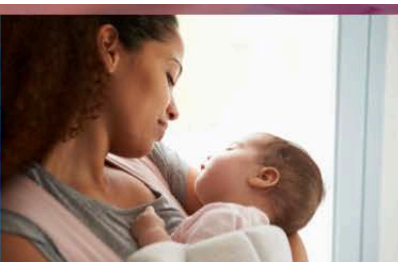
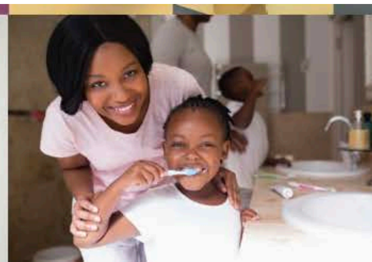
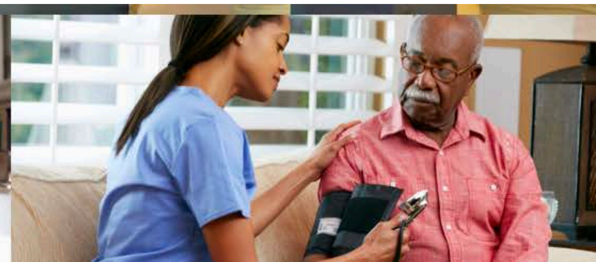
Maternal Opioid Misuse Model

Presentation to Maryland Medicaid Advisory Committee

Medicaid Office of Innovation, Research and Development

November 19, 2020

Overview

Maternal Opioid Misuse (MOM) Model

MOM Model Overview

- Funder: Center for Medicare and Medicaid Innovation (CMMI) at Centers for Medicare and Medicaid Services (CMS)
- Overview: Addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD), leveraging Maryland managed care organizations (MCOs) to drive transformation of the health care delivery system that serves this vulnerable population
- Goal: Test the effect of the integration of clinical care coordination and other services critical for health, well-being and recovery on the quality of care, health outcomes and cost
- Funding: $3.6 million over five years (calendar year (CY) 2020-2024), with the opportunity to receive an additional $1.5 million based on achievement of performance targets

Partners

- **Maryland Medicaid MCOs**: Intervention lead, providing enhanced case management and care coordination services to MOM participants
- **CRISP**: IT lead, building a care coordination module and health-related social needs (HRSN) screening tool, making MOM care plan visible in CRISP
- **Hilltop**: Data-reporting support, technical assistance in payment strategy
- **Maryland Addiction Consultation Service (MACS)**: Technical assistance partner for provider capacity-building

Timeline

- Pre-Implementation Year (Jan. 2020 – Jun. 2021): MCO design collaboratives, contractual arrangements, health IT investments, data-sharing and reporting infrastructure
- Transition Period (Jul. 2021 – Jun. 2022): Grant funding available for care-delivery services not otherwise covered by Medicaid
- Full Implementation (Jul. 2022 – Dec. 2024): Full implementation, including coverage and payment strategies (*i.e.,* not grant funding)

Alignment

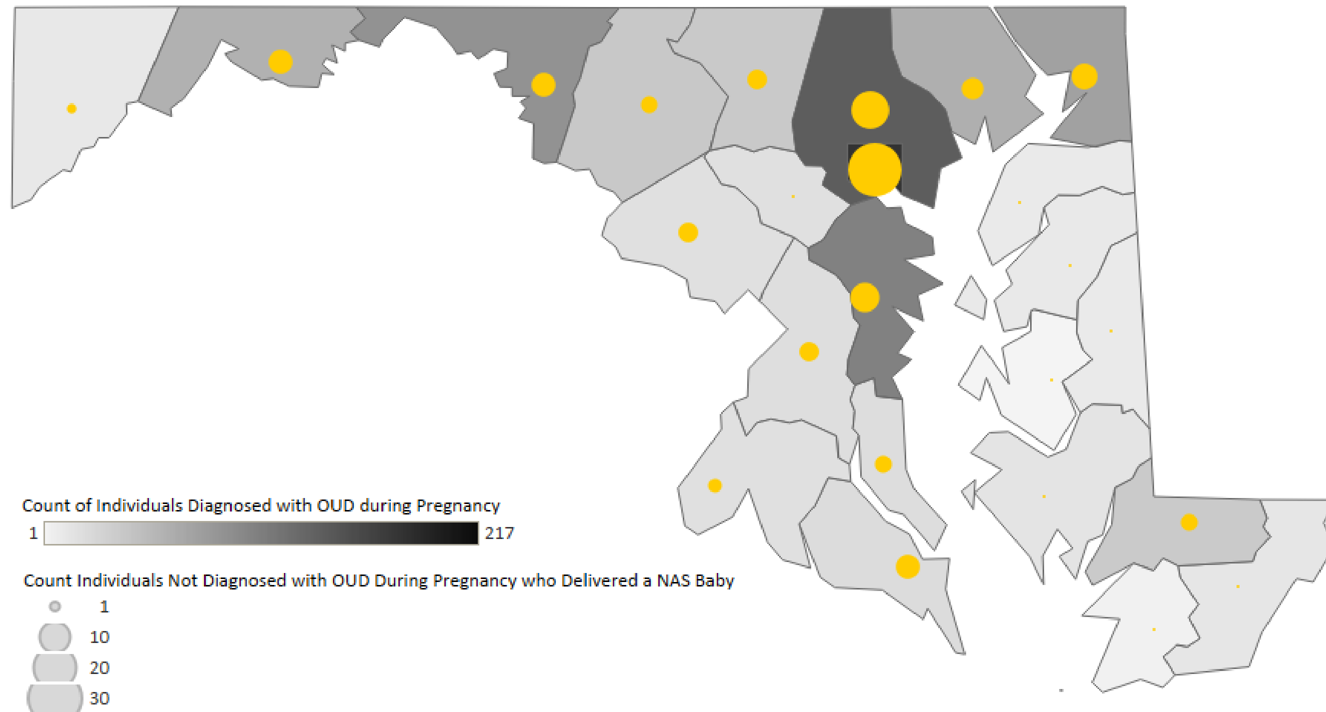
MOM model success will rely on alignment across partners working in maternal and early child health and behavioral health.

- Prevention and Health Promotion Administration
- Local Health Departments
- Behavioral Health Administration (including the behavioral health administrative service organization) and Public Behavioral Health System
- Department of Social Services
- Opioid Operational Command Center
- Obstetric and substance use providers
- Community-based organizations

2020 MOM Model To-Date

- Three MCO Design Collaboratives
  - HRSN screening tool
  - Core elements for a care plan
  - Participant engagement strategies
  - Data-sharing elements
  - Informed consent
  - Staffing models and case management workflow
- Major deliverables under development
  - HRSN screening tool and informed consent
  - Care Coordination Module
  - Coverage and payment strategy
  - Provider Incentive Program

Potential MOM Participants by Jurisdiction



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MOM Model Workflow

Referral Pathways

MCOs identify potentially-eligible participants through the following avenues and forward referrals to case managers:

- *No wrong door referral from other agencies: LHDs, Local Behavioral Health Authorities (LBHAs), law enforcement, emergency departments, somatic and behavioral health providers, Department of Human Services*
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Maryland Prenatal Risk Assessment (MPRA)
- MCO data-mining and enrollment screening
- Referral from behavioral health ASO
- Referral from a community-services organization (CSO)
- See also: Participant Engagement Strategies Brief

Clinical Eligibility and Intake

- Case managers receive referrals and contact identified potential participants to verify interest and confirm clinical eligibility
  - Current MD state resident
  - Current HealthChoice member
  - Currently pregnant (cannot enroll postpartum)
  - OUD Diagnosis - Must have a formal OUD diagnosis, at any point in participant's medical history, before the participant enrolls into the model. Additional guidance will be forthcoming
- Schedule an intake appointment (conducted in-person*)
  - Review approximate length of appointment and what to expect during session

**Subject to change due to COVID-19*

Intake

- Informed Consent
  - Case Manager explains program requirements and participant right to voluntarily participate and withdraw and answers any questions
  - Collect participant signature for informed consent and any other intake forms in addition to those required by the MOM model
- Initial Care Plan
  - Developed jointly during intake session
  - Confirm/collect participant contact information, denote preferred contact method and emergency/secondary contacts
  - Confirm/collect information on all providers participant is currently under the care of and their contact information
  - Identify 2-3 goals based on participant identified areas of need, to be reviewed during every monthly meeting and updated as needed

Screenings

Screenings that must be conducted within seven days of MOM model enrollment:

- **HRSN** – adapted Accountable Health Communities (AHC) social determinants of health screening tool
- **Depression** – PHQ-2; PHQ-9 if indicated
- **Tobacco** – MDQuit, AHC or Global Tobacco Surveillance System (TBD)
- **Anxiety** – GAD-7
- **Alcohol –** AHC (tentative)
- **Patient Activation Measure (PAM)** – enter into the Flourish tool administered by Insignia Health and document participant score in care plan

Comprehensive Case Management

- Initial HRSN screening, PAM assessment and care plan development
- Development and periodic reassessment of MOM care plan and screenings
- Supportive shared decision-making process to understand and select from the landscape of health-related social needs resources

Care Coordination

- Serve as the established case manager across different providers, the behavioral health ASO and CSOs serving the MOM model participant
- Provide appropriate linkages to somatic and behavioral health providers as identified within care plan for infant and mother
- Follow up on needed services and supports

Health Promotion

- Discussing relapse and creating a relapse safety plan
  - Providing naloxone and educating friends/family on use of naloxone
- Providing literature on Maryland Crisis Connect
  - Available 24/7 to people in need of crisis intervention, risk assessment for suicide, overdose prevention, support, guidance and information or linkage to community behavioral health providers
- Discussing options for family planning
- Nutritional counseling
- Wellness programs
- Education about sexually-transmitted infections and other infectious diseases; *e.g.*, viral hepatitis and HIV/AIDS Preventive healthcare education
- Assisting with medication adherence
- Educating family regarding appropriate infant developmental milestones and healthy attachment behaviors

Individual and Family Supports

- With participant permission, involving partner and family in care activities
- Training family about the role of recurrence of use and use of naloxone
- Connecting families and children with needed supports such as parenting classes or family counseling

Linkages to Community and Support Services

- Connecting participants to resources related to the SDOH screening by completing warm handoffs with programs to support the individual participant’s needs
- Linking participants with social supports, such as disability benefits, social services, SUD treatment, housing, legal services, life skills training and educational/vocational training
- Key to success: Building relationships between MCOs, LHDs, LBHAs and others to leverage unique local opportunities and programs for MOM model participants

Substantial Outreach

Substantial outreach is a specific protocol for re-engaging MOM model participants, which case managers will follow in the event that MOM model participants become disengaged from care (*i.e.*, become lost to follow-up).

MCOs will receive a PMPM payment for providing substantial outreach for disengaged beneficiaries for two-month periods.

Participants may be considered in 'substantial outreach,' and MCOs may qualify for PMPM payments multiple times throughout their enrollment period.

There are a variety of loss-to-follow-up activities that the Department will accept to continue the PMPM payment.

Last Month of MOM Participation

Discharge Planning

- Conduct final case management visit, providing at least one core model component:
  - Linkages (wrapping up connecting MOM participant to social needs)
  - Health promotion (*e.g.,* giving out naloxone; family planning materials)
  - Care coordination and warm handoffs
- Assess outstanding needs:
  - Review care-plan developed goals, determine areas that may need continued support and provide a discharge plan to participant upon the end of services
  - Final SDOH screening and referrals
- Documentation
  - Document all tasks and relevant screenings into the Care Coordination Module
  - Indicate participant is no longer active in services—notating discharge reason—and submit care alert
  - If participant is having their case closed for reasons other than completing services, follow alternative documentation procedure in place of final case management visit

Questions?

MOM Model Contact Information

General: mdh.mommodel@maryland.gov

For resources and updates, check out our website: https://mmcp.health.maryland.gov/Pages/MOM-Model.aspx

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