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State Medicaid Strategies to Promote Early Identification and Treatment of Pregnant Women with Substance Use Disorder

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States face rapidly rising rates of substance use disorder (SUD) and overdoses among pregnant women and increases in maternal deaths and poor birth outcomes, such as neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS).[1] To understand how states promote early identification of SUD and treatment access for pregnant women, the National Academy for State Health Policy (NASHP) researched Medicaid quality measures and targeted initiatives for pregnant women with or at risk of SUD in every state and Washington, DC. This issue brief highlights state strategies, such as developing a state Medicaid Opioid Strategy with a focus on pregnant and parenting women, and leveraging financial incentives, quality measures, waivers, and public-private partnership to improve maternal and birth outcomes and curb state costs associated with SUD.

Introduction

Substance use during pregnancy is a contributing factor in maternal deaths, poor birth outcomes among infants, and NAS/NOWS, which have significant impact on women, children, families, and society.[2] Additionally, it is costly for states to treat infants with NAS.[3] Medicaid is the largest payer of pregnancy-related and behavioral health care, including SUD treatment. Medicaid spends an estimated $8.7 billion annually on opioid use disorder (OUD)-related health

Key Terms

- **Substance use disorder** (SUD) occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.
- **Opioid use disorder** (OUD) is a problematic pattern of opioid use leading to clinically significant impairment or distress.
- **Medication-assisted treatment** (MAT) is an evidence-based treatment treatment approach for individuals with SUD that combines medications with counseling and behavioral therapy.
- **Neonatal abstinence syndrome** (NAS) is a result of the sudden discontinuation of fetal exposure to substances that were used or misused during pregnancy.
- **Neonatal opioid withdrawal syndrome** (NOWS) occurs when in-utero opioid exposure leads to a well-described complex of withdrawal signs and symptoms.
- **Screening, Brief Intervention, and Referral to Treatment** (SBIRT) is an evidence-based practice to identify, reduce, and prevent problematic substance use and dependence.

care costs.[4] The Substance Abuse and Mental Health Services Administration (SAMHSA) projects that the total share of Medicaid spending on SUD services will increase from 21percent in 2009 to 28 percent in 2020.[5] As a key payer, Medicaid plays a significant role in covering and delivering services to identify and treat SUD in pregnant women.

Pregnant women and new mothers with SUD have unique needs. As a result of stigma, pregnant women with SUD are more likely to delay prenatal care and experience limited access to critical care during pregnancy.[6] During the postpartum period, women with SUD can experience stigma while caring for an infant with NAS and may lack child care required for them to attend treatment.[7] In addition, pregnant and parenting women may be hesitant to seek SUD treatment or prenatal care for fear of criminal justice or child welfare involvement.[8] Health centers can play a key role in providing high-quality care to pregnant women covered by Medicaid. Seventy-four percent of women attending health centers have early entry into prenatal care and many centers can provide SUD treatment along with prenatal care.[9] Several medical and professional associations recommend universal screening of pregnant and postpartum women for mental health and substance use disorders through a brief counseling intervention and appropriate referral as the standard of care.[10] Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice that providers, including obstetricians and gynecologists, can use to identify, reduce, and prevent problematic substance use and dependence.[11] Substance use during pregnancy is at least as common as many of the medical conditions screened for and managed during pregnancy, including preeclampsia, gestational diabetes, cystic fibrosis, and anemia.[12]

NASHP researched how Medicaid agencies meet the unique needs of pregnant women with SUD by assuring quality measurement addresses that needs are met or other related targeted initiatives. States engage Medicaid providers and managed care organizations to address this issue through a variety of strategies, including a statewide Medicaid opioid strategy, quality measures, financial incentives, waivers and public-private partnerships. Through these efforts, states promote early identification and screening, support provider education, facilitate referral and follow-up, increase access to medication-assisted treatment (MAT), and monitor birth outcomes.

Medicaid SUD Coverage and Benefits for Pregnant Women

There is no formal federal definition for the services to pregnant women that states must cover, beyond inpatient and outpatient hospital care. Each state determines the specific scope of maternity benefits for beneficiaries, including those related to SUD identification and treatment. However, state benefits must meet essential coverage guidelines. Behavioral health and SUD minimum essential coverage includes: behavioral health treatment such as psychotherapy and counseling; mental and behavioral health inpatient services; and SUD treatment.[13,14] Covered

SUD services vary from state to state, but typically include detoxification, individual and group therapy, and MAT.

Federal law –The Support for Families and Patients (SUPPORT) Act – underscores the importance of MAT as a treatment approach. The SUPPORT Act requires all states to cover MAT, including all Food and Drug Administration-approved treatment, counseling, and behavioral therapy by 2020.[15] All states currently cover MAT medications, but vary in terms of which medications are covered (buprenorphine, naltrexone, methadone).[16] Currently, more state Medicaid programs cover buprenorphine and naltrexone than methadone. Both buprenorphine and methadone are safe and effective treatments for OUD during pregnancy.[17]

State interagency strategies to promote early identification and access to treatment among Medicaid-eligible women with SUD:

- Expand postpartum coverage for SUD treatment and facilitate transitions between care settings.
- Implement innovative care delivery models that integrate reproductive health care and SUD treatment, offer family-centered treatment, or provide community-based supports to address women's unique needs.
- Consider workforce policies such as provider licensing changes or use of peer support specialists or telehealth to increase access to SUD care in rural areas.
- Align financing and policy across systems, such as health care and child welfare.
- Educate providers and patients to reduce the stigma associated with pregnant and parenting women accessing SUD treatment.
- Involve women who are in recovery in policy design and implementation.

Source State Options for Promoting Recovery among Pregnant and Parenting Women with Opioid or Substance Use Disorder, NASHP, October 2018.

The SUPPORT Act also provides states with different opportunities to increase access to services for pregnant women with SUD. For example, its Medicaid SUD waiver demonstration seeks to increase Medicaid provider capacity. Fourteen states and Washington, DC received an 18-month planning grant to support ongoing assessment of SUD treatment needs and to bolster the network and treatment capacity of Medicaid providers who offer SUD treatment or recovery services.[18] States also have the opportunity under the SUPPORT Act to waive the exclusion of coverage for services provided in institutions for mental diseases (IMD). This waiver allows states to receive federal financial participation for the continuation of substance use services in residential treatment facilities.[19] Currently, 25 states have waived the IMD exclusion and four states have waiver applications pending.[20]

Examples of State Medicaid Coverage and Quality Improvement Strategies

There are a number of ways states can promote early identification and access to SUD treatment among pregnant and parenting women (see textbox). NASHP's research identified the following four key strategies that state Medicaid agencies are implementing addressing coverage or quality improvement.

Develop a statewide Medicaid opioid strategy with a focus on pregnant and parenting women. Medicaid agencies can leverage contracts with managed care organizations (MCOs) to prioritize outreach and enrollment for pregnant women to ensure early identification of SUD, access to services such as MAT, and coordination of services. **Tennessee** Medicaid (TennCare) has developed an opioid strategy[21] that includes women of childbearing age as a priority population. Tennessee incorporated multiple data sources, including medical claims, pharmacy claims, dental claims, and data from the state's Prescription Drug Monitoring Database. Then, the state requires the MCOs to use data to engage with and directly outreach to women of childbearing age who may be at risk for developing opioid use disorder and/or having an NAS/NOWS birth. The member engagement and outreach focuses on patient education and linkage of members to primary care, SUD treatment, and behavioral health services. As a result, all MCOs have increased their screening and care coordination efforts and focused on expanding access to high-quality MAT services. A major emphasis has been placed on training and increasing the number of high-quality MAT providers across the state. Additionally, TennCare's opioid strategy includes partnering with the MCOs and pharmacy benefit managers to implement opioid prescribing guidelines and benefit limits to reduce opioid overexposure for first-time and non-chronic users.

Implement Medicaid incentives or measures to promote SBIRT and increase pregnant women's access to SUD treatment.
Medicaid agencies can promote women's access to SBIRT and follow-up treatment through quality measures, provider or MCO incentives, and performance improvement projects (PIPs). (To learn more about state Medicaid agency quality improvement approaches, explore NASHP's State Medicaid Quality Measurement for Women's Heath 50-state map). For example, **Connecticut's** Department of Social Services (DSS) introduced its Obstetrics Pay-for-Performance (OBP4P) Program in 2013 in order to improve care for pregnant women and the outcomes of their newborns covered by Medicaid.[22] Providers participating in the OBP4P program receive an additional payment on top of the current fee-for-service payments. In 2019, DSS introduced the newest cycle of its OBP4P program which, in addition to improving care for pregnant women and outcomes of newborns, seeks to decrease the incidence of avoidable maternal mortality and morbidity by identifying risk factors, such as substance use.[23] These payments incentivize providers to provide a postpartum visit between 22 and 84 days after delivery in which substance use, along with other health and risk factors, may be addressed.[24]

Florida Medicaid recently kicked off Birth Outcomes Initiatives to reduce primary cesarean-section, pre-term birth, and NAS rates. The state's Medicaid health plans have committed to achieving regional targets for reducing the rate of NAS each year over a five-year period. The baseline NAS rates statewide were 19.6 per 1,000 live births in 2016 and 17.7 per 1,000 live births in calendar year 2017. The common interventions the health care plans are implementing to reach their targets include substance misuse treatment programs, healthy behavior programs, provider engagement, and value-based payment/incentive programs. Specific interventions for substance use programs include early identification of pregnant women using opioids and increased access and referrals to MAT. The Healthy Behavior Programs include incentives to reward members for meeting medication and substance use treatment milestones. Different ways to engage providers include education on early identification and referrals as well as training in SBIRT.[25]

Leverage waivers to expand coverage and access to SUD treatment.

States use Medicaid waivers to promote innovation, including expanding coverage and access to SUD treatment. Within federal Medicaid waiver guidance, states can specifically focus on care for pregnant women with SUD. **Vermont's** 1115 waiver facilitates a multi-faceted approach to addressing the opioid epidemic that includes:

- Preventing SUD/opioid use disorder (OUD);
- Creating a continuum of care for SUD/OUD treatment and recovery;
- Aligning with the American Society of Addiction Medicine Level of Care guidelines;
- Using evidence-based patient placement criteria; and
- Monitoring provider capacity.

As part of its continuum of care for SUD/OUD treatment and recovery, Vermont offers several residential programs for people covered by Medicaid, Medicare, or commercial insurance and for self-payers. A specialized 26-bed residential program exists specifically for pregnant women and mothers with children under the age of five. These programs provide access to a variety of professionals and services, including services for individuals with co-occurring needs and clinically necessary MAT services.[26] The Department of Vermont Health Access and the Department of Children and Families are responsible for quality oversight of this specialized residential program.[27]

Participate in public-private partnerships to promote access to coordinated, team-based care for women

State Medicaid agencies also can participate in innovative public-private partnerships that help finance care for pregnant women with SUD. The partnerships can support pilots to demonstrate impact or help scale up initiatives with demonstrated success. Hospital-based quality improvement projects support innovation in coordinated inpatient care. In **Florida,** Medicaid is on the steering committee of the state's Perinatal Quality Collaborative (FPQC) and administers

two of the FPQC's performance improvement projects. The Neonatal Abstinence Syndrome (NAS) Performance Improvement Project is working to standardize NAS management with Florida NICUs and decrease the length of stay related to NAS. The Maternal Opioid Recovery Effort (MORE) Performance Improvement Project focuses on improving treatment and care within hospital delivery systems for pregnant women affected with OUD. These quality improvement projects run in parallel with each other with the overall goal of improving birth outcomes, identification, clinical care and coordinated treatment for pregnant women and their infants.[28]

Montana Medicaid and the Montana Health Care Foundation partnered to form the Perinatal Behavioral Health Initiative (PBHI). PBHI aims to improve timely access to care and outcomes for pregnant and postpartum women experiencing behavioral health challenges. The initiative will provide funding and technical assistance to allow medical practices to implement a coordinated and team-based approach for women with SUD or mental illness. The teams will include obstetric providers, behavioral health specialists, and care coordinators.[29]

Conclusion

States are innovating new ways to provide access to SUD treatment for pregnant women enrolled in Medicaid. Promoting early identification of SUD, increasing access to MAT, and focusing on improving birth outcomes are strategies states use to improve treatment and outcomes for pregnant women with SUD. State Medicaid agencies leverage waivers, public-private partnerships, MCO guidance and engagement, and performance-based measures and incentives to promote early identification and access to treatment for Medicaid-eligible pregnant women to decrease costs and improve the lives of women and their families.

Notes

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