Centers for Medicare & Medicaid Services

Maternal Opioid Misuse (MOM) Model Overview Webinar

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OPERATOR: This is Conference #3184904.

Hello, and welcome to today's webcast. My name is (Mike) and I will be your event specialist today. Please note that lines have been placed on mute to prevent any background noise and that today's webcast is being recorded. If you would like to view the presentation in a full screen view, please click the full screen button in the lower right-hand corner of your screen. Press the escape key on your keyboard to return to your original view. For optimal viewing and participation, please disable your pop-up blockers.

And finally, should you need technical assistance, as a best practice, we suggest you first refresh your browser. If that does not resolve the issue, please click on the support option in the upper right-hand corner of your screen for online troubleshooting.

It is now my pleasure to turn today's program over to J. Alice Thompson. The floor is yours.

J. Alice Thompson: Thank you so much. My name is J. Alice Thompson, and I am the program lead for the Maternal Opioid Misuse or MOM Model. We are really excited to present the MOM Model to you today. This model is the next step in CMS's multi-pronged strategy to contribute to the federal effort to combat the opioid crisis. The Integrated Care for Kids, or InCK Model, announced in August, was the first project related to this strategy developed by the CMS Innovation Center. We believe that the MOM Model, in conjunction with the InCK model and several other projects in the pipeline, will contribute to sustainable

improvements in care for CMS beneficiaries struggling with substance use disorder, including opioid use disorder or OUD.

I just want to note one thing before I jump into the presentation. I want to note that while we will not be answering questions during the webinar, please feel free to send your questions via the chat feature. We will be compiling a list of frequently asked questions, and it will be posted to our website in the future.

So, in the time that I have, I will provide a background of our work at the CMS Innovation Center. I will discuss how we approached developing the Maternal Opioid Misuse Model, describe the purpose and opportunity that MOM represents, give an overview of the design of the model, and finally outline some next steps.

The CMS Innovation Center was created by the Affordable Care Act, and it allows CMS additional flexibilities to test innovative service delivery and payment models to increase the value of healthcare. The high-level goals of all Innovation Center models are to reduce and improve quality to CMS programs including Medicare, Medicaid, and the Children's Health Insurance Program or CHIP.

Innovation Center models also align with the broader CMS framework to shift from volume to value. Three scenarios represent success for Innovation Center models based on the authorizing statute -- first, improving quality while remaining cost neutral; second, remaining quality neutral but reducing costs; and finally, the best result would be improving quality and reducing costs.

So it is in this context that the CMS Innovation Center has been approaching the opioid crisis and exploring ways to better address the costly lack of coordination and integration of care for CMS beneficiaries as well as contributing factors such as inefficient coverage, provider capacity, and fragmented patient experience of critical services. In our multi-pronged strategy, the Innovation Center has focused on key vulnerable populations, including the population of

focus in the MOM Model, pregnant and post-partum women with opioid use disorder and their infants.

By focusing on pregnant and post-partum women with OUD and their infants to address these issues in the MOM Model, the Innovation Center has a number of key opportunities for impact. First, since opioid use in pregnancy increases the risk of poor maternal and neonatal outcomes including neonatal abstinence syndrome, by focusing on improving maternal care, the model can improve outcomes for both the mother and the infant.

Secondly, CMS disproportionately shoulders the costs of OUD. For example, Medicaid is the primary payer for maternal hospital stays related to substance use disorders. And Medicaid pays for the majority of costs for caring for infants exposed in utero to substances such as opioids. Given this, MOM is well positioned to see significant benefits by improving the care for pregnant and post-partum women with OUD and their infants.

Finally, by focusing on state-driven care transformation, the Innovation Center has the opportunity to both leverage and create synergies between the Innovation Center authorities and state Medicaid flexibility. In order to inform the development of this model, the Innovation Center engaged in extensive, strategic conversations with external subject matter experts, the Center for Medicaid and CHIP Services or CMCS, as well as other federal partners including the Substance Abuse Mental Health Services Administration or SAMHSA; Health Resources and Services Administration, HRSA; and the Centers for Disease Control and Prevention, CDC. The key issues in delivering effective care for this population identified in these discussions included, first, a lack of access to care especially in rural areas.

Another issue that was raised by a number of times was fragmentation of care across settings. The current delivery system surrounding pregnant and post-partum women with OUD is characterized by a

costly lack of coordination and integration. Coverage barriers such as variation in covered services and how services are reimbursed even when the services are covered can be significant contributors to this fragmentation. In addition, there are current – there is currently a limited number of providers that can be prescribe medication-assisted treatment. And many of those either don't accept Medicaid or won't enroll pregnant women due to a lack of education around treatment guidelines.

Finally, we heard a number of critical concerns related to stigma and the criminalization of substance use during pregnancy acting as significant barriers to women seeking care. The MOM Model is specifically designed to address these challenges for pregnant and post-partum women with OUD. MOM is a patient-centered service delivery model which aims to, first, improve quality of care and reduce costs for pregnant and post-partum with women with OUD in their infants; expand access, service delivery capacity, and infrastructure based on state needs; and, third, create sustainable coverage and payment strategies that support ongoing coordination and integration of care.

Over the past few years, CMCS has been developing strategies for states to address these challenges through existing authorities such as OUD Health Home (SPAs) or 1115 waivers. It was extremely important that we at the Innovation Center worked to ensure that our models focused on Medicaid support these authorities and complement structures laid out by CMCS.

In order to achieve these goals, MOM will focus on three key interventions including providing support for the delivery of coordinated and integrated physical healthcare, behavioral healthcare, and wraparound services; leveraging the use of existing Medicaid flexibilities to support sustainable care for the model population and align financial incentives to sustain this transformation; and finally, catalyzing care transformation through the investment in institutional

and organizational capacity to address these key challenges in the provision of coordinated and integrated care.

The Innovation Center has structured the MOM Model to ensure that these interventions can be tailored to the specific needs of communities hardest hit by the crisis. Key to this approach was the decision to direct the model to state Medicaid agencies. Under MOM the Innovation Center will issue up to 12 awards to state Medicaid agencies, which will drive implementation choices to meet their local needs, such as whether to implement the model statewide or in a sub-state region. Each state applicant must engage one or more care delivery partners to develop the model application and, if selected as an awardee, to implement the model.

Care delivery partners can be a (health) system, a hospital system, or a payer such as a Medicaid Managed Care plan. Care delivery partners will work with the state to establish relationships with clinical partners, build capacity at the service delivery level, and implement the state's care delivery approach. Again, the reason for designing the model this way was to ensure the Innovation Center was supporting and not supplanting efforts currently underway in the state. We believe this approach will allow state Medicaid programs with a variety of structures including high managed care penetration to be well positioned to implement the model.

While the structure of the MOM Model allows for a great deal of state flexibility, what our research and outreach has told us is that high quality care for pregnant and post-partum women with OUD, should include a specific set of comprehensive service categories and an integrated and coordinated care delivery structure. So ensuring this kind of care will be central to the model test. To help to guarantee the provision of effective care, the MOM Model will require awardees to provide integrated physical and behavioral healthcare services, such as mediation-assisted treatment, maternity care, relevant primary care services, and mental health services.

In addition, wraparound services, like coordination, engagement, and referral to community and social supports are critical for the effective provision of those clinical services. So they are required as well. Within these requirements, states will have the flexibility to define a specific set of wraparound services that satisfy the following five categories. First, comprehensive care management, care coordination, health promotion, individual and family supports, and referral to community and social services.

This slide brings together all of the aspects of care envisioned under the model. As you can see, the MOM Model is designed for the full set of services to be provided to pregnant Medicaid beneficiaries with OUD during the pre-natal, peri-partum, or during labor and delivery, and the post-partum period. In addition, maternal care is to be coordinated with care being provided to the infant during the post-partum period.

I will now talk about the structure and funding of the model, and how it will contribute to state's effort to transform care for this population. First, the MOM Model has a five-year performance period, which is designed to both support states in transforming their provision of care to the comprehensive and integrated approach I just outlined as well as to ensure the transformation can be sustained. To these ends, the performance period of the model is broken down into three segments.

The pre-implementation period is a one-year period when states and care delivery partners focus on developing and strengthening relationships with critical organizations and providers, build capacity, and design coverage and payment strategies for sustainability. In the transition period, which is year two of the model, awardees and their partners will continue to build capacity and finalize their coverage and payment strategies. In addition, care delivery partners will begin to provide care to pregnant and post-partum women with OUD. During this one-year transition period, the Innovation Center will fund coordination engagement and referral services that are not covered. The model includes this funding to expedite and accelerate the delivery of care.

Finally, during the full implementation period, in years three through five of the model, to foster sustainability, the state will become completely responsible for covering and paying for the comprehensive set of services for the model population, and ensuring the integrated and coordinated care structure is effectively sustained through the selected coverage and payment strategy designed by the state and approved by CMS.

The funding associated with the model is aligned with these three periods, and is designed to directly support states and localities in building the capacity to pay for and deliver these services; accelerate the delivery of coordination, engagement, and referral services that are not currently covered; and finally, to incentivize sustainability of care transformation. Specifically, MOM will provide three types of funding -- implementation funding, transition funding, and milestone funding.

First, implementation funding is available for all five years of the model and allows awardees to address structural barriers to care transformation, including the development or adoption of telemedicine platforms, conducting provider education to increase capacity and access, as well as building data-sharing infrastructure critical to the provision of integrated and coordinated care. Another key use of these funds will be to support states in developing sustainable and effective coverage and payment strategies for this integrated and coordinated model of care by leveraging Medicaid flexibilities like Health Homes waivers and other state plan amendments.

Transition funding, the second type of funding, is provided in year two of the model. This will pay for those wraparound, coordination, engagement, and referral services allowing care delivery partners to start caring for women prior to the state's needing to finalize their coverage and payment strategy. During the full implementation period in years three through five of the model, the Innovation Center will offer the opportunity for states to receive the third type of funding, milestone funding, which is designed to sustain care transformation. Awardees

will have the ability to unlock this milestone funding through the achievement of a limited number of quality metrics that are central to the model aim, including utilization, quality of maternal and infant care, and improved care coordination.

The total funding across all 12 awardees will be up to $64.6 million. However, the amount per awardee will vary based on proposed scope and awardee needs. Additional information on the model's award timeline, funding, and specific eligibility criteria will be available through the notice of funding opportunity, which we expect will be released in early 2019. We anticipate applications submission in spring of 2019, and recognize the need for sufficient time to develop the necessary partnerships and meet other key criteria in preparation for application submission.

It is our hope that by giving potential state applicants time prior to the release of the notice of funding opportunity that they will be able to begin some of this preparation. With this current timeline, we expect to award cooperative agreements to state Medicaid agencies in the fall of 2019.

There are a number of things potential applicants can do prior to the release of the notice of funding opportunity. First, since we have designed the MOM Model with flexibilities for states to tailor the model to their specific (contexts), beginning to identify state and local priorities will be helpful in getting a head start on planning an application for the model. Secondly, given the required partnership between state Medicaid agencies and the care delivery partner, beginning to think about what entities might be appropriate partners in your state will be critical. And finally, if you want to get plugged into the MOM resources to stay up to date on new information coming out about the MOM Model and the release of the NOFO.

So we do have an email address associated with the model. And you can use this to send questions to the model team. In addition, there is a model website where we will post key documents as they are

released. Finally, a great way to stay up to date on MOM news is to join our listserv. We are currently sending out the sign up link to you all now through the WebEx.

That ends our webinar for today. Thank you again for your interest in the MOM Model and we look forward to sharing more information soon.

Operator: Thanks to all our participants for joining us today. We hope you found this webcast presentation informative. This concludes our webcast and you may now disconnect. Have a good day.

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