount of internal stakeholder engagement to bridge differences in priorities and practices between Medicaid and sister state agencies.

Vermont's Medicaid agency identified the need for internal collaboration as a key success factor both in the design and implementation phases of its health home. The design of its opioid health home was a result of collaboration between the Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP), the Department of Vermont Health Access (DVHA) (Vermont's Medicaid program), and Vermont's Blueprint for Health (Blueprint)—the state's health care reform initiative.

In building the health home model, the state leveraged ADAP's existing relationships with established providers as well as existing provider education mechanisms. The Blueprint for Health, part of DVHA, coordinates the overall administration of the health home effort as well as the PCMH initiatives that are building blocks to the opioid treatment health home model. Blueprint community health teams (CHTs) are being used to provide the additional care management services to Hub and Spoke health homes. Pulling from multiple agencies, Vermont built on each state agency's strongest attributes to develop a health home model that meets both the goals of the state and the needs of the individuals it serves.

- 3. Support providers in transforming into effective opioid treatment health homes.**
Offering support and education to providers is vital to the success of health homes for individuals with opioid dependency. The three

Spotlight on Vermont's Health Home Model

Vermont's health home approach is referred to as the "Hub and Spoke" model. This approach builds on existing infrastructure, including: (1) two levels of care for MAT; and (2) the Blueprint for Health (Blueprint), a statewide, multi-payer initiative to improve health care delivery. Depending on the initial determination of complexity and/or appropriate treatment method, individuals are referred to either a Hub or Spoke.

Hubs are based on OTPs, which are highly regulated specialty treatment centers for individuals with complex addictions and comorbid mental health conditions. Methadone treatment must be provided in the OTP, and, in Vermont, OTPs may also dispense buprenorphine.

Spokes are based on OBOT programs, which are general medical office settings where physicians are specifically licensed to provide buprenorphine to individuals with less clinically complex conditions. The office settings include primary care, ob-gyn, psychiatry, and other specialties.

Leveraging Existing Infrastructure for Care Management Staffing: Through Vermont's Blueprint, public and commercial payers make additional payments to primary care practices that meet Patient Centered Medical Home (PCMH) standards and also share in the cost of community health teams (CHT) that provide multidisciplinary support for PCMHs and their patients. The CHTs are staffed with nurse coordinators, clinical case managers, social workers, and other staff. CHTs extend the capacity of primary care practices by supporting patient assessments, coordinating community-based support services, and providing multidisciplinary care. Because the Blueprint is a public-private partnership, CHTs are funded collectively by Vermont's large health insurance payers. Transforming the OTPs and OBOTs to Hubs and Spokes includes adding staff to the CHT infrastructure to provide the core health home services to opioid-dependent individuals and to coordinate patient care across the primary, acute, behavioral, and long-term care systems.

Enhanced Federal Match for New Services: Costs for previously existing opioid treatment services remain matched at Vermont's regular federal match rate. Since new health home staffing at the Hub is approximately 30 percent of overall Hub costs, only 30 percent of a Hub's reimbursement rate is eligible for the enhanced 90 percent federal match. Enhanced Spoke staffing provides all new care management services; therefore, a Spoke receives a 90 percent federal match for all health home costs.

states' approved SPAs include a variety of health home provider education approaches that can be repeated as new providers come onboard or staff turns over. In the three approved SPAs, state options for fostering provider education included:

- **Maryland** used a series of webinars and regional meetings to support information sharing and problem solving among OTP health home teams. The state is also performing outreach to foster linkages with community providers that may collaborate with health homes.
- **Rhode Island** built its education activities upon experience from earlier health home models and substance abuse programs. The state supplemented general health home education activities by adding training on health literacy, motivational interviewing, and emotional trauma in order to enhance provision of care management and care coordination activities. In addition, Rhode

Island is also planning to provide the Whole Health Action Management (WHAM) training program¹¹ developed by the SAMHSA-HRSA Center for Integrated Health Solutions to its peer workforce in order to strengthen their ability to support opioid-focused health homes.

- **Vermont's** ADAP and the Blueprint for Health are sponsoring learning collaboratives and trainings to support OTPs and OBOTs in transitioning to Hub and Spoke health homes. Regional OBOT collaboratives and statewide Hub and Spoke learning collaboratives are designed to: (1) provide education on best practices in care management for individuals with opioid dependence; (2) report on quality measures; and (3) share health home quality improvement efforts (e.g., Plan, Do, Study, Act cycles). The state provides continuing education credits to providers participating in the regional collaboratives.

- 4. Encourage information sharing between providers.** Collectively, the three states cited federal confidentiality requirements as a barrier to effective integration of care and sharing of vital information between the health home and other medical professionals. Federal regulations (i.e., 42 CFR Part 2) were established to protect the privacy of individuals with alcohol and substance use disorders by limiting who can access information regarding treatment.¹² Because 42 CFR Part 2 applies to any entity receiving federal assistance that provides an alcohol or substance abuse diagnosis, treatment, or referral to treatment, OTPs are included under this provision.

As more states are moving toward an integrated health care delivery approach, 42 CFR Part 2 poses unique challenges for information sharing. States pursuing an opioid dependency health home program may consider training opportunities that: (1) ensure that health home team members understand privacy laws and what information can be shared between providers absent a signed release; (2) encourage the use of 42 CFR Part 2-compliant release forms; and (3) encourage enhanced support to beneficiaries on the benefits of sharing substance use information with

other providers, including how the information will be used in their health home treatment plans.

Conclusion

The Medicaid health home option in the ACA affords states considerable opportunity to customize health home services to the unique competencies of providers and needs of beneficiaries. Such considerations are critical for all aspects of program design—ranging from how the population is identified to how providers are qualified and services delivered and reimbursed.

As more states pursue health homes, additional customization for specific target populations, including individuals with opioid dependence, may be expected. The considerations used to shape the opioid dependency health home programs in Maryland, Rhode Island, and Vermont offer helpful guideposts for the development of health home programs in other states, including models that target substance use disorder more broadly. Based on the experiences of these three states, health homes should be considered as an integral model for addressing opioid use disorders in the Medicaid program.

Endnotes

- ¹ P. Muhuri, J. Gfroerer, and M.C. Davies. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. SAMHSA CBHSQ Data Review, August 2013. Available at: <http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf>.
- ² Centers for Disease Control and Prevention. Prescription Drug Overdose in the United States: Fact Sheet. Available at: <http://www.cdc.gov/homeandrecreationalafety/overdose/facts.html>.
- ³ Substance Abuse and Mental Health Services Administration. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
- ⁴ National Institute on Drug Abuse. DrugFacts: Comorbidity: Addiction and Other Mental Disorders. Available at: <http://www.drugabuse.gov/publications/topics-in-brief/comorbid-drug-abuse-mental-illness>.
- ⁵ CMCS Informational Bulletin: Medication Assisted Treatment for Substance Use Disorders; July 11, 2014. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-11-2014.pdf>.
- ⁶ Ibid.
- ⁷ A state plan is an agreement between a state and the federal government that describes how the state administers its Medicaid program. In it, the state assures that it will abide by federal rules to claim federal matching funds. States submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) if they wish to make changes to their Medicaid programs. For more information see: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html>.
- ⁸ Healthcare Brief: Medication Assisted Treatment for Opioid Addiction. Office of National Drug Control Policy. Available at: http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.
- ⁹ Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
- ¹⁰ Health Home Information Resource Center. Health Home State Plan Amendment Matrix. Available at: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>; Maryland Health Home SPA, available at: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Maryland-SPA-13-15.PDF>; Rhode Island Health Home SPA, available at: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Rhode-Island-SPA.PDF>; and Vermont's health home SPA, available at: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Downloads/VT/VT-13-001.pdf>.
- ¹¹ See <http://www.integration.samhsa.gov/health-wellness/wham> for more information about SAMHSA's Whole Health Action Management peer support training program.
- ¹² American Society of Addiction Medicine (ASAM) Magazine. Confused by Confidentiality? A Primer on 42 CFR Part 2, August 15, 2013. Available at: <http://www.asam.org/magazine/read/article/2013/08/15/confused-by-confidentiality-a-primer-on-42-cfr-part-2>.