Maternal Opioid Misuse (MOM) Model: Frequently-Asked Questions

This document contains the Department's responses to questions that have arisen during the MOM model pre-implementation year (CY 2020). The Department expects the design to continue to evolve and will update this information as needed. (Last updated: 12 May 2020)

Alignment and Workflow

1. **What is the expectation for model uniformity among MCOs?**

   As a federally-funded demonstration under the auspices of the Center for Medicare and Medicaid Innovation (CMMI), Maryland's MOM model is subject to evaluation by a third-party evaluator, requiring a large degree of uniformity toward that end. In addition to the evaluation, an aligned approach will facilitate MOM engagement with providers who may contract with multiple MCOs. Depending on the model implementation design resulting from the quarterly MCO design collaboratives, the MCOs will have some degree of customization, possibly in areas such as the use of incentives, approaches to staffing, technology used for intake, etc.

2. **How will MCOs complement and not duplicate existing linkages to care efforts in their jurisdiction?**

   The Department has met with several stakeholder groups to discuss the MOM model and identify areas for collaboration—with the aim of reducing the potential for duplication—including the Maternal and Child Health Bureau, the Behavioral Health Administration, the Opioid Operational Command Center, the Mosaic Group and local health departments. In designing staffing models, MCOs may choose to leverage the experience of other organizations and agencies, such as local health departments, who have significant experience or established mature programs serving pregnant women with OUD.

3. **What is your expectation regarding the Behavioral Health Administration's collaboration with the MCOs?**

   The Behavioral Health Administration and the administrative services organization (ASO), Optum, will be key partners in MOM implementation, particularly in the area of collaboration between case managers from the MCOs and the ASO to assure consent to share bi-directional data and feedback about the behavioral health treatment of MOM participants.

Beneficiary Engagement

4. Is there a projection of volume of enrollees into the MOM Model for each MCO?

The Department estimates that approximately 1,500 individuals per year would meet MOM eligibility criteria. This figure takes into consideration both individuals with opioid use disorder (OUD) who had been identified during pregnancy and the number with no history of OUD but who gave birth to infants with Neonatal Abstinence Syndrome (NAS). The Department expects that 35 percent to 60 percent of potentially-eligible individuals will enroll as MOM participants.

5. How will beneficiaries be identified to participate in the MOM Model?

There are various referral and service pathways through which a potential MOM participant could be identified, such as the Maryland Prenatal Risk Assessment, hot-spotting and data-mining and referrals, *i.e.,* from the behavioral health ASO and community-based organizations. The state also employs a no-wrong door approach to refer individuals to substance use treatment, which engages diverse actors including local health departments, local addiction authorities, law enforcement, first responders, emergency departments, somatic health care centers, mental health service providers and other recovery support service providers.

6. Will the grant offer any incentives to participants?

The Department and the MCOs will not use MOM model funding to support program incentives to MOM model participants. MCOs may continue to provide existing incentives or leverage other, non-Medicaid funding sources to support new incentives but will not be required to do so under the terms of the MOM model. MCOs will need to continue to follow the Department's policy guidance on the use of incentives, titled "Guidelines for Incentives and Other Promotional Activities for Potential and Current Enrollees of Medicaid Managed Care Plans," including the maximum allowable incentive value.

Separately, the federal third-party evaluator has the discretion to offer some modest, in-kind incentives that comply with federal restrictions.

Informed Consent and Data-Sharing

7. For beneficiaries who have declined to have their medical records be a part of CRISP, what is the process for them?

Due to the nature of the MOM intervention—which includes data-sharing elements that rely on CRISP—MOM participants will need to participate in CRISP to receive MOM model services. Individuals who decline MOM participation will continue to receive access to existing somatic and behavioral health providers through the Medicaid benefit package, including identification, referral and comprehensive OUD treatment, such as medication-assisted treatment (MAT), as well as prenatal, perinatal and postpartum services.

8. **Can MCOs see who has opted out of CRISP?**

   CRISP internally honors people's decision to opt out as private. Querying gives a 'no information is returned' response. At this time, CRISP does not release the list of patients who have opted out of CRISP.

9. **Will the Department create a standard consent form, or can the MCOs use their own consent form?**

   The Department will create a standard consent form specific to the MOM model. It will undergo review by the Department's Institutional Review Board (IRB). The consent will include data-sharing for both MOM model services and evaluation, as well as an anticipated qualitative data-gathering component by the federal third-party evaluator. The Department is considering how the current release of information process for Part 2-covered data will fit within the MOM workflow.

10. **Do MCOs need to submit to their own IRB?**

    No. The MOM model informed consent will undergo review by the Department's IRB (see Question 9). Once the Department has received approval from its IRB—as well as CMMI—it is the Department's understanding that MCOs have their own, varying internal approval process for informed consents, which may involve an IRB.

11. **Are MOM model awardee states collaborating on aligned informed consent forms?**

    Each MOM state is required to develop its own informed consent. The Department will fully participate to the extent that CMMI Learning System activities and other forums allow for alignment across states.

12. **For participants who are involved in social services, how will you address data-sharing concerns among providers? What types of data will be shared with who?**

    Information shared—*i.e.,* through CRISP—for MOM model operations among a participant's care team will protected by the Health Insurance Portability and Accountability Act (HIPAA). MCOs should not divulge protected health information, including substance use disorder status, when making referrals on behalf of MOM participants to social services agencies and community-based organizations, as those entities fall outside the bounds of HIPAA. See the presentation from the Q2 Design Collaborative for information on CRISP policies related to data privacy.

13. **How do you plan to address the historical distrust of this population with receiving services?**

    The Department is aware of the sensitivity of this population and will explore innovative staffing models, such as the use of certified peer recovery specialists, to help bridge the historical distrust. Provider training through the Maryland Addiction Consultation Service (MACS) will support providers in how to appropriately engage individuals in conversations about their opioid use. The Department encourages the use of strengths-based approaches, trauma-informed care, person-first language and culturally-responsive care as evidence-based methods for reducing stigma and building rapport with MOM model participants.

14. **What happens if a member decides they no longer want to participate in the MOM Model? What will the workflow be, and will their data be removed and no longer shared?**

    MOM model participants who no longer want to be enrolled in the model will continue to receive access to existing somatic and behavioral health providers through the Medicaid benefit package,

including identification, referral and comprehensive OUD treatment, such as MAT, as well as prenatal, perinatal and postpartum services. Eligible beneficiaries are permitted to re-enroll in the MOM model at any time.

Workflow details will be determined in a future MCO design collaborative. It is anticipated that the MCO case manager would work with the beneficiary and CRISP to implement any changes to data-sharing that the beneficiary desires. From an evaluation standpoint, CMMI will still receive quantitative data on these participants, *i.e.,* claims (through T-MSIS) and vital statistics.

Evaluation and Outcomes

15. **What parameters around neonatal intensive care unit (NICU) admissions will be measured? Most of these babies will go to the NICU for neonatal abstinence syndrome (NAS); this is an expected outcome.**

    The Department understands that substance-exposed newborns and resulting NICU stays are an expected outcome for the MOM population. Additional detail from CMMI and its evaluation contractor should be available later in CY 2020; the Department anticipates measures related to number of NICU days and related cost.

16. **Could the Department provide a specific list of qualitative and quantitative measures for the MOM model evaluation?**

    CMMI and its implementation contractor will be releasing a data dictionary with all reporting elements, anticipated for late spring 2020; the evaluation contractor will be conducting pre-implementation activities in support of the third-party evaluation during CY 2020. The Department will share this detail with the MCOs as soon as it is available.

Social Determinants of Health

Screening Tool

17. **Would the request for a standardized tool only be applicable to the MOM model enrollees?**

    The standardized tool would only be required for MOM enrollees. MCOs can determine if they would also like to use these same tools for other members that are not enrolled in the MOM model but might benefit from such tools.

18. **Currently MCOs do not have permission to enter data into CRISP—permissions are for read-only access. Would a screening tool populated in CRISP for MCOs to complete in real time constitute a change in current permissions and access to CRISP?**

    CRISP will ensure that the screening tool and other care coordination module tools are available to the MCO case managers via integrations with MCO current tools or through direct entry into the tools. CRISP will work with the Department to develop MOM model policies and procedures to enable MCO

case managers to publish and edit care plans and care alerts and to complete screenings through the MOM model care coordination tool.

Resource Directories

19. **Community-based resource tools are publicly-available and house a litany of social needs services such as food pantries, housing and transportation. Is the MOM project leveraging these tools before creating its own?**

    While the MOM model will require MCOs to apply a standard tool to screen for needs related to the social determinants of health, the Department will not require MCOs to use a specific resource directory. Separate from the MOM grant, the Department is currently collaborating with CRISP to develop a resource directory for those who do not already have one; this would be available for the MCOs.

    CRISP will take an integration-first approach to allow organizations to avoid duplicating work in areas where they have already invested. There are many third-party platforms that provide tools to evaluate and address social needs. CRISP would be able to leverage these tools by sharing screening results, referrals, etc. through CRISP, with others in the healthcare team that may not have access to those proprietary platforms. CRISP is open to integrating with those platforms if those platforms are willing to share data.

    If MCOs use resource directories that are not integrated with CRISP, MCO case managers would be responsible for maintaining case notes on referrals made in the MOM care coordination module.