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## ***CMCS Informational Bulletin***

**DATE:** September 4, 2020

**FROM:** Anne Marie Costello, Acting Deputy Administrator and Center Director

**SUBJECT:** Guidance to Improve Care for Infants with Neonatal Abstinence Syndrome and Their Families

Section 1005(a) of the “Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act” (P.L. 115-271) or the “SUPPORT for Patients and Communities Act” requires that the Department of Health and Human Services (HHS) issue guidance that discusses developments in the care of infants with Neonatal Abstinence Syndrome (NAS) and their families, with the goal of improving such care. Specifically, it requires the HHS Secretary to issue guidance to states regarding opportunities to improve care for infants with NAS and their families. The provision requires that the guidance include:

1. States’ best practices regarding innovative or evidence-based payment models focusing on prevention, screening, treatment, plans of safe care, and post discharge services for parents with substance use disorders (SUD) and infants with NAS;
2. Recommendations for states on financing opportunities through Medicaid and the Children’s Health Insurance Program (CHIP) for parents with SUD, infants with NAS, and home-visiting services;
3. Guidance and technical assistance to state Medicaid agencies on additional flexibilities and incentives for screening, prevention, and post discharge services (including parenting supports), and infant-caregiver bonding (including breastfeeding when appropriate); and
4. Guidance for suggested terminology and ICD codes to identify infants with NAS and neonatal opioid withdrawal syndrome, which could include opioid-exposure, opioid withdrawal not requiring pharmacotherapy, and opioid withdrawal requiring pharmacotherapy.

### **I. Background**

SUD affect the lives of millions of Americans. That impact is felt not only by the individuals living with SUD, but also by their families and their children.<sup>1</sup> For their infants and children, that impact may not only be felt through life experiences and challenges associated with having a parent with a SUD, but also through the physical complications resulting from exposure to

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<sup>1</sup> In this document, the term “Substance Use Disorder” (SUD) includes opioid use disorders (OUD). The substance classes that may be associated with a diagnosis of substance use disorder include alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics or anxiolytics, stimulants, tobacco, and other or unknown substances. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013 at pg 482-483

opioids or other substances before birth.

As the incidence of opioid use grows in this country, the incidence of NAS grows concurrently. According to a publication in the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly, the national prevalence of opioid use disorder per 1,000 delivery hospitalizations increased from 1.5 cases in 1999 to 6.5 cases in 2014, an increase of 333%.<sup>2</sup> Over the past decade, the United States has experienced significant increases in rates of opioid-related emergency department visits and hospitalizations,<sup>3</sup> NAS, and pregnant women with opioid use disorder.<sup>4</sup>

Within state Medicaid programs, the increase is even higher. In 2017, nearly two million non-elderly adults in the United States had an opioid use disorder (OUD), and of these adults, nearly four in ten were covered by Medicaid.<sup>5</sup> The rate of U.S. infants diagnosed with opioid withdrawal symptoms rose from 2.8 to 14.4 per 1,000 hospital births from 2004 to 2014.<sup>6</sup> More than 80 percent of infants treated for NAS have their care paid for by Medicaid.<sup>7</sup>

In response to these growing needs, stakeholders are striving to identify innovative and evidence based treatments and payment models that focus on prevention, screening, treatment, plans of safe care, and post discharge services that can improve care and clinical outcomes for mothers and fathers with substance use disorders, as well as for babies with NAS.

### Neonatal Abstinence Syndrome (NAS)

NAS is a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.<sup>8</sup> Clinically significant neonatal withdrawal most commonly results from exposure to opioids, but symptoms of neonatal withdrawal have also been noted in infants

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<sup>2</sup> Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. *MMWR Morb Mortal Wkly Rep* 2018;67:845–849. DOI: <http://dx.doi.org/10.15585/mmwr.mm6731a1>

<sup>3</sup> HHS. (2018) Testimony from Brett P. Giroir & Kimberly Brandt on Tracking Opioid and Substance Use Disorders in Medicare Medicaid, and Human Services Programs before Committee on Finance. Retrieved March 19, 2019 from <https://www.hhs.gov/about/agencies/asl/testimony/2018-04/tracking-opioid-and-substance-use-disorders-medicare-medicaid-hhs-programs.html>

<sup>4</sup> CDC. (2018) Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. *MMWR Morbidity and Mortality Weekly Report*: 67:845–849. <http://dx.doi.org/10.15585/mmwr.mm6731a1>

<sup>5</sup> Orgera, K. and Tolbert, J. The Opioid Epidemic and Medicaid’s Role in Facilitating Access to Treatment. Kennedy Family Foundation Issue Brief, Published: May 24, 2019 <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicoids-role-in-facilitating-access-to-treatment/>

<sup>6</sup> Vanderbilt University Medical Center Reporter. Study Tracks Impact of NAS on State Medicaid Programs (2018, March 23) <http://news.vumc.org/2018/03/23/study-tracks-impact-of-nas-on-state-medicoid-programs%E2%80%88/>

<sup>7</sup> Patrick SW, Schumacher RE, Benneyworth BD, Krans EE, McAllister JM, Davis MM, “Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009,” *JAMA*, 2012, 307(18):1934-40. doi: 10.1001/jama.2012.3951 and also Patrick SW, Davis, MM, Lehman CU, Cooper WP “Increasing Incidence and Geographic Distribution of Neonatal Abstinence Syndrome: United States 2009-2012”

<sup>8</sup> Some experts use the term, “Neonatal opioid withdrawal syndrome (NOWS)” when referring to withdrawal specifically from opioids. Neonatal opioid withdrawal syndrome. [Sutter MB](#), [Leeman L](#), Hsi A *Obstet Gynecol Clin North Am*. 2014 Jun;41(2):317-34. doi: 10.1016/j.ogc.2014.02.010

exposed to antidepressants, anxiolytics, and other non-opioids. NAS is not characterized as an addiction or substance use disorder; rather it is a medical condition resulting in a physiologic response to the infant's exposure to cessation of the opioid or other substance the mother was using. Experts consider NAS to be an expected and treatable result of women's prenatal opioid or other substance use, although long-term ramifications for the infants are still unknown.<sup>9</sup>

NAS is a complex condition and symptoms vary from infant to infant, based on a number of factors, including but not limited to the longevity and history of substance use by the mother and the quantity and type of opioid and/or other substances used. The clinical indications of NAS include high pitched and excessive crying, irritability, poor sleep, sweating, poor feeding, respiratory distress, seizures, tremors and other signs. Symptoms of NAS usually develop within 72 hours of birth, but may develop anytime in the first week of life, including after hospital discharge.

Conceptually, every infant with *in utero* opioid and/or other substance exposure falls along the continuum of withdrawal symptoms, ranging from mild and at times clinically insignificant or subtle signs, to much more severe signs. The diagnosis of NAS is made by observing these clinical signs of neonatal withdrawal that the newborn exhibits in the days to weeks after birth. Current medical recommendations highlight attempts to initially treat these infants with non-pharmacologic approaches, including placing the infant in a dark and quiet environment, swaddling, rocking, breastfeeding, rooming in, and providing high-calorie nutrition in frequent small feedings, among other techniques, before resorting to pharmacologic treatment, such as the use of liquid methadone, buprenorphine, or morphine.<sup>10</sup>

### Pregnant Women with Substance Use Disorder

Substance use, including opioid use during pregnancy, has increased dramatically in recent years.<sup>11</sup> Opioid use has been associated with increased odds of threatened preterm labor, early onset delivery, poor fetal growth, and stillbirth, and women who used opioids during pregnancy were four times as likely to have a prolonged hospital stay and were almost four times more likely to die before discharge.<sup>12</sup> Women are particularly vulnerable in the first year postpartum.<sup>13</sup> Medication assisted treatment (MAT)<sup>14</sup> is an effective form of treatment for OUD during pregnancy, but lack of access to treatment among pregnant women with OUD is a

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<sup>9</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

<sup>10</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

<sup>11</sup> "Opioid Crisis in Medicaid: Saving Mothers and Babies," Health Affairs Blog, May 1, 2018.

<sup>12</sup> Whiteman, VE, Salemi, JL, Mogos, M F, et al, Maternal Opioid Drug Use during Pregnancy and Its Impact on Perinatal Morbidity, Mortality, and the Costs of Medical Care in the United States. *Journal of Pregnancy, 2014*, 906723. <http://doi.org/10.1155/2014/906723>

<sup>13</sup> Opioid overdose events are lowest in the third trimester but increase in the year after delivery, with 7–12 months postpartum a particularly vulnerable time for women with OUD. Schiff DM, Nielsen T, Terplan M, et al. Fatal and nonfatal overdose among pregnant and postpartum women in Massachusetts. *Obstet Gynecol.* 2018; 132(2): 466–474 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6060005/>

<sup>14</sup> Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines counseling and behavioral therapy and medications to treat substance use disorders. For more information, see: <https://www.samhsa.gov/medication-assisted-treatment>

widespread issue.<sup>15</sup> Additionally, since some forms of the medications used in MAT are opioids, it is important to note that, although MAT is the treatment of choice for most pregnant women, an infant born to a woman who is being stably treated with MAT may also experience NAS.

Studies show a higher risk of opioid use during pregnancy among Medicaid beneficiaries, and total hospital costs for NAS births covered by Medicaid increased from \$65.4 million in 2004 to \$462 million in 2014.<sup>16</sup> Relatedly, parental drug use is the second-most-common reason for foster care entry for all children.<sup>17</sup>

Treatment for SUD is mostly provided by specialty facilities that typically offer some combination of SUD services such as detoxification, pharmacotherapy, individual and/or group psychotherapy, and other psychosocial services in one or more settings (i.e., inpatient, residential, or outpatient).<sup>18</sup> However, according to one recent study, 40 percent of U.S. counties do not have an addiction treatment facility that provides outpatient care and accepts Medicaid. This lack of treatment capacity is most prevalent in rural counties in southern and mid-western states and in areas with a higher proportion of racial and ethnic minorities.<sup>19</sup>

The number of women of childbearing age, defined as ages 15–44, who reported past-month heroin use increased to 109,000 in 2013–2014, an increase of 31 percent from 2011–2012.<sup>20</sup> The number of women ages 15–44 who reported past-month misuse of prescription pain relievers such as oxycodone increased to 98,000 in the same period, an increase of 5.3 percent.<sup>21</sup> Estimates are that, each year between 2008 and 2012, one-third of reproductive-age women enrolled in Medicaid and more than one-quarter of those with private insurance filled a prescription for an opioid pain medication.<sup>22</sup> The prevalence of OUD during pregnancy more

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<sup>15</sup> Smith K, Lipari R, Women of Childbearing Age and Opioids, SAMHSA: The CBHSQ Report, Jan. 17, 2017

<sup>16</sup> Winkelman TNA., Villapiano N, Kozhimannil KB, et al. Incidence and Costs of Neonatal Abstinence Syndrome Among Infants With Medicaid: 2004–2014. *Pediatrics*. 2018; 141(4):e20173520, <http://pediatrics.aappublications.org/content/141/4/e20173520..info>

<sup>17</sup> The AFCARS Report, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, U.S. Department of Health and Human Services website, Preliminary FY’2017 Estimates as of August 10, 2018-No.25 <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf>

<sup>18</sup> Cummings JR, Wen H, Ko M, et al, *Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States*, *JAMA Psychiatry*, 71(2): 190-196 (Feb 2014)

<sup>19</sup> Cummings JR, Wen H, Ko M, et al, *Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States*, *JAMA Psychiatry*, 71(2): 190-196 (Feb 2014)

<sup>20</sup> Center for Behavioral Health Statistics and Quality CBHSQ, 2015, Table 6.71A <https://www.samhsa.gov/data/sites/default/files/NSDUH-DefTabs-2015/NSDUH-DefTabs-2015/NSDUH-DefTabs-2015.pdf>

<sup>21</sup> CBHSQ, 2015, Table 6.71A

<sup>22</sup> Ailes, E; Dawson, A; Lind, J; Gilboa, S; Frey, M; Broussard, C; Honein, M; “Opioid Prescription Claims Among Women of Reproductive Age — United States, 2008–2012” January 23, 2015 / 64(02);37-41 <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6402a1.htm>

than doubled between 1998 and 2011 to 4 per 1,000 deliveries.<sup>23,24</sup>

Barriers to treatment exist, including lack of available treatment for pregnant women. Without treatment, pregnant women with OUD face increased risks of preterm delivery, low infant birth weight, and transmitting HIV to their infants.<sup>25</sup> Further, postpartum women have additional difficulty in locating appropriate SUD treatment providers with capacity or a willingness to serve them. The challenges are exacerbated by the importance and desire of mothers to remain with their infants for treatment of the infants' NAS and the difficulty of finding options for treatment that can meet both the infants' and the mothers' needs.<sup>26</sup>

An underlying principle in the literature is that a healthy pregnancy results in a healthy infant and mother. For example, the Substance Abuse and Mental Health Administration (SAMHSA) Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants recognizes the mother and infant as a dyad, and the recommendations are provided in light of what actions will optimize the outcomes for the mother–infant dyad as a whole, with guidance provided from preconception to several months postpartum and for the first few years of infant development.<sup>27</sup>

In light of these trends, as well pursuant to the direction provided in section 1005(a) of the SUPPORT for Patients and Communities Act, this guidance provides updated information and guidance for states as they strive to improve care and evaluate best practices for treating these infants, as well as their mothers, fathers and caregivers.

## **II. Innovative Payment Models: Infants with NAS and Parents with SUD**

The development of innovative payment models for NAS services is still in its infancy and it would be premature to report any models as best practices regarding innovative or evidence-based payment models focusing on prevention, screening, treatment, plans of safe care, and post discharge services for parents with SUD and infants with NAS. Acknowledging this, the Centers for Medicare & Medicaid Services (CMS) would like to highlight that states have flexibility to develop innovative payment models and set payment rates for services provided within the Medicaid program to promote efficiency, access and quality of care for NAS services. Medicaid authorities, such as state plan authority under section 1902 of the Act, managed care authorities

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<sup>23</sup> Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018, citing Maeda A, Bateman BT, Clancy CR, Creanga AA, Leffert LR. [Opioid abuse and dependence during pregnancy: temporal trends and obstetrical outcomes](#). *Anesthesiology*. 2014 Dec; 121(6):1158-65.

<sup>24</sup> Newly updated figures were provided in January 2020 for the years of 2015 – 2018, for a slightly different age group of pregnant women aged 12-44. <https://www.macpac.gov/publication/access-to-treatment-for-pregnant-women-with-a-substance-use-disorder-and-infants-with-neonatal-abstinence-syndrome/>

<sup>25</sup> SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women, id, at pg 2-3

<sup>26</sup> Saia, K; Schiff, D; Wachman, E; et al. “Caring for Pregnant Women with Opioid Use Disorder in the USA: Expanding and Improving Treatment,” *Current Obstetrics and Gynecology Reports*, Set. 2016, Vol 5, Issue 3, pp 257-263

<sup>27</sup> SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants., <https://store.samhsa.gov/system/files/sma18-5054.pdf> pg 4

under 1915(b), primary care case management authority under section 1932(a), and section 1115(a) demonstration authority provide states with a number of avenues to implement innovative payment models for NAS services. States may also consider these types of innovative payment models for NAS services that are covered under the CHIP state plan or could be provided through a health services initiative (HSI), as discussed below in section III.B.

Through partnerships with states, CMS has approved innovative fee-for-service payment methodologies that reward providers for improvements in care coordination, clinical care quality, and service cost reduction. Medicaid statute, regulations, and policies provide states with flexibility to design innovative value based payment methodologies for NAS services. States have flexibility in setting rates and designing payment models for services provided within the Medicaid program to promote efficiency, access and quality of care. A state may pay providers for medically necessary Medicaid services and recognize the varied costs of providing care based on the setting(s) in which the services are provided or the severity of need. For instance, states may pay higher rates for services provided to individuals with significant care needs or in geographic areas where access to care may be of concern. Further, states may pay for individually covered services or, if determined as a more efficient payment method, may develop bundled rates to pay for services. States may also offer providers financial incentives to improve beneficiary outcomes based on meeting certain quality benchmarks, which may include treatment outcomes or recognized standards of care.<sup>28</sup>

One of the innovative models states may consider for NAS services is the episode of care payment model. The goal of an episode of care model is to treat and pay for a clinical condition or procedure during a set period of time period. In episodes of care, the episode is a predefined clinical condition with preset payment amounts or target costs that are based on expected practitioner costs, care setting, and the procedures performed. An entity or provider, called an “accountable entity,” manages the treatment of the clinical episode from beginning to the defined clinical end point and is held accountable for the clinical outcomes, quality of care and cost of the episode.

Through a single, bundled payment or an average target cost per episode, providers bear the financial risk of keeping an episode’s service costs under the bundled payment amount or cost target. If an episode of care costs less than the bundled payment or target cost amount and the provider meets the required quality measure targets, the accountable entity may keep a portion of the difference or receive a performance payment. However, if the costs exceed the bundled payment amount or target cost, the provider may be financially liable for the difference between the bundled payment amount and an episode’s actual cost.<sup>29</sup>

We encourage states to work closely with the CMS Center for Medicaid and CHIP Services (CMCS) when developing innovative payment models for the treatment of NAS that promote efficiency, access and quality of care for NAS services. States should design NAS payment

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<sup>28</sup> Additional information regarding Medicaid financing options is included in subsequent sections of this Informational Bulletin (pg 17)

<sup>29</sup> States should adhere to the guidance published on the Medicaid.gov website when developing bundled payments for episodes of care fee-for-service payment methodologies: <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/medicaid-spa-toolkit/index.html>

methodologies for prevention, screening, treatment, plans of safe care, and post discharge services that reward providers for improved quality of care, expand access to NAS services, and establish efficient rates.

### **Federal Resources: Best Practices for Infants with NAS and Pregnant Women with SUD**

As stated above, development of innovative payment models for NAS services is still in its infancy. We recognize that states are grappling with options to address and fund the increasing demand for services that best match the needs and resources within their individual communities. In order to assist states in their deliberations, we offer a summary of guidance issued by various federal agencies. These resources focus on various aspects of best practices and describe existing recommendations and initiatives around prevention, screening, treatment and post discharge services to infants with NAS, and to their parents and potential caregivers.

#### Protecting Our Infants Act: Report to Congress and Implementation Plan Update

The Protecting our Infants Act of 2015 (P.L. 114-91) (POIA) called for HHS to study and develop recommendations for preventing and treating prenatal opioid use disorders and NAS. In addition, HHS was directed to continue to assist states in improving the quality of data collection and availability of data related to NAS, and to encourage public health measures aimed at decreasing its prevalence.

In 2017, HHS released its first follow up POIA Report to Congress. This report includes an updated review of background information on NAS, summarizes HHS activities around NAS, and presents clinical and programmatic evidence and recommendations for prevention and treatment, including strategies to address identified gaps, challenges and recommendations.<sup>30</sup>

In 2019, HHS released a second follow-up report updating the status of implementation of the recommendations of the prior POIA releases.<sup>31</sup> In this report, HHS “developed an implementation plan focusing on preventing prenatal opioid exposure, providing evidence-based treatment for both mother and infant, increasing the accessibility of family-friendly services for pregnant and parenting women with opioid use disorders, supporting continuing education for healthcare providers, and determining optimal family and developmental support services for children who have experienced prenatal opioid exposure.”<sup>32</sup>

The reports include the status of agency actions addressing recommendations in four areas: Systemic Changes; Clinical Changes; Data and Surveillance Changes; and Research and Evaluation Changes.<sup>33</sup> The actions address HHS activities designed to promote potential

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<sup>30</sup> [https://www.samhsa.gov/sites/default/files/topics/specific\\_populations/protecting-our-infants-act-report-congress-2017.pdf](https://www.samhsa.gov/sites/default/files/topics/specific_populations/protecting-our-infants-act-report-congress-2017.pdf)

<sup>31</sup> This report also satisfies the requirement under section 7062 of the SUPPORT for Patients and Communities Act to submit to Congress and make publicly available the report regarding implementation of the recommendations in the POIA strategy.

<sup>32</sup> <https://aspe.hhs.gov/report/status-report-protecting-our-infants-act-implementation-plan>

<sup>33</sup> The categories were updated in the 2019 report as follows: Data and Surveillance, Research and Evaluation, Programs and Services, Education

intervention prior to conception, during pregnancy, postpartum for mothers, ongoing SUD treatment for mothers and fathers, treatment for infants with NAS, and implementation of ongoing parental treatment engagement, recovery support, and early intervention services in family function and mitigation of consequences of prenatal substance exposure and NAS.<sup>34</sup>

#### Comprehensive Addiction and Recovery Act: Government Accountability Office (GAO) Report

The Comprehensive Addiction and Recovery Act of 2016 (CARA; P.L. 114-198) is a sweeping law that addresses the full continuum of care from primary prevention to recovery support, including significant changes to expand access to addiction treatment services and overdose reversal medications. Among other provisions of the CARA Act, it required the GAO to examine the federal action needed to address NAS in the United States. Their 2017 report discusses various ways in which services are provided to infants with NAS, describes recommended practices and challenges for addressing NAS, and examines practices and strategies for addressing NAS, including treatment for women with SUD during pregnancy and treatment for infants diagnosed with NAS after birth. Their report provides an analysis of issues, a discussion of recommended practices, challenges faced by health care providers and examines HHS' strategy for addressing NAS.<sup>35</sup>

#### SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants

SAMHSA published comprehensive clinical guidance for treating both pregnant and parenting women with opioid disorder and their infants.<sup>36</sup> This guidance also includes sixteen comprehensive Fact Sheets describing clinical scenarios and action steps for phases of treatment from prenatal care and infant care to maternal postnatal care.

Section I of their guidance discusses prenatal care, including prenatal screenings and treatment, initiating, modifying, and managing pharmacotherapy for women during pregnancy, and issues around labor and delivery, including peripartum pain relief.

Section II addresses infant care, including a discussion of screening and assessment protocols for infants, management of NAS, breastfeeding considerations, infant discharge planning, and early intervention for the infants.

Section III addresses Maternal Postnatal Care, including adjusting pharmacotherapy dose postpartum, maternal discharge planning, and maternal return to substance use.

The guidance includes forms and templates, development assessments, and a master reference list of citations and articles for further details. It is designed to be helpful to a wide audience of clinicians, policymakers, and other stakeholders.

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<sup>34</sup> <https://aspe.hhs.gov/report/status-report-protecting-our-infants-act-implementation-plan>

<sup>35</sup> Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome  
<https://www.gao.gov/assets/690/687580.pdf>

<sup>36</sup> <https://store.samhsa.gov/system/files/sma18-5054.pdf>



SAMHSA has additional fact sheets on opioid use disorder and pregnancy, which are available on their website. For more information, see: <https://store.samhsa.gov/product/Opioid-Use-Disorder-and-Pregnancy/sma18-5071fs1>

SAMHSA and Administration for Children and Families: A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders<sup>37</sup>

This guide highlights a coordinated, multi-system approach to best serve the needs of pregnant women with OUD and their infants. It discusses advance planning for the treatment of pregnant women with OUD that addresses safe care for mothers and their newborns that can help prevent unexpected crises at the time of delivery. This guide provides background information on the treatment of pregnant women with OUD, summarizes key aspects of guidelines that have been adopted by professional organizations across medical, behavioral, and mental health disciplines, presents a comprehensive framework to organize these efforts in communities, and provides a collaborative practice guide for community planning to improve outcomes for these families. The guide's Appendices provide details on implementing the recommendations in the guide as well as a summary of lessons from one community's experience over the past decade.

Center for Disease Control and Prevention (CDC) Grand Rounds: Public Health Strategies to Prevent Neonatal Abstinence Syndrome<sup>38</sup>

This article provides background, prevention and intervention strategies, and additional reference information for the prevention and treatment of NAS.

CDC Guideline for Prescribing Opioids for Chronic Pain<sup>39</sup>

This guide provides recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. The recommendations address the use of opioid pain medication in certain special populations (e.g., older adults and pregnant women) and in populations with conditions posing special risks (e.g., a history of substance use disorder).<sup>40</sup>

The CDC has also developed an interactive training series that provides online training in applying CDC's Guideline for Prescribing Opioids.<sup>41</sup>

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<sup>37</sup> Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: <http://store.samhsa.gov/>

<sup>38</sup> Ko JY, Wolicki S, Barfield WD, et al. CDC Grand Rounds: Public Health Strategies to Prevent Neonatal Abstinence Syndrome. MMWR Morb Mortal Wkly Rep 2017;66:242–245. DOI: [http://dx.doi.org/10.15585/mmwr.mm6609a2external\\_icon](http://dx.doi.org/10.15585/mmwr.mm6609a2external_icon)

<sup>39</sup> <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

<sup>40</sup> Morbidity and Mortality Report: *Recommendations and Reports* / March 18, 2016 / 65(1);1–49 [https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm)

<sup>41</sup> <https://www.cdc.gov/drugoverdose/training/online-training.html>

## Health Resources and Service Administration (HRSA) Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome<sup>42</sup>

HRSA funds the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), which “supports voluntary, evidence-based home visiting services for pregnant women and parents with young children up to kindergarten entry living in at-risk communities.”<sup>43</sup> HRSA published this resource for awardees to provide relevant research, offer information on treatment strategies for awardees and their state partners, and highlight efforts underway in a number of states. This resource discusses a wide variety of practical applications, strategies for action by state and local components of the home visiting community, implementation of evidence based home visiting models and other examples from states, and a wide array of resources, background, research evaluation data and policy information and resources for use in developing strategies for prevention and treatment of SUD.<sup>44</sup>

## Office of Disability, Aging and Long-Term Care Policy: State Policy Levers for Expanding Family-Centered Medication-Assisted Treatment<sup>45</sup>

Since MAT is the recommended clinical practice for treating pregnant and postpartum women with OUD, this report from the HHS Office of Disability, Aging and Long-Term Care Policy sought to define how MAT can be combined with family-centered services. This report further examined a selection of state and local treatment programs targeted to pregnant and parenting women and their families to identify key challenges and opportunities in expanding access to comprehensive, family-centered services and MAT treatment for this population.<sup>46</sup>

## Office of Special Education Issue Brief: Intervention IDEAs for Infants, Toddlers, Children and Youth Impacted by Opioids

The U.S. Office of Special Education published an Issue Brief that provides prevalence information regarding the impact of opioids on infants, toddlers, children and youth, as well as a list of risk factors associated with opioid exposure. The document also provides strategies for prevention and intervention, including descriptions and quality indicators, and provides specific

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<sup>42</sup> <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/MIECHV-Opioid-NAS-Resource.pdf>

<sup>43</sup> HRSA Home Visiting Program: Supporting Families Impacted by Opioid Use and NAS, at pg3

<sup>44</sup> For additional information on Medicaid and Home Visiting, see the Joint Informational Bulletin,

“Coverage of Maternal, Infant, and Early Childhood Home Visiting Services,” <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf>

<sup>45</sup> Julie Seibert, PhD, Holly Stockdale, MA, Rose Feinberg, MA, Erin Dobbins, MA, Elysha Theis, BA, and Sarita L. Karon, PhD, RTI International . <https://aspe.hhs.gov/basic-report/state-policy-levers-expanding-family-centered-medication-assisted-treatment> This report was prepared under contract #HHSP233201600021I between the U.S. Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy (DALTCP) and the Research Triangle Institute Expanding Access to Family-Centered Medication-Assisted Treatment Issue Brief

<sup>46</sup> For additional information, see Expanding Access to Family-Centered Medication-Assisted Treatment Issue Brief <https://aspe.hhs.gov/pdf-report/expanding-access-family-centered-medication-assisted-treatment-issue-brief> and State Policy Levers for Expanding Family-Centered Medication Assisted Treatment <https://aspe.hhs.gov/pdf-report/state-policy-levers-expanding-family-centered-medication-assisted-treatment>

resources for more information. The Issue Brief additionally discusses NAS interventions, various forms of therapy for children and youth, and treatment programs for mothers with SUD, designed for use by parents, schools, and programs.<sup>47</sup>

### Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and the Community Act (SUPPORT for Patients and Communities Act): Provisions and Subsequent Guidance

The SUPPORT for Patients and Communities Act<sup>48</sup> includes many provisions to improve services to infants with NAS and their families. While many provisions will assist states in addressing the opioid epidemic, certain provisions are particularly relevant to benefits and the delivery of services under the Medicaid program. Title I of the SUPPORT for Patients and Communities Act includes many Medicaid-specific provisions to address the opioid crisis,<sup>49</sup> and Title III, Subtitle B, Chapter 1 contains provisions that provide more flexibility with respect to Medicaid covered MAT for opioid disorders.<sup>50</sup> Title V contains subtitles that provide other changes to Medicaid and CHIP, including CHIP mental health and substance use disorder parity, activities and guidance regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (the Act) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and otherwise eligible for Medicaid, and a Medicaid state plan option to provide Medicaid coverage, from October 1, 2019 through September 30, 2023, to beneficiaries age 21 through 64 who have at least one SUD diagnosis and reside in an eligible Institution for Mental Diseases.<sup>51</sup> Other sections address protection of pregnant women and infants<sup>52</sup> and supporting family-focused residential treatment.<sup>53</sup>

### U.S. Government Accountability Office, Report to Congressional Committees: Medicaid: Opioid Use Disorder Services for Pregnant and Postpartum Women, and Children

Section 1005(b) of the SUPPORT for Patients and Communities Act requires that GAO conduct a study and submit a report to Congress addressing gaps in coverage for pregnant women with SUD under the Medicaid program. This report, issued in October, 2019, provides information and an overview of selected states that provide Medicaid and other coverage for OUD for eligible pregnant and postpartum women, states that provide Medicaid coverage for annual screenings and other medically necessary services for SUD for eligible children, and a discussion of the use of telehealth in schools.<sup>54</sup>

### **Medicaid Guidance and Resources: Best Practices for Infants with NAS and Pregnant Women with SUD**

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<sup>47</sup> <https://osepideasthatwork.org/sites/default/files/IDEAsIIssBrief-Opioids-508.pdf>

<sup>48</sup> Pub. L. 115-271, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

<sup>49</sup> Sections 1001-1018 of the SUPPORT for Patients and Communities Act

<sup>50</sup> Sections 3201-3204 of the SUPPORT for Patients and Communities Act

<sup>51</sup> Sections 5001-5061 of the SUPPORT for Patients and Communities Act

<sup>52</sup> Sections 7061-7065 of the SUPPORT for Patients and Communities Act

<sup>53</sup> Sections 8081-8083 of the SUPPORT for Patients and Communities Act

<sup>54</sup> <https://www.gao.gov/products/GAO-20-40>

Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants (2018)  
CMS, CMCS Informational Bulletin

In June 2018, CMS issued an Informational Bulletin that provides states with information for designing approaches to treatment of infants with NAS, including Medicaid coverage options and limitations.<sup>55</sup> It contains a summary of a number of studies on NAS treatment, which suggest possible strategies states may want to consider in building effective coverage programs. It further discusses ways in which Medicaid can support the mothers, fathers, and caregivers of the infants in providing care that can improve health outcomes for their infants with NAS.

This Informational Bulletin also provides a discussion of Medicaid payment options for coverage of NAS Treatment to infants. It also discusses options for provision of services to mothers, fathers, and caregivers who are Medicaid eligible in their own right, as well as mothers, fathers and caregivers who may not have Medicaid eligibility themselves, but are involved in learning and delivering critical services for the benefit of the infant. It includes a discussion of different settings in which the services may be delivered, as well as options for design of Medicaid payment methodologies.

Section 1007 of the SUPPORT for Patients and Communities Act: State Guidance for Implementation of the Treatment for Infants with Neonatal Abstinence Syndrome in Residential Pediatric Recovery Centers CMS, CMCS Informational Bulletin

On July 26, 2019, CMS issued an Informational Bulletin, in accordance with the new provisions in the SUPPORT for Patients and Communities Act. The Bulletin provides guidance to states by describing the impact of the law's newly defined "residential pediatric recovery centers" on states' delivery of services to infants with NAS and to their mothers, family members and caregivers.<sup>56</sup>

Section 1010 of the SUPPORT for Patients and Community Act: Medicaid Strategies for Non-Opioid Pharmacologic and Non-Pharmacologic Chronic Pain Management CMS, CMCS Informational Bulletin

This Informational Bulletin<sup>57</sup> describes Medicaid authorities that states may use for coverage of non-opioid pharmacologic and non-pharmacologic pain management therapies, highlights some preliminary strategies used by several states, and includes useful resources to help states consider appropriate pain relief approaches within the context of the national opioid crisis. While the focus of this Informational Bulletin is on non-opioid chronic pain management, states may consider the strategies outlined here for the treatment of acute pain as well.

Strategies to Address the Opioid Epidemic, CMS State Medicaid Director Letter (SMDL) # 17-003 issued November 1, 2017

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<sup>55</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

<sup>56</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf>

<sup>57</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib022219.pdf>

Demonstration projects authorized under section 1115 of the Act allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. On November 1, 2017, CMS announced a section 1115(a) demonstration initiative to improve access to and quality of treatment for Medicaid beneficiaries as part of a Department-wide effort to combat the nation’s ongoing opioid crisis. This initiative aims to give states flexibility to design demonstrations that improve access to high quality, clinically appropriate treatment for SUDs while incorporating metrics for analyzing whether outcomes for Medicaid beneficiaries are in fact improving. Through this section 1115 initiative, states can receive Federal Financial Participation (FFP) for the continuum of services to treat addiction to opioids or other substances, including services provided to beneficiaries who are short-term residents in inpatient treatment facilities that qualify as IMDs, primarily to receive SUD treatment.<sup>58</sup>

Leveraging Medicaid Technology to Address the Opioid Crisis, CMS SMDL, # 18-006, issued June 11, 2018

This SMDL provides information to states on which Federal funding authorities might support health information technology efforts such as telemedicine and prescription monitoring tools, which could be used in states’ efforts to ensure effective treatment availability and opioid awareness activities.<sup>59</sup>

Section 8081 of the SUPPORT for Patients and Communities Act: Family Focused Residential Treatment Programs

Section 8081 requires guidance to be issued that describes existing opportunities and flexibilities under the Medicaid program, including under waivers authorized under section 1115 or 1915 of the Social Security Act, for states to receive federal Medicaid funding for the provision of SUD treatment for pregnant and postpartum women, parents and guardians, and, to the extent applicable, their children, in “family-focused residential treatment programs.” Section 8081 also requires the guidance to describe how states can employ and coordinate funding provided under the Medicaid program, the title IV-E foster care maintenance program, and other programs administered by HHS, as well as relevant sections of the Family First Prevention Services Act,<sup>60</sup> to support the provision of treatment and services provided by a “family-focused residential treatment facility.” The term “family-focused residential treatment program” means a trauma-informed residential program primarily for substance use disorder treatment for pregnant and postpartum women and parents and guardians that allows children to reside with such women or their parents or guardians during treatment to the extent appropriate and applicable.

### **III. Services and Financing Options for States under Medicaid and CHIP**

#### **A. Services and Options Under the Medicaid Program**

##### **Medicaid Services to Infants with NAS**

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<sup>58</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD17003.pdf>

<sup>59</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>

<sup>60</sup> Title VII of the Bipartisan Budget Act of 2018, Pub.L. 115–123, Feb. 9, 2018.

CMS issued comprehensive guidance regarding NAS and the critical role Medicaid plays in meeting the needs of infants.<sup>61</sup> This guidance provides background on the role of Medicaid in the care of infants, including a discussion of potential Medicaid services and available financing options. The guidance also discusses best practices focusing on prevention, screening, treatment (including the importance of involvement of mothers in the infants' treatment whenever possible) and post-discharge services (including continuity of care) for infants and their families.<sup>62</sup> Subsequently, in response to the requirements of Section 1007 of the SUPPORT for Patients and Communities Act, CMS issued further clarification to states regarding the use and financing options for the optional provider type, "residential pediatric recovery centers (RPRCs)."<sup>63</sup>

## **Medicaid Services to Parents and Caregivers**

Medical assistance is defined as payment for part or all of the cost of care and services for individuals who are Medicaid-eligible.<sup>64</sup> Therefore, Medicaid can cover services provided to parents and other caregivers if they are Medicaid-eligible in their own right and meet a state's medical necessity criteria for the service.

The following is an overview of some of the Medicaid state plan benefits that states may use to cover screening, prevention, and treatment services for parents and other caregivers. CMS is available to provide technical assistance to states on these benefit options and other authorities that could be used to address needed services for parents and caregivers.

### Screening, Diagnostic, and Preventive Services

The United States Preventive Services Task Force (Task Force) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.<sup>65</sup> The Task Force assigns each recommendation a letter grade (an A, B, C, or D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service.

Until recently, the Task Force did not include a recommendation for screening for unhealthy drug use among adults. As of June 9, 2020, the Task Force recommends screening by asking questions about unhealthy drug use in adults age 18 years or older.<sup>66</sup> Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.) Other recommendations related to unhealthy alcohol use and tobacco use

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<sup>61</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

<sup>62</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

<sup>63</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf>

<sup>64</sup> Section 1905(a) of the Social Security Act

<sup>65</sup> <https://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf>

<sup>66</sup> <https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening>

were recommended by the Task Force in prior years. In 2018, the Task Force recommended screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.<sup>67</sup> In 2015, the Task Force also recommended that clinicians ask all pregnant women about tobacco use, advise pregnant women who use tobacco to stop, and provide behavioral interventions for cessation to pregnant women who use tobacco.<sup>68</sup> Other Task Force recommendations related to women’s screening and preventative services may be of interest and can be found on the Task Force web site.<sup>69</sup>

A state could opt to cover screening for pregnant women for drug use under several Medicaid state plan benefits such as the screening services, diagnostic services, and preventive services. Screening services are defined as “the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.”<sup>70</sup> States would need to discuss their proposed screening services and the relevant population(s) with CMS in order for CMS to determine whether the state would need to submit a SPA to revise current coverage policies.

The diagnostic services benefit is another optional state plan benefit that states may use to cover diagnostic services for SUDs. Diagnostic services are defined as “any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the

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<sup>67</sup> [Task Force recommendation on Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions), issued November 13, 2018, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions> Assigned a Grade B

<sup>68</sup> [Task Force recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions), issued September 21, 2015, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions> Assigned a Grade A

<sup>69</sup> The Task Force recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. See Recommendation on Screening for Perinatal Depression, issued February 12, 2019: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions>.

The Task Force also recommends the hepatitis C virus (HCV) infection screening for adults in the age group 18 to 79 years. This update comes against the background of increasing HCV over the last ten years, primarily due to higher injection drug use, and closer monitoring. See Recommendation on Screening for HCV, issued March 2, 2020: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening>.

The Task Force also recommends providing interventions during pregnancy and after birth to support breastfeeding. See Recommendation on [Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions), issued October 25, 2016,

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions>. Section 2713 of the Public Health Services Act requires health plans to cover, without cost-sharing, Task Force Grade A and B preventive services, immunizations recommended by the Advisory Committee on Immunization Practices, preventive services and care for children/adolescents, and such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration with respect to women. This link discusses the updated HRSA guidelines for women: <https://www.hrsa.gov/womens-guidelines/index.html>

<sup>70</sup> 42 CFR 440.130(b)

scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.”<sup>71</sup>

The optional state plan preventive services benefit can also be used to cover “services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under state law to:

- (1) Prevent disease, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency.”<sup>72</sup>

Preventive services must involve direct patient care and address the individual’s physical or mental health, rather than the individual’s environment. States typically use the preventive services benefit to cover services such as tobacco cessation counseling and diabetes preventive services such as nutritional and physical exercise counseling. Licensed and unlicensed practitioners may furnish preventive services.<sup>73</sup> To modify the state’s current coverage of preventive services, a state plan amendment (SPA) may need to be submitted to CMS, including descriptions for each proposed service, an identification of each practitioner type qualified to furnish each service, and a brief summary of the practitioner qualifications. For licensed practitioners, the state plan need only indicate that they are licensed, unless the state requires additional qualifications beyond licensure. For unlicensed practitioners, the state plan must include any certification, registration, education, experience and supervisory arrangements that the state requires for an individual to be qualified to provide the service.

In addition, states could opt to cover under their preventive services benefit all the Task Force’s grade A and B recommendations, and all approved adult vaccines and their administration as recommended by the Advisory Committee on Immunizations Practices, without cost-sharing, and receive a one percent increase in their FMAP.<sup>74</sup>

### Treatment Services

The rehabilitative services benefit is an important optional state plan benefit for coverage of SUD treatment services.<sup>75</sup> Medicaid regulations at 42 CFR § 440.130(d) broadly define rehabilitative services as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” As with preventive services, a state seeking to modify its current coverage of rehabilitative services may need to submit a SPA for CMS review, including service descriptions for each proposed service, an identification of each practitioner type qualified to furnish each service, and a brief summary of the practitioner qualifications. Examples of SUD treatment services that states could cover under the rehabilitative services benefit include

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<sup>71</sup> 42 CFR 440.130(a)

<sup>72</sup> 42 CFR 440.130(c)

<sup>73</sup> <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf>

<sup>74</sup> Section 4106 of the Affordable Care Act

<sup>75</sup> Section 1905(a)(13) of the Social Security Act



assessments, individual and group therapy, peer support services, MAT, withdrawal management, and skills restoration.

Another optional state plan benefit that states can use to cover treatment services is the “other licensed practitioner” benefit.<sup>76</sup> As set forth in 42 CFR Section 440.60(a), other licensed practitioner services are “any medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” Under this benefit, states do not need to detail the covered services or list practitioner qualifications in the state plan or proposed SPA. States only need to include language indicating that the services of a licensed practitioner, such as a licensed psychologist, social worker, or addiction counselor, are covered. States could also cover unlicensed practitioners under the supervision of the licensed practitioner provided that the supervision is in accordance with the licensed practitioner’s scope of practice under state law and the licensed practitioner assumes professional responsibility for the unlicensed practitioner.

### Care Management

Targeted Case Management is an optional benefit that can be included as a Medicaid state plan benefit.<sup>77</sup> Effective case management includes: assessing the need for medical, educational, social and other services; development of a specific individualized care plan; referral and related activities to help the individual obtain needed services; and monitoring and follow up activities to ensure that changes in the needs or status of the individual are reflected in the care plan and that the plan is effectively implemented and adequately addresses the needs of the individual. Case management assistance to caregivers in accessing transportation, appropriate child care, and other services post discharge may be critical in meeting continuing health care needs.

### Medicaid Health Homes

One option to coordinate care for infants with neonatal abstinence syndrome and their parents could be a SUD-focused Health Home. Section 1945 of the Social Security Act describes an optional Medicaid state plan benefit for states to establish Health Homes to integrate care for people with Medicaid who have chronic conditions as a way to treat the “whole person.” It is also important to note all new SUD-focused Health Homes can receive ten quarters of 90% enhanced federal match from the effective date of the SPA.

A state can provide the following services under a Health Home: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support and referral to community and social support services. A Health Home can be established for people (both children and adults) with Medicaid who meet the following criteria: have two or more chronic conditions, have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition. In statute, substance use disorder is listed as a chronic condition.

When developing an SUD-focused Health Home, a state must keep in mind the following

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<sup>76</sup> Section 1905(a)(6) of the Social Security Act

<sup>77</sup> 42 CFR 440.169

definition and criteria. The term “SUD-focused state plan amendment” is defined in section 1945(c)(4)(D) of the Social Security Act to mean a SPA under section 1945 of the Act that is designed to provide Health Home services primarily to SUD-eligible individuals. The term “SUD-eligible individual” is defined in section 1945(c)(4)(D) of the Act to mean an individual who satisfies all of the following: 1) is an eligible individual with chronic conditions, 2) has a substance use disorder, and 3) has not previously received health home services under any other SPA.

### Medicaid Primary Care Case Management and Integrated Care Models

Medicaid Primary Care Case Management includes case management related services that include the location, coordination, and monitoring of primary health care services, and are provided under a contract between the state and either a Primary Care Case Manager, a physician group practice, or an entity that employs or arranges with physicians to furnish the services.<sup>78</sup>

Integrated Care Models (ICMs) are characterized by organized and accountable care delivery and payment methodologies aligned across payers and providers to ensure effective, seamless, and coordinated care. By orienting the system around the needs and preferences of beneficiaries, successful ICMs can demonstrate improved health care outcomes and result in improved beneficiary experience, while reducing overall health care expenditures. ICMs include integration of various types of health care services such as primary, acute, specialty, dental, behavioral (including SUD), and long-term support services.

Medicaid guidance regarding ICMs, including a discussion of reimbursement and potential for shared savings, may be of assistance to states in utilizing these models to provide this continuous and coordinated care to parents and their infants with NAS.<sup>79</sup>

### **Medicaid Financing Options for Infants with NAS and their Mothers, Fathers, and Caregivers**

#### Financing Options in the Treatment of NAS for Infants and Their Families

Prior to the passage of the SUPPORT for Patients and Communities Act, CMS issued an Informational Bulletin entitled “Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants.”<sup>80</sup> In this guidance, CMS not only discussed the complex condition of NAS and its diagnosis and treatment, but also provided guidance regarding Medicaid coverage and potential payment options for the treatment services to infants with NAS and their mothers, fathers and caregivers.

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<sup>78</sup> 42 CFR 440.168

<sup>79</sup> “Integrated Care Models” CMCS State Medicaid Director Letter, SMDL#12-001 ICM#1, July 10, 2012

<https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf>

“Policy Considerations for Integrated Care Models” CMCS State Medicaid Director Letter, SMDL #12-002 ICM#2

July 10, 2012 <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>

“Shared Savings Methodologies” CMCS State Medicaid Director Letter, SMDL #13-005 ICM#3

<https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf>

<sup>80</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

The Informational Bulletin included a detailed discussion of Medicaid coverage, including an overview of general Medicaid requirements, and guidance regarding delivery and payment for NAS treatment in a variety of settings. CMS issued subsequent guidance, providing further clarification on the optional provider type of “residential pediatric recovery center” as required by Section 1007 of the SUPPORT Act for Patients and Communities.<sup>81</sup>

### Financing Options in the Treatment of Mothers and Fathers with SUD

States have multiple options for structuring their Medicaid program in order to receive federal financial participation for services delivered to pregnant and postpartum women, parents and guardians.

Additionally, states have flexibility in setting payment rates for services provided within the Medicaid program to promote access and quality care. For instance, states may pay higher rates for services provided to individuals with significant care needs or in geographic areas where access to care may be of concern. States may also offer providers financial incentives to improve beneficiary outcomes based on meeting certain targets, which may include treatment outcomes.

Under current Medicaid law, medical assistance payment for room and board is only available with respect to the facilities that provide Medicaid-covered, institutionally-based, benefits: nursing facilities, inpatient hospitals, psychiatric hospitals for individuals under age 21, institutions for mental diseases for individuals age 65 or older that otherwise would qualify as an inpatient setting, and intermediate care facilities for individuals with intellectual disabilities that also meet certain federal standards and conditions of participation requirements prescribed by the Secretary. Thus, an RPRC would only be able to receive a Medicaid payment for room and board if the RPRC furnishes services under one of these benefits and meets the applicable requirements.

Treatment services to address SUD for a Medicaid eligible parent or caregiver may be delivered outside of residential settings, in residential treatment settings, or in inpatient settings, depending on the needs of the individual. The extent to which expenditures for services are eligible for federal match depends on a range of factors, including the eligibility category of the beneficiary, the setting in which the services are furnished, and the Medicaid authority under which the state has elected to cover the services.<sup>82</sup>

### Medicaid Limited Exception to the Institution for Mental Diseases (IMD) Exclusion for Certain Pregnant and Postpartum Women

On July 26, 2019, CMS issued guidance to states on section 1012 of the SUPPORT for Patients and Communities Act, entitled Help for Moms and Babies. Section 1012 creates a new limited exception to the IMD exclusion.<sup>83</sup> Specifically, section 1012(a) states that for a woman who is

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<sup>81</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf>

<sup>82</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

<sup>83</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf>

eligible on the basis of being pregnant (and up to 60-days postpartum), who is a patient in an IMD for purposes of receiving treatment for a SUD, who is either enrolled under the state plan immediately before becoming a patient in the IMD, or who becomes eligible to enroll while a patient in an IMD, the IMD exclusion shall not prohibit federal financial participation (FFP) for medical assistance for items and services provided outside of the IMD to the woman. States may now claim FFP for pregnancy and pregnancy related services provided outside the IMD to women who meet these criteria. This limited exception became effective on October 24, 2018, the date of enactment of the SUPPORT for Patients and Communities Act.

### Financing Options under Medicaid Managed Care

Under certain conditions, the Medicaid managed care regulations at 42 CFR part 438 allow states to continue paying Medicaid capitation payments to managed care organizations and prepaid inpatient health plans for enrollees aged 21-64 receiving short term inpatient treatment in an IMD when the requirements in 42 CFR 438.3(e)(2)(i)-(iii) and 438.6(e) are satisfied. Many states enroll pregnant women into managed care and by using these provisions, have been able to provide more treatment options than were otherwise available under the state plan.

### Options under Medicaid Section 1115 Demonstration Projects

Section 1115 of the Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. In addition, demonstrations need to be budget neutral to the federal government. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

As part of the HHS effort to combat the ongoing opioid crisis, on November 1, 2017, CMS issued guidance describing additional flexibilities to help states improve access to and quality of SUD treatment through Medicaid section 1115 demonstrations.

For more information on these substance use disorder demonstration projects, see: <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/1115-sud-demonstrations/index.html>. For more information on the flexibilities to design section 1115 demonstrations to improve access to high quality, clinically appropriate treatment for OUD and SUDs as discussed in the SMDL on “Strategies to Address the Opioid Epidemic” issued Nov. 1, 2017, see: [www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf](http://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf)

## **B. Services and Options under CHIP**

### **Options and financing for prevention, screening, treatment to parents with SUD, infants with NAS and home visiting services**

CHIP HSI are an option under title XXI of the Act that states can consider to fund activities related to the prevention, screening and treatment of SUD and NAS, including home visiting

programs. Under section 2105(a)(1)(D)(ii) of the Act, states have the option to develop state-designed HSIs that improve the health of low-income and targeted low-income children.<sup>84</sup> Under implementing regulations at 42 CFR 457.10, HSIs must include activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals related to improving the health of children. HSIs may be directed at low-income pregnant women or parents; however, HSIs may only provide services for adults if the project directly improves the health of children. Additional details on the financing of HSIs are discussed below.

There is a wide variety of approved HSI projects. States have used HSIs to provide health care services,<sup>85</sup> health-related educational programs in schools, community-based public health outreach, and provider education on current treatment and prescribing practices. HSIs also provide opportunities for states to fund activities targeted to children who have been impacted by NAS or OUD, or their parents as long as the activities directly impact the health of the child. For example, several states currently use HSIs to provide home visitation programs for vulnerable populations, such as teen parents or children who are at risk for involvement or have been involved with child protective services. States may consider home visitation programs designed specifically for families with infants diagnosed with NAS that are focused on improving parental capacity and ability to care for infants with this condition. States could also consider using HSIs to supplement funding where the need exceeds existing resources, such as building on existing SUD prevention programs targeting children and young adults. Additionally, states have implemented HSIs to increase the use of naloxone, an important life-saving overdose reversal agent. Specifically, states have provided naloxone kits to families with children under 19 who have individuals in the home at risk for opioid overdose and training for teachers and other school employees on how to administer naloxone. When designing a HSI proposal, we encourage states to utilize evidence based programs or practices when developing interventions to ensure that HSI funds are being used effectively to improve the health of children.

Federal funding for HSIs comes from a portion of the state's available CHIP allotment for the relevant fiscal year. HSI expenditures (including for administration of the HSI itself) are subject to a cap (referred to in regulation as the "10 percent limit") that also applies to administrative expenses and other certain expenditures described in section 2105(a)(1)(D) of the Act. Under section 2105(c)(2)(A) of the Act and regulations at 42 CFR 457.618, federal payment for HSIs, administrative expenditures and other certain expenditures cannot "exceed the 10 percent limit of the total of expenditures under the plan" claimed by the state for the federal fiscal year as reported through the appropriate quarterly federal claiming forms. Within the 10 percent limit, states should fund costs associated with administration of the CHIP state plan first; any funds left over can be used for an HSI, subject to the 10 percent cap. In addition, consistent with section 2105(c)(6)(B) of the Act and 42 CFR 457.626, states must assure that title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding (other than an

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<sup>84</sup> 42 CFR 457.10 – "Low income" and "targeted low income" children include children up to a state's CHIP eligibility level or 200 percent of the FPL, if higher. "Child" means an individual under the age of 19 including the period from conception to birth.

<sup>85</sup> HSIs may not be used to cover health care services when Medicaid, non-governmental insurers, or other sources of funding (including other federal sources of funding) would reasonably be expected to pay for the services or the services could be coverable under those funding sources, consistent with the requirements of 42 CFR 457.626.

insurance program operated or financed by the Indian Health Service). Depending on the nature of the project, states should demonstrate that they have a process in place to coordinate work with other agencies administering federally funded programs and with respect to other expenditures of federal funds.

To implement a HSI, states must submit a CHIP SPA that includes a detailed description of the HSI and a completed budget in sections 2.2 and 9.10 respectively of the CHIP state plan. States must be able to illustrate that the proposed HSI would impact the health of children. Additionally, as required under section 2108 of the Act, states must report on CHIP annually, including any outcomes related to their HSIs. We encourage states interested in pursuing a HSI to consult CMS about their proposal or to submit a draft SPA prior to making an official submission. For technical assistance, please reach out to your CHIP project offer to discuss possible HSI proposals. If there are additional questions specific to this guidance, please contact Meg Barry, Deputy Director, Division of State Coverage Programs, at (410)-786-1536.

#### **IV. Additional Opportunities and Technical Assistance Available to State Medicaid Agencies**

##### Technical Assistance and Information through the Medicaid Innovation Accelerator Program (IAP)

The Medicaid IAP was developed to help improve the care and health of Medicaid beneficiaries and to reduce costs by supporting states' ongoing delivery system and payment reforms through targeted technical assistance, tool development, and cross-state learning opportunities.

By supporting states' ongoing payment and delivery system reforms, IAP aims to improve the health and health care of Medicaid beneficiaries and to reduce costs. As part of IAP's work with state Medicaid agencies in the areas of reducing SUDs and designing value-based payment for maternal and infant health, the program works with state Medicaid agencies to support data analysis and create data analytics tools related to screening, prevention, and post discharge services for maternal substance use disorders. This work has included data analysis resources that use maternal and infant claims data related to care for pregnant and postpartum Medicaid beneficiaries with OUD and infants born with NAS. For more information, visit <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html>.

##### Home Visiting Services and the Continuum of Care

Home visiting programs promote nurturing caregiver-child relationships essential to the healthy development of infants impacted by NAS. Intervening early and offering supportive, comprehensive services to families can promote responsive, caring parent-child relationships that can prevent or reverse negative health effects on the child caused by major stressors like a caregiver's mental and/or substance use disorder, neglect or abuse.<sup>86</sup> Home visiting is often cited as an evidence-based intervention that could help prevent or reduce the impact of

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<sup>86</sup> Center for the Developing Child, Harvard University, web page on Toxic Stress. Retrieved 2/2019 <http://developingchild.harvard.edu/science/key-concepts/toxic-stress/>.

behavioral health challenges through the promotion of protective factors and mitigation of risk factors.<sup>87</sup> Home visiting programs have a unique opportunity to support families affected by SUD and NAS by implementing innovations that build on the trusting relationships between home visitors and families and utilizing programs' existing networks of outreach, assessment, referral and service coordination. Consistent home visits build trusting relationships between home visitors and caregivers, which may serve as a gateway to SUD treatment.<sup>88</sup> Home visiting programs coordinate with health, early care and education, and family support partners and are able to identify and address gaps in services, develop appropriate referral agreements, increase interoperability among data systems, and improve system-wide standards of care.

The continuum of care model,<sup>89, 90, 91</sup> highlights promotion, prevention, treatment and maintenance approaches available to address behavioral health disorders. Across the continuum of care, home visiting programs innovate to support families affected by SUD and NAS through a number of strategies, such as:

- establishing and enhancing centralized access points and targeted referral agreements to enroll families affected by SUD and NAS;
- screening families for SUD on a periodic basis in accordance with a validated tool;
- tailoring services, in fidelity to home visiting models, to meet the needs of families affected by SUD by using SBIRT (Screening, Brief Intervention, and Referral to Treatment<sup>92</sup>), motivational interviewing, and other practices;
- incorporating SUD symptom and harm reduction to family goal planning;
- addressing family risk factors for SUD and NAS, and promoting protective factors that mitigate risk;
- implementing home visiting model enhancements to address substance misuse;
- expanding parents' knowledge of child development to promote positive parent-child relationships;
- supporting mothers in caring for babies affected by neonatal abstinence syndrome, Fetal Alcohol Spectrum Disorder, or other challenges connected to SUD;
- referring families to assessment and treatment, including MAT when indicated;
- providing case management to help families maintain necessary care for infants affected by NAS and help parents adhere to SUD treatment and maintenance plans;

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<sup>87</sup> <https://www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/principles-substance-abuse-prevention-early-childhood>

<sup>88</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration. (2018). HRSA's Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome.

<sup>89</sup> Institute of Medicine. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. P. J. Mrazek & R. J. Haggerty (Eds.). Washington, D.C.: The National Academies Press. doi:<https://doi.org/10.17226/2139>

<sup>90</sup> National Research Council, & Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. M. E. O'Connell, T. F. Boat, & K. E. Warner (Eds.). Washington, DC: National Academies Press. doi:<https://doi.org/10.17226/12480>

<sup>91</sup> U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

<sup>92</sup> Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. More information is available here: <https://www.integration.samhsa.gov/clinical-practice/sbirt#why>.

- providing ongoing professional development, mental health consultation and reflective supervision to build knowledge and skills among home visitors in identifying and meeting families' behavioral health needs;
- building a home visiting workforce peer support model that includes parents in recovery;
- utilizing and scaling continuous quality improvement methods to improve outcomes for families affected by SUD and NAS;
- incorporating gender-informed and trauma-informed approaches that reduce the stigma and discriminatory perceptions and impact of SUD and NAS into organizational policies and practices and maximize home visiting as a strategy to prevent SUD;
- coordinating with local mental health, SUD treatment, and other service providers, including health centers and recovery support systems, to improve families' access to high-quality treatment and social supports; and
- building state and local comprehensive and equitable two-generation systems of care to improve coordination of services for at-risk communities and families that include pregnant and parenting women and their children impacted by SUD and NAS, including collaboration with maternal and child health, early childhood, behavioral health, and child welfare partners.

These services strive to coordinate medical and other critical services for parents and caretakers and their infants at home. The majority of home visiting programs deliver services such as screening, case management, family support, counseling, and skills training, although each program utilizes its own eligibility criteria and service structure.

Medicaid coverage for home visiting services would depend on whether 1) the infant and/or parent or other caregiver is Medicaid-eligible; and 2) the proposed services are (or could be) coverable through existing Medicaid coverage authorities. Examples of Medicaid state plan benefits that include services that may be furnished as part of a Medicaid funded home visiting approach are: case management, physical therapy, occupational therapy, speech-language and audiology services, preventive services, rehabilitative services, and home health services.<sup>93</sup> States interested in covering new or additional home visiting services may contact CMS for technical assistance in evaluating whether the proposed services are coverable under the state plan and whether a SPA would be required.

States may also wish to consider other Medicaid authorities to furnish services within a home visiting program such as managed care authorities, home and community-based services waiver programs, and section 1115 demonstration programs. For further information, states can refer to the Joint Informational Bulletin on Coverage of Maternal, Infant, and Early Childhood Home Visiting Services.<sup>94</sup>

#### Residential Treatment for Pregnant and Postpartum Women Grant Program (SAMHSA)

The purpose of this program is to expand comprehensive treatment, prevention and recovery support services for women and their children in residential substance use treatment facilities,

<sup>93</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf>

<sup>94</sup> Coverage of Maternal, Infant, and Early Childhood Home Visiting Services, CMS/HRSA Joint Informational Bulletin at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf>



including services for non-residential family members of both the women and children.

The populations of focus are low-income (according to federal poverty guidelines) women, age 18 and over, who are pregnant, postpartum (the period after childbirth up to 12 months), and their minor children, age 17 and under, who have limited access to quality health services. SAMHSA has identified traditionally underserved populations, especially racial and ethnic minority women, as populations of focus. SAMHSA is particularly concerned about the high morbidity and mortality rates of pregnant women and their infants among African Americans. Under this grant program, services should be extended, when deemed appropriate, to fathers of the children, partners of the women, and other family members of the women and children who do not reside in the residential treatment facility.<sup>95</sup>

### The National Center for Substance Abuse and Child Welfare

The National Center for Substance Abuse and Child Welfare is co-funded by SAMHSA and the Administration for Children and Families (ACF) and has extensive resources to assist child welfare, substance use professionals and courts around issues related to substance abuse and child welfare.<sup>96</sup>

### State Pilot Programs for Treatment of Pregnant and Postpartum Women through Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA has designed a pilot program in order to incorporate a wider range of family-centered services for pregnant and postpartum women, their children, and family members in non-residential/outpatient treatment settings. The goal of the pilot is to help states provide a well-coordinated and integrated system, by encouraging new approaches and models of care that can be sustained overtime. There are currently 24 service sites in six states funded through the pilot. The project has identified many promising practices and participating states have developed mechanisms to bridge gaps in the continuum care of women.<sup>97</sup>

SAMHSA also funded fourteen states through its Opioid State Targeted Response strategy to target pregnant women and their newborns<sup>98</sup> and three grantees receiving SAMHSA MAT-Prescription Drug and Opioid Addiction awards are focusing specifically on pregnant women.<sup>99</sup>

### Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Grant Program

Project LAUNCH provides education and trainings for medical professions and other child serving systems (such as child welfare or substance abuse treatment providers) related to management of NAS.<sup>100</sup> Project LAUNCH grantees have the opportunity to educate all of these providers about best practices related to NAS, both in the hospital and post-discharge.

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<sup>95</sup> For additional information, see: <https://www.samhsa.gov/grants/grant-announcements/ti-17-007>

<sup>96</sup> For more information, see: <https://ncsacw.samhsa.gov/>

<sup>97</sup> <https://www.samhsa.gov/grants/grant-announcements/ti-17-016>

<sup>98</sup> <https://www.samhsa.gov/state-targeted-response-technical-assistance>

<sup>99</sup> The states are Kentucky, Louisiana, and Massachusetts

<sup>100</sup> Project LAUNCH is guided by a unique, federal-level partnership among SAMHSA, ACF, HRSA, and CDC. <https://healthysafechildren.org/grantee/project-launch>

## Approaches to Family Centered Care

Given the interplay of addiction, family, and pregnancy, states and programs are increasingly acknowledging the value of providing treatment to pregnant and parenting women through family-centered programs. These programs include women, their children, partners, and/or other family members in the treatment process, and provide clinical care for all affected family members. In addition to clinical treatment -- which includes use of MAT as a best practice for treating pregnant and parenting women -- family-centered programs include community-based services such as child care, transportation, housing, employment, training, parenting education, and linkages to financial aid and other human services programs.

Given the comprehensive nature of the provided services, the implementation of these programs often entails utilizing Medicaid funding for covered services, and identifying alternative federal and/or state funding for areas not included in Medicaid funding, such as housing or child care. States have specifically used the SAMHSA State Targeted Response grants<sup>101</sup> and the SAMHSA State Opioid Response Grants<sup>102</sup> to finance screening and treatment programs for pregnant and postpartum women with OUD. Alternative payment models, like the recently announced Maternal; Opioid Misuse (MOM) model developed through the Center for Medicare and Medicaid Innovation (the Innovation Center) and discussed below, could allow providers greater flexibility in designing programs that support case managers, peer recovery specialists, and other non-clinical support professionals and services deemed essential to facilitating family-centered care.

In addition, formal and informal partnerships among state agencies that serve this population can address many of the barriers to consistent treatment that social risk factors, like housing, food, and transportation insecurity. Since few family-centered programs are available, provider education, especially around the use of MAT as a best practice for treating pregnant and parenting women with OUD, is fundamental to improving access to services for families affected by the opioid crisis.<sup>103</sup>

## MOM Model, CMS Innovation Center

The MOM Model is a five-year model designed to improve care for pregnant and postpartum women enrolled in Medicaid with OUD and their infants. The model began on January 1, 2020, and the following 10 states were awarded funding: Colorado, Indiana, Louisiana, Maine, Maryland, Missouri, New Hampshire, Tennessee, Texas, and West Virginia. The MOM model requires states to address fragmentation of care for this population and to support an integrated and comprehensive model of care, including maternity care, OUD treatment, primary care, and behavioral health care. States must also ensure the provision of referrals to community supports and relevant social services to meet the comprehensive needs of the model's target population.

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<sup>101</sup> <https://www.samhsa.gov/grants/grant-announcements/ti-17-014>

<sup>102</sup> <https://www.samhsa.gov/newsroom/press-announcements/201909041245>

<sup>103</sup> Julie Seibert, PhD, Holly Stockdale, MA, Rose Feinberg, MA, Erin Dobbins, MA, Elysha Theis, BA, and Sarita L. Karon, PhD, RTI International . <https://aspe.hhs.gov/basic-report/state-policy-levers-expanding-family-centered-medication-assisted-treatment>

The model encourages states to tailor their programs for the communities they serve. This flexibility will provide opportunities for research into best practices, potentially building the evidence base for various screening tools, treatment types, treatment planning, coordination strategies, and post-discharge services. For more information, see <https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/>

### Guidance Regarding Plans of Safe Care

CARA made changes to Title I of the Child Abuse Prevention and Treatment Act (CAPTA), and more specifically added the following requirements:

- Modifies the state plan requirement at 106(b)(2)(B)(ii) for the state to apply the policies and procedures to address the needs of infants born with and identified as being affected by all substance abuse (not just illegal substance abuse as was the requirement prior to this change).
- Modifies the state plan requirement at 106(b)(2)(B)(iii) for plans of safe care for infants born and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder to add requirements for the state to:
  - ensure the safety and well-being of infants following the release from the care of health care providers, by (1) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and (2) monitoring these plans to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver (in accordance with state requirements); and develop the plans of safe care for infants affected by all substance abuse (not just illegal substance abuse as was the requirement prior to this change).
- Additionally, changes were made to required data reporting requirements. More information can be found in [Information Memorandum \(IM\) 16-05](#).<sup>104</sup>

The National Center on Substance Abuse and Child Welfare (NCSACW)<sup>105</sup> is providing technical assistance to support states' capacity to address families with infants affected by prenatal substance exposure. The NCSACW has identified best practices that reflect coordinated, multi-systemic approaches that are grounded in early identification and intervention, to assist child welfare, medical, SUD treatment and other systems to support families affected by opioid use disorders. Collaborative planning and implementation of services are yielding promising results in communities across the country. Examples of best practices include the use of:

- Early identification, screening and engagement of pregnant women who are using substances.
- Appropriate treatment for pregnant women, including timely access to treatment; access to comprehensive MAT; guidelines and standards for treatment that include preparing mothers for the birth of their infant who may experience withdrawal syndrome and potential involvement with Child Protective Services (CPS); and beginning the development of a plan of safe care prior to the birth event.

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<sup>104</sup> <https://www.acf.hhs.gov/cb/resource/im1605>

<sup>105</sup> This project is an initiative of HHS jointly funded by SAMHSA and the ACF Administration on Children, Youth, and Families (Children's Bureau)

- Consistent hospital policies for screening pregnant women, postpartum women and their infants; if universal screening is not feasible, then clearly defined, non-biased criteria for who is screened; and hospital standards and practices for care of the infant and mother that promote infant/mother attachment and bonding (e.g., breastfeeding, rooming in, skin-to-skin contact).
- Consistent hospital notifications to CPS, including developing a set of questions and responses that will help CPS hotline workers assess risk and protective factors and safety concerns for the infant and mother; comprehensive assessments of the infant’s physical health and the mother’s physical and social/emotional health and parenting capacity, which will be used to develop a thorough discharge plan and inform a multi-disciplinary plan of safe care.
- Memoranda of Agreement that allow for timely information sharing and monitoring infants and families across multiple systems.
- Ongoing care plans for mothers and their infants that include home visitation, early intervention services and recovery supports; and plans of safe care that are of sufficient duration to ensure a greater likelihood of family stability and well-being, with sufficient monitoring of maternal depression and anxiety, continuing recovery and parental capacity to meet her infant’s needs as well as her own.

Resources to help develop and implement these best practices are available in the document, “A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical and Service Providers”.<sup>106</sup> Additional documents, briefs, webinars and other technical assistance materials related to best practices in this area can be found at:

<https://ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx>.

### HRSA Funded Resources, Activities and Tools

#### *Title V Maternal and Child Block Grant Funds*

Administered by the Health Resources and Services Administration’s (HRSA) Maternal and Child Health Bureau (MCHB), the purpose of the Title V Maternal and Child Health (MCH) Services Block Grant<sup>107</sup> is to improve the health of the nation’s mothers, children, and families through federal/state partnerships that provide each state with needed flexibility to respond to its unique MCH population needs. The Maternal and Child Health Block Grant Program funds states and jurisdictions to provide health care and public health services for pregnant women, infants, children, including children with special health care needs, and their families. As one of the program’s National Outcome Measures, HRSA’s MCHB annually compiles, and makes available to states, national and state-level data on the proportion of infants born with drug dependency (NAS). This measure responds to the legislative requirement for such data to be reported and monitored.

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<sup>106</sup> [https://ncsacw.samhsa.gov/files/Collaborative\\_Approach\\_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)

<sup>107</sup> <https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program>

Examples of state Title V MCH Block Grant program activities that address NAS include:

- Providing leadership and actively participating in state-level, interagency partnerships and collaborations to enhance the early identification, treatment and prevention of NAS in pregnant women and their newborns;
- Coordinating with state healthcare organizations and providers in the development of standardized screening procedures, data protocols and treatment strategies for substance exposed newborns and their mothers;
- Promoting screening tools in early detection of high-risk women and newborns, which includes educating hospital staff and obstetric practices on evidence-based practice models;
- Advancing care coordination for the NAS-impacted mother-infant dyad Educating families and soliciting community engagement to develop and implement NAS plans of safe care;
- Working to improve data reporting and surveillance related to NAS; and
- Implementing maternal safety bundles or other best practices on obstetric care for women with opioid use disorder.

#### *The Rural Health Impact Program*

The [Rural Health IMPACT](#) Program<sup>108</sup> provides tailored technical assistance to communities to implement evidence-based, two-generational strategies that promote health and wellbeing of children (prenatally to age 3) and create economic opportunities for their families. This includes supporting rural demonstration sites to (1) ensure rural children and their families have access to high quality health, development, education, and family support services that are aligned and coordinated, and (2) improve early identification of and intervention for families who have experienced or are at-risk for adverse childhood experiences, maternal depression and other mental health issues, substance use disorders including opioid use and NAS and other factors that lead to poor health and social outcomes. Current implementation focuses on families of infants with NAS or other prenatal substance exposure.

#### *The Infant Toddler Court Program*

The overall goal of the Infant-Toddler Court Program<sup>109</sup> is to improve the health, well-being, and development of infants, toddlers, and families in the child welfare system. The program provides training, technical assistance (TA), implementation support, and evaluation research for infant-toddler court teams, which are community-based teams that bring together experts in areas including developmental health, judicial leadership, partnership engagement, and family advisors to address the specific needs of this at-risk population. The infant-toddler court team provides case management and family support to infants, toddlers and their families in the child welfare system many of whom are affected by substance use disorders. Court teams promote the implementation of two-generation, trauma-informed, evidence-based early interventions in the

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<sup>108</sup> <https://www.hrsa.gov/grants/find-funding/hrsa-18-105;>  
<https://mchb.hrsa.gov/earlychildhoodcomprehensivesystems>

<sup>109</sup> <https://mchb.hrsa.gov/earlychildhoodcomprehensivesystems;>  
<https://www.hrsa.gov/grants/find-funding/hrsa-18-123>

court and child welfare systems and across child- and family-serving systems. Court teams also work upstream to prevent child abuse and neglect in communities.

### *Provider Resources*

Clinical providers supporting the Maternal and Child Health Bureau (MCHB) funded grant programs, like the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program in particular, use evidence-based approaches to screen, intervene, and refer perinatal women and parents of young children, to treatment and recovery support services; they also provide health education and guidance for parents of young children including caring for infants born with NAS.

MCHB funds the development and implementation of maternal safety bundles, sets of evidence-based practices, for birthing facilities and providers on the management of women with opioid dependence.<sup>110</sup> This safety bundle includes tools and training resources, and is one of nine that is being implemented through MCHB’s Alliance for Innovation on Maternal Health (AIM) program. The ultimate goal of the program is to strengthen the quality of maternity care services in order to prevent obstetric emergencies. MCHB also funds the development and dissemination of “Bright Futures” pediatric guidelines, which recommends screening adolescents and young adults for alcohol, drug and tobacco use at preventive care visits; and screening those aged 12 to 21 for depression, which can be a risk factor for substance use.<sup>111</sup>

### *Technical Assistance Resources for States and State Partners*

In October 2018, the MIECHV program released a technical assistance resource document titled [“HRSA’s Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome.”](#)<sup>112</sup> This resource for federal awardees – and other state partners – provides essential information about the opioid epidemic, opioid use disorder, and NAS. It includes relevant research; offers strategies for MIECHV awardees and their state partners in early childhood, public health, and substance misuse and mental health treatment; and highlights promising efforts underway in Maine, Colorado, West Virginia, and Massachusetts.

The Supporting State Maternal and Child Health Policy Innovation Program (MCH PIP) aims to support innovative policy initiatives at the state level that improve access to quality health care for MCH populations.<sup>113</sup> These cooperative agreements were awarded to four national MCH stakeholders, representing key state-level policymakers and MCH programs. Together, these four stakeholders will each convene *policy academies* for key state and local MCH policy and programs leaders. The first cohort of academies has a considerable focus on substance use and behavioral health overall, in addition to maternal and infant mortality.

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<sup>110</sup> <https://mchb.hrsa.gov/maternal-child-health-topics/maternal-and-womens-health/#AIM>

<sup>111</sup> <https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html>

<sup>112</sup> <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/MIECHV-Opioid-NAS-Resource.pdf>

<sup>113</sup> <https://mchb.hrsa.gov/sites/default/files/mchb/AboutMCHB/mch-pip-factsheet.pdf>

Under the MCH PIP, the National Conference of State Legislatures (NCSL) developed a [Maternal and Child Health Database](#) that provides up-to-date information about enacted maternal and child health (MCH) legislation.<sup>114</sup> Legislative topics include the impacts of substance use on the MCH population, maternal and child mental health, maternal and infant mortality, women's health, childhood obesity and nutrition, and newborn screening. (NCSL, 2019)

MCHB is supporting a challenge called “[Addressing Opioid Use Disorder in Pregnant Women and New Moms](#).”<sup>115</sup> This challenge supports innovative technology-based solutions to improve access to quality health care for pregnant and new mothers struggling with OUD. Up to \$375,000 in prizes will support tech innovations to reduce barriers in obtaining safe and effective care and treatment, especially for families in rural and geographically isolated areas.

Lastly, HRSA has a number of investments targeting SUD. For information on HRSA-supported resources, technical assistance, and training, visit [www.hrsa.gov/opioids](http://www.hrsa.gov/opioids).

### Centers for Disease Control and Prevention (CDC) Funded Activities and Tools

#### *Addressing Opioid Use Disorder to Improve Infant and Maternal Health Projects*

As part of the CDC’s strategy to prevent opioid overdoses and harms, the Division of Reproductive Health (DRH) ) and the National Center on Birth Defects and Developmental Disabilities (NCBDDD) continues their work to prevent, identify, and improve access to treatment of OUD among pregnant and postpartum women and women of reproductive age and better understand and respond to NAS. With support from CDC’s National Center of Injury Prevention and Control (NCIPC) , DRH expanded its opioid-related activities in 2018 and 2019. This work includes conducting activities and providing technical assistance and information related to conducting surveillance and research, building state, local and tribal capacity for prevention, and supporting providers, health systems, and payers. More information on the research, publications, learning collaboratives, and state technical assistance projects is available on their website.<sup>116</sup>

NCBDDD activities aim to improve NAS surveillance; improve understanding of NAS in the context of medication assisted treatment (MAT); support state leadership teams to improve infant health and prenatal care of women with OUD; improve understanding of the spectrum of maternal, infant, and child health outcomes following treatment for OUD during pregnancy; and explore current policies and practices of child welfare agencies for the identification, referral for diagnosis and care of children with prenatal exposure to alcohol and other drugs, including opioids. More information on NCBDDD activities can be found on the CDC website.<sup>117</sup>

#### *The Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI)*

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<sup>114</sup> <http://www.ncsl.org/research/health/maternal-and-child-health-database.aspx>

<sup>115</sup> <https://mchbgrandchallenges.hrsa.gov/>

<sup>116</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/opioid-use-disorder-pregnancy/addressing-opioid-use-maternal-infant-health.htm#bldg>

<sup>117</sup> <https://www.cdc.gov/ncbddd/aboutus/pregnancy/nas.html>

OMNI is a collaborative Learning Community that shares strategies and best practices for policies and programs designed to improve the identification and treatment of pregnant and postpartum women with opioid use disorder and infants prenatally exposed to opioids. Thirteen state teams - that consist of state health officials; Title V directors; behavioral, mental health, or alcohol and drug abuse directors; Medicaid medical directors; and provider or facility champions - are participating in the initiative.<sup>118</sup>

*CDC State Perinatal Quality Collaboratives*<sup>119</sup>

In 2019, supplemental funding was available to expand the work of existing CDC-funded PQC's to improve quality of care and outcomes for pregnant and postpartum women with opioid use disorder and newborns with NAS. This funding will support training and help states build their capacity to use best practices for screening, treating, and coordinating care for these at-risk populations. This includes provider training, protocol implementation and screening and linkage to care

*Maternal and Infant Network to Understand Outcomes Associated with Treatment for Opioid Use Disorder During Pregnancy (MAT-LINK)*<sup>120</sup>

CDC receives funding from the HHS Office of the Assistant Secretary for Planning and Evaluation's Patient-Centered Outcomes Research Trust Fund (PCOR-TF) to implement MAT-LINK. MAT-LINK aims to improve our understanding of the spectrum of maternal, infant, and child health outcomes following treatment for OUD during pregnancy by establishing a surveillance network, consisting of four clinical sites, to collect existing data on maternal, infant, and child health outcomes associated with treatments for OUD during pregnancy.

*State, Territorial, Local, and Tribal Based Neonatal Abstinence Syndrome (NAS) Standardized Surveillance Case Definition Implementation Project*<sup>121</sup>

CDC receives funding to conduct surveillance of outcomes of infants born with NAS. In collaboration with the Council of State and Territorial Epidemiologists (CSTE), NCBDDD is supporting four health departments to conduct NAS surveillance using the CSTE Standardized Case Definition (Tier 1) while leveraging existing surveillance infrastructure. The new standardized case definition will allow for more consistent and comparable data on NAS across jurisdictions to improve our understanding of the epidemiology of NAS.

**V. Guidance regarding effective terminology and ICD codes to identify infants with neonatal abstinence syndrome and neonatal opioid withdrawal syndrome, which could include opioid-exposure, opioid withdrawal not requiring pharmacotherapy,**

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<sup>118</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/opioid-use-disorder-pregnancy/addressing-opioid-use-maternal-infant-health.htm>

<sup>119</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm>

<sup>120</sup> <https://www.cdc.gov/ncbddd/aboutus/mat-link.html>

<sup>121</sup> <https://www.cdc.gov/ncbddd/aboutus/pregnancy/nas.html>



### **and opioid withdrawal requiring pharmacotherapy.**

Section 1005(a)(4) of the SUPPORT for Patients and Communities Act requires that the Secretary of HHS issue guidance regarding suggested terminology and ICD<sup>122</sup> codes to identify infants with NAS and neonatal opioid withdrawal syndrome (NOWS), which could include opioid-exposure, opioid withdrawal not requiring pharmacotherapy, and opioid withdrawal requiring pharmacotherapy.

ICD-10-CM is the HIPAA<sup>123</sup> adopted code set for medical diagnoses.<sup>124</sup> The CDC's National Center for Health Statistics (NCHS) is responsible for maintenance of the ICD-10-CM classification. CMS worked with classifications and public health staff from CDC to identify the relevant ICD-10-CM diagnosis codes to satisfy this statutory requirement.

In selecting the ICD-10-CM diagnosis codes, CMS and CDC agency staff reviewed the conditions classified in Chapter 16- Certain Conditions Originating in the Perinatal Period, in code ranges P00-P96. The term "neonatal opioid withdrawal syndrome" (NOWS) does not appear in the ICD-10-CM classification. Additionally, the terms NAS and NOWS are generally used interchangeably.<sup>125</sup> There are also currently no specific ICD-10-CM diagnosis codes for opioid-exposure, opioid withdrawal not requiring pharmacotherapy, and opioid withdrawal requiring pharmacotherapy in neonates. Each state payer determines how standard codes will be used to meet their program operating needs and their claims adjudication process.

The most relevant diagnosis code is currently ICD-10-CM diagnosis code P96.1 (Neonatal withdrawal symptoms from maternal use of drugs of addiction). This code is applicable to drug withdrawal syndrome in infants of dependent mothers and NAS. This code should be used on the newborn record; not on the maternal record. Approximate synonyms include neonatal drug withdrawal syndrome, maternal drug abuse and neonatal drug withdrawal syndrome, and neonatal withdrawal symptoms from maternal use of drugs of abuse.

However, in addition to diagnosis code P96.1, there are more specific ICD-10-CM codes for infants that may be used concurrently and are related to the effects of maternal use of drugs of addiction. These codes can be assigned for infants exhibiting some signs/symptoms but not experiencing withdrawal and include:

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<sup>122</sup> International Classification of Diseases, Tenth Revision, Clinical Modification, <https://www.cdc.gov/nchs/icd/icd10cm.htm#FY%202020%20release%20of%20ICD-10-CM>

<sup>123</sup> Health Insurance Portability and Accountability Act of 1996, Pub. Law 104-191

<sup>124</sup> ICD codes are updated annually and the most current version of the codes must be used. For more information on ICD coding, see <https://www.cms.gov/Medicare/Coding/ICD10/index.html>

<sup>125</sup> "NAS describes neonates who are at-risk for poly-substance exposure including opioids. NAS has been used interchangeably by some with the term neonatal opioid withdrawal syndrome (NOWS), which is used to describe opioid-only withdrawal symptoms." <https://www.uptodate.com/contents/neonatal-abstinence-syndrome/abstract-text/29100261/pubmed> cited by LM Jansson, Neonatal Abstinence Syndrome, <https://www.uptodate.com/contents/neonatal-abstinence-syndrome>. Also, Neonatal Opioid Withdrawal Syndrome (NOWS) is not included in the language used in systematic collection of medical terms, i.e. the Systematized Nomenclature of Medicine (SNOMED) <http://www.snomed.org>.

<b>ICD-10-CM Diagnosis Code</b>	<b>Description</b>
P04.14	Newborn affected by maternal use of opiates
P04.16	Newborn affected by maternal use of amphetamines
P04.1A	Newborn affected by maternal use of anxiolytics
P04.40	Newborn affected by maternal use of unspecified drugs of addiction
P04.41	Newborn affected by maternal use of cocaine
P04.42	Newborn affected by maternal use of hallucinogens
P04.49	Newborn affected by maternal use of other drugs of addiction
P04.81	Newborn affected by maternal use of cannabis

**Conclusion**

CMS recognizes the challenges states are facing as they grapple with the ramifications of the opioid crisis, particularly as the crisis affects women and their children and families. We encourage states to contact CMS to discuss potential new or novel approaches within existing Medicaid authorities that states envision may be helpful to their beneficiaries. States interested in learning more on this topic and/or requesting technical assistance may contact Kirsten Jensen, Director, Division of Benefits and Coverage at [Kirsten.Jensen@cms.hhs.gov](mailto:Kirsten.Jensen@cms.hhs.gov).