

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services  
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Washington, DC 20201



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## FACT SHEET

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# Maternal Opioid Misuse (MOM) Model

The Center for Medicare and Medicaid Innovation's (Innovation Center) Maternal Opioid Misuse (MOM) model is the next step in the Centers for Medicare & Medicaid Services' (CMS) multi-pronged strategy to combat the nation's opioid crisis. The model aims to address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce costs for mothers and infants.

Why develop a model for pregnant and postpartum women with OUD?

**1** Substance use-related morbidity, mortality, and healthcare utilization have skyrocketed among pregnant and postpartum women.

**2** OUD in pregnancy increases the risk of poor maternal and neonatal outcomes, including neonatal abstinence syndrome (NAS).

**3** A lack of access to treatment and coordination of care for pregnant and postpartum women with OUD worsens health outcomes and costs.

The surge in substance use-related illness and death in recent years particularly affects pregnant women. In fact, substance use is now a leading cause of maternal death.<sup>1</sup> Pregnant and postpartum women who misuse substances are at high risk for poor maternal outcomes,

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<sup>1</sup> CMS Quality Conference: State responses to the Opioid Crisis. Slides available at [https://s3.amazonaws.com/uploads.formwebconnex.com/store/01C4TJY7CZWY1DZ337Z/bo14\\_state-responses-to-the-opioid-crisis-wk6r6.pptx](https://s3.amazonaws.com/uploads.formwebconnex.com/store/01C4TJY7CZWY1DZ337Z/bo14_state-responses-to-the-opioid-crisis-wk6r6.pptx).

including preterm labor and complications related to delivery; problems frequently exacerbated by malnourishment, interpersonal violence, and other health-related social needs<sup>2</sup>. Infants exposed to opioids before birth also face negative outcomes, with a higher risk of being born preterm, having a low birth weight, and experiencing the effects of NAS.<sup>3</sup> In addition, Medicaid pays the largest portion of hospital charges for maternal substance use, as well as a majority of the \$1.5 billion annual cost of NAS.<sup>4</sup> Despite the significant and costly burden of maternal opioid misuse, numerous barriers impede the delivery of well-coordinated, high-quality care to pregnant and postpartum women with OUD, including:

- **Lack of access to comprehensive services during pregnancy and the postpartum period**, even though state Medicaid programs may be able to provide the necessary coverage through state plan amendments or waivers.
- **Fragmented systems of care**, which miss a critical opportunity to effectively treat women with OUD at a time when they may be especially engaged with the healthcare system.
- **Shortage of maternity care and substance use treatment providers** for pregnant and postpartum women with OUD covered by Medicaid, especially in rural areas, where the opioid crisis is magnified.

What are the model's goals?

**Improve and postpartum  
wprove quality of care  
and reduce  
expenditures** for  
pregomen with OUD as  
well as their infants.

**Increase access to  
treatment, service-  
delivery capacity, and  
infrastructure** based  
on state-specific needs.

**Create sustainable  
coverage and payment  
strategies** that support  
ongoing coordination  
and integration of care.

The MOM model will award cooperative agreements to states in order to support state Medicaid agencies, front-line providers, and healthcare systems, as they address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD. The primary model goals are to:

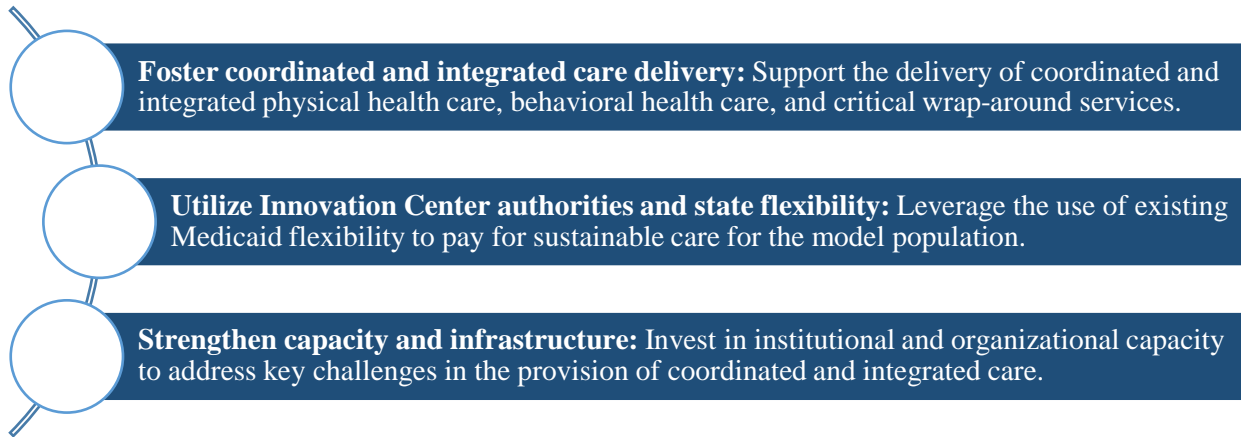
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<sup>2</sup> Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017; 130:e81–94. Available here: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>.

<sup>3</sup> D Wendell, Andria. (2013). Overview and Epidemiology of Substance Abuse in Pregnancy. *Clinical obstetrics and gynecology*. 56. 10.1097/GRF.0b013e31827feeb9.

<sup>4</sup> Patrick, et al., "Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012," *J. Perinatol* (Aug 2015), <https://www.ncbi.nlm.nih.gov/pubmed/25927272>.

## How will the model achieve these goals?



## Who will participate in the model?

The Innovation Center will execute up to 12 cooperative agreements with states, whose Medicaid agencies will implement the model with one or more “care-delivery partners” in their communities. The state will be expected to complete the application, which must demonstrate that it has partnered with at least one care-delivery partner.



**State Medicaid agencies** will develop and implement coverage and payment strategies; work with the Center for Medicaid and CHIP Services (CMCS) to implement necessary authorities, including state plan amendments and/or program waivers; ensure provision of usable claims and encounter data to operate and evaluate the model; and, coordinate with care-delivery partners to support information-sharing.



**Care-delivery partners** will provide services to model beneficiaries, either directly or through clinical partners. Primary responsibilities will include: establishing relationships with clinical partners; building capacity at the service-delivery level to support care-delivery transformation; and, implementing a coordinated and integrated care-delivery approach. The care-delivery partner(s) may be a health system or a payer, such as a Medicaid managed care plan (MCP).

## Whom will the model serve?

The MOM model would serve pregnant Medicaid and Children's Health Insurance Program (CHIP) beneficiaries with OUD who have elected to participate, during the prenatal, peripartum (i.e., surrounding labor and delivery), and postpartum periods.

## What services are included in the model?

The MOM model requires that pregnant and postpartum women with OUD receive a comprehensive set of services delivered in a coordinated and integrated approach. The necessary physical and behavioral health care (e.g., maternity care, medication-assisted treatment, mental health screening and treatment, etc.) would be provided by a team of healthcare professionals (e.g. maternity care and behavioral health providers) with different specialties as part of a single delivery model. To remove barriers that would prevent a pregnant woman with OUD from receiving treatment, the care-delivery partner(s) will also create and strengthen linkages to other necessary support services. This approach ensures that beneficiaries will receive a consistent set of services in all model areas, while allowing awardees flexibility to adapt the model to their specific context.

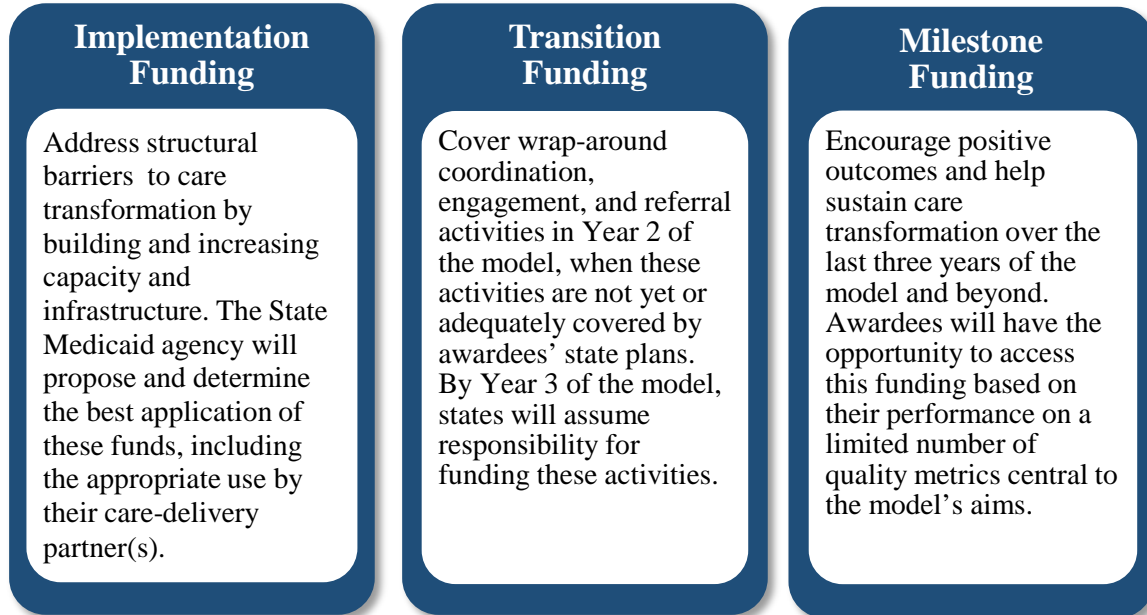
The model will also require awardees to coordinate care, engage beneficiaries, and provide referrals for necessary services to meet the model population's comprehensive needs. States will have the flexibility to define a specific set of services that satisfy the following five components:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Individual and family support; and,
5. Referral to community and social services.

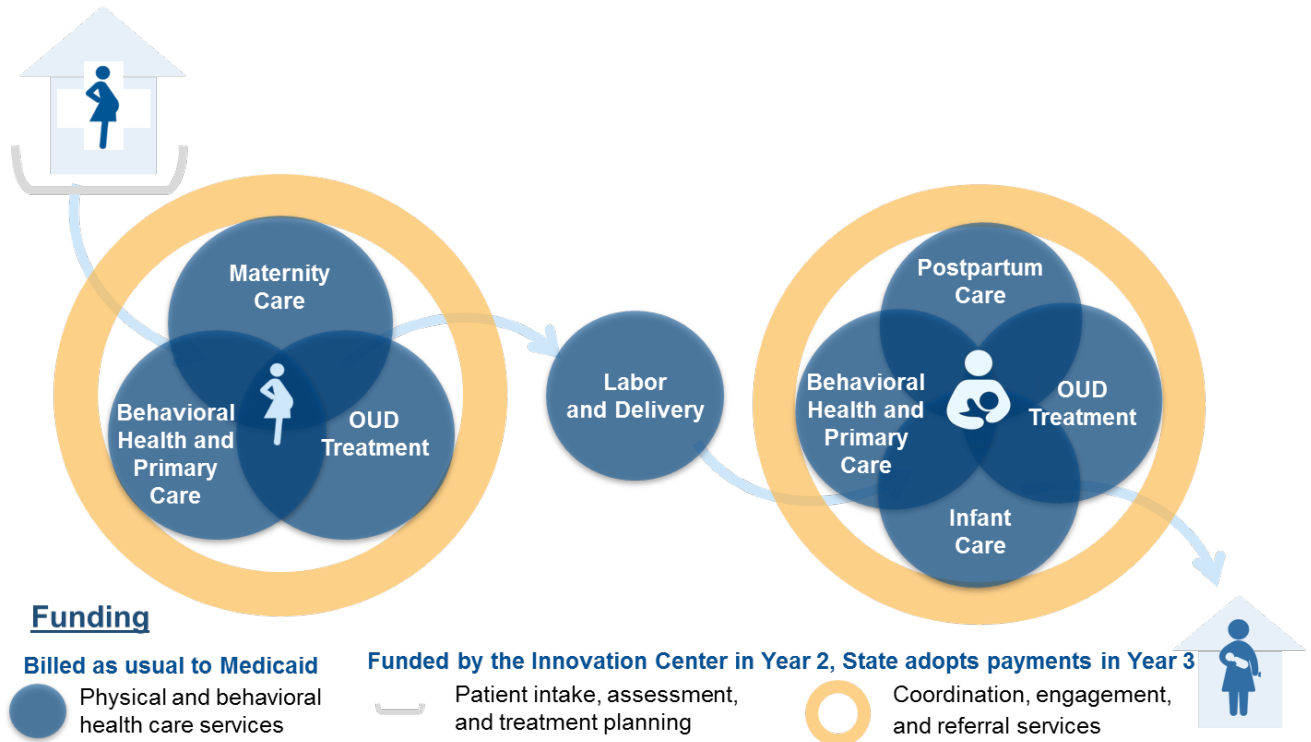
MOM model funding may not be used to supplant or duplicate Medicaid-funded services. Coordinated services billed as usual to Medicaid will include, for example: well-woman care, OUD treatment, prenatal and postpartum care, labor and delivery, and infant care (including neonatal intensive care unit stays).

## What types of funding will be provided to support the model goals?

To foster coordinated and integrated care for the model population, the Innovation Center will support awardees with the following three types of funding:



The figure below provides an overview of the MOM model care-delivery structure and funding sources.



## What is the model timeline?

The MOM model will have a five-year performance period from fall 2019 to fall 2024. The implementation funding, transition funding, and opportunity for milestone funding will be provided in three distinct model periods: Pre-implementation (Year 1), Transition (Year 2), and Full Implementation (Years 3-5).



Care delivery will begin in Year 2 of the model, the Transition Period. During this year, funding for care-delivery services that are not otherwise covered by Medicaid will be provided by Innovation Center funds. By Year 3, the start of the Full Implementation Period, states must implement their coverage and payment strategies. This overall structure seeks to balance rapid model initiation and state flexibility, while minimizing administrative burden. In particular, the MOM model design supports each awardee's ability to quickly begin delivering coordinated and integrated care to pregnant and postpartum women with OUD during the Transition Period, while supporting states in developing a long-term coverage and payment strategy that aligns with their state Medicaid program.

## How will funding be awarded?

CMS anticipates releasing a Notice of Funding Opportunity (NOFO) in early 2019 to solicit cooperative agreement applications to implement the MOM model. The state Medicaid agency will be expected to complete the application, which must demonstrate that it has partnered with at least one care-delivery partner. A maximum of \$64.6 million will be available across up to 12 state awardees over the course of the five-year model. The NOFO will explain model requirements and eligibility criteria for potential applicants.

## Resources and Support

**Email:** [MOMmodel@cms.hhs.gov](mailto:MOMmodel@cms.hhs.gov)

**Visit:** <https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/>

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