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State Options for Promoting Recovery among Pregnant and Parenting Women with Opioid or Substance Use Disorder

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The devastating financial and human costs of the opioid epidemic are heightening states' focus on substance use prevention and treatment for pregnant and parenting women. The National Academy for State Health Policy (NASHP) interviewed state Medicaid, behavioral health, and public health officials from Colorado, Pennsylvania, and Texas to learn about their unique interagency approaches to treating and supporting pregnant and parenting women with substance use disorder (SUD). This issue brief explores their effective strategies to promote recovery in this population.

Introduction

The prevalence of opioid use disorder (OUD) has risen dramatically among pregnant women, more than quadrupling from 1999 to 2014.[1] Substance use is a contributing factor in pregnancy-associated deaths in several states.[2] The rise in opioid use among pregnant women has generated a corresponding rise in neonatal abstinence syndrome (NAS), with a five-fold increase in the number of infants treated for NAS between 2000 and 2012 (from 1.2 per 1,000 hospital births per year to 5.8 per 1,000).[3] Additionally, opioid and other substance use among parents are connected to an increase in children entering the child welfare system.[4] The costs associated with opioid use are significant. Medicaid spends an estimated $8.7 billion annually on OUD-related health care costs.[5] In 2014 alone, Medicaid covered approximately $462 million in hospital costs, accounting for 82 percent of all NAS-related births in the United States.[6] The opioid epidemic is also associated with $6.1 billion per year in spending on child and family assistance, including child welfare.[7]

Substance use disorders (SUDs) affect women across all racial and ethnic groups, socioeconomic backgrounds, and rural, urban, and suburban locales, and misuse of substances other than opioids, such as alcohol and methamphetamines, continue to be a significant challenge for states.[8] Individuals, including pregnant and parenting women, with OUD also often misuse other substances.[9] As of Aug. 1, 2018, 19 states had SUD treatment programs targeting pregnant women, and 17 states and Washington, DC gave pregnant women priority access to state-funded treatment programs.[10] Many states have identified pregnant and postpartum women as a priority population for their SUD programming, yet gaps remain in care for this vulnerable population.

In spring 2018, NASHP interviewed state officials from Colorado, Pennsylvania, and Texas to learn about their interagency strategies to support pregnant and parenting women with SUD, particularly Medicaid-enrolled women. Their approaches include:

- Supporting access and coverage through early identification of substance use, by expanding postpartum coverage for SUD treatment, and by facilitating transitions between care settings;
- Implementing innovative care delivery models, such as integrating reproductive health care and SUD treat-

ment, using family-centered care models, and providing supports for social determinants of health; and
- Using cross-system financing and collaboration to promote alignment across policies and programs and to leverage multiple federal and state funding streams.

Based on the experiences of Colorado, Pennsylvania, and Texas, NASHP also identified the following key considerations for state policies and initiatives for pregnant and parenting women:

- Provide community-based supports to meet the unique needs of women with SUD.
- Implement workforce strategies and other initiatives to increase access to SUD care in rural areas.
- Educate providers and patients to reduce the stigma associated with pregnant and parenting women accessing SUD treatment.
- Coordinate and align health care and child welfare policies.
- Involve parenting women who are in recovery in policy or program design and implementation.

What are substance and opioid use disorders?

What are substance and opioid use disorders? Substance use disorder (SUD) refers to a condition in which the use of alcohol or drugs leads to health problems, disability, and/or functional impairment, such as failure to meet responsibilities at work or home. Opioid use disorder (OUD) is a form of SUD that involves the use of opioids – a class of illegal (e.g., heroin) and prescription (e.g., oxycodone and hydrocodone) drugs that affect an individual's pain perception.[11]

The Scope and Impact of SUD among Pregnant and Parenting Women

Substance misuse is prevalent among pregnant and parenting women in the United States and has far-reaching consequences for the health and well-being of women and their children. States are grappling with a number of factors in their efforts to establish and strengthen policies and programs for pregnant and parenting women with SUD, including:
- Differences in substance use between women and men;
- A rapid rise in opioid use among pregnant women;
- The vulnerability of women with SUD in the postpartum period; and
- The impact of SUD on infants and children.

Women Experience SUD Differently than Men, and Pregnancy Is an Important Consideration

While there are many similarities, there are key differences in how SUD affects men and women. Historically, men have exhibited higher rates of overall substance misuse than women, but that gap is narrowing.[12] Additionally, women use and respond to drugs differently than men do. On average, women exhibit a faster onset and progression of SUD than men after first exposure to substances, and women experience greater impairments in social functioning, such as relationships and employment, than men.[13,14] Women are also less likely than men to engage in SUD treatment.[15] As a result of these differences, women with SUD benefit from gender-responsive treatment programs – programs that are tailored to the unique needs of women.[16]

OUD among pregnant women has risen dramatically in recent years. In 1999, 1.5 per 1,000 of women had OUD at delivery, and now OUD affects 6.5 in every 1,000 women at delivery.[17] While prevalence in pregnant women increased in all states with available data, it was higher in certain states. For example, in Vermont almost 5 percent of women giving birth had OUD.[18] Across the United States, pregnant women who took opioids for non-medical uses were more likely than non-pregnant women to obtain their opioids from doctors.[19]
The postpartum period can be a particularly vulnerable time for women with SUD. New mothers face unique challenges, including the relative lack of specialized and prioritized postpartum treatment resources, the

stigma of having an infant exposed to substances, postpartum hormonal changes, and postpartum depression.[20] Women with OUD are significantly more likely to discontinue medication-assisted treatment (MAT) in the postpartum period than during pregnancy.[21] Finally, many women lose public health insurance coverage during the postpartum period. For these reasons, women can experience elevated opioid overdose rates in the postpartum period. In Massachusetts, opioid overdose rates were four times higher in the postpartum period than during the third trimester.[22] Relapse for other substances, such as cocaine, alcohol, and marijuana, is also common during the postpartum period.[23]

The rise in OUD among pregnant women is linked to a corresponding rapid increase in NAS among infants.[27] NAS is a condition that newborns experience as a result of prenatal opioid exposure, which leads to symptoms including feeding difficulties, irritability, respiratory problems, and seizures. Infants with NAS are often admitted to neonatal intensive care units or experience prolonged hospital stays, thereby separating a mother and her infant during a critical time for bonding and development.[28] NAS also is costly to treat – the average cost of a hospital stay for an infant with NAS is more than $16,000.[29] Additionally, prenatal exposure to other substances can also impact an infant. For example, alcohol use during pregnancy can lead to fetal alcohol spectrum disorders (FASD), which can cause intellectual and behavioral disabilities and physical problems, such as abnormal facial features.[30] FASD affects at least 1 percent of children; however, recent research finds the prevalence of FASD may be up to 10-times higher than previously recognized, potentially affecting between 3.1 percent and 9.9 percent of US children.[31,32] Use of cocaine and methamphetamines during pregnancy also affect brain development and, consequently, child development.[33,34]

Medication-assisted treatment (MAT): A standard of care for pregnant women with OUD

MAT is an evidence-based treatment approach for individuals with SUD that combines medications with counseling and behavioral therapy.[24] MAT, using methadone or buprenorphine, is the standard of care for pregnant women with OUD, and leads to improved birth outcomes, including higher birthweight, reduced incidence of NAS, and shorter hospital stays for the infant.[25] Medication also can be part of treatment for other SUDs, although research involving pregnant women has focused primarily on methadone and buprenorphine. Fifty percent of pregnant women with OUD in publicly-funded treatment programs receive MAT.[26]

Medicaid Plays a Prominent Role in SUD Coverage for Women

Medicaid is a critical source of coverage for pregnant and parenting women and children. It is the country's largest payer of pregnancy-related care. In 2016, the program covered 42.6 percent of US births,[35,36] and 19 percent of parents, including 36 percent of single mothers.[37,38] Medicaid also plays a particularly important role in covering services that identify and treat SUD, including OUD. It is the largest payer of behavioral health services, which include substance use services, and accounted for 21 percent of SUD treatment spending in 2014.[39,40]

A survey of opioid use among women of childbearing years found that more than half (52.5 percent) of pregnant women between the ages of 15 to 44 were covered by Medicaid when they entered treatment.[41] Pregnant and parenting women can become eligible for Medicaid in several ways. The specific substance use services covered by Medicaid vary by state, but typically include individual and group counseling, detoxification, and MAT.[42]

Medicaid Eligibility Pathways for Pregnant and Parenting Women

Medicaid Eligibility Pathway	Description
Pregnancy-Related Coverage	All states are required to cover pregnant women with incomes below 133 percent of the federal poverty level (FPL) through 60 days postpartum. However, they may cover pregnant women with higher incomes. Among all states, the median income limit for pregnancy-related Medicaid coverage is 200 percent FPL, or $32,920 annually for a single woman pregnant with one child.[43,44] After the 60 days, a woman's Medicaid coverage is terminated, unless she qualifies under a different eligibility pathway.[45]
Medicaid Expansion	In the 31 states (including Colorado and Pennsylvania) that have elected to expand Medicaid to low-income adults under the Affordable Care Act (ACA), pregnant and parenting women can qualify under the Medicaid expansion eligibility category. The income limit for this coverage is 138 percent FPL, or $22,715 annually for a single woman with one child.[46] If a woman earns more, she is generally eligible for subsidized insurance coverage through the ACA's Health Insurance Marketplace (marketplace).[47]
Traditional Medicaid	In all states, pregnant women may qualify through traditional Medicaid. Eligibility is based on an individual's income at or below the state's threshold and meeting one of the following eligibility categories: pregnant woman, parent of children 18 and younger, disabled, or over age 65. In the 19 states that did not expand Medicaid, the median income limit is 43 percent FPL, or $7,078 annually for a single mother with one child.[48,49] In these states, there are women who earn too much to qualify for Traditional Medicaid but not enough to qualify for subsidized marketplace coverage.[50] Some women who no longer qualify for Medicaid due to increased income can receive six to twelve additional months of Medicaid eligibility under the Transitional Medical Assistance (TMA) authority.[51]

Adapted from: https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/

State Policy Options and Strategies to Support Pregnant and Parenting Women

In response to the opioid epidemic, states are developing and refining comprehensive strategies designed to meet the needs of pregnant and parenting women with SUD, and mitigate the negative impacts on their overall health and well-being. These strategies, as demonstrated by Colorado, Pennsylvania, and Texas, cut across state agencies and systems and embody collaborative approaches designed to maximize resources and optimize outcomes for women and children. The strategies fall within three primary domains:

- Improve access to and coverage of services and supports;
- Implement care delivery models that recognize the unique needs of women and families; and
- Leverage funding streams and coordination across systems.

Improving Access to and Coverage of Services and Supports

Untreated substance use can lead to poor outcomes for women and their children. Enhancing and expanding access to and coverage for SUD treatment services for pregnant and parenting women is key to supporting this population and setting them on a path to improved health and social functioning. Ensuring access to services and supports and keeping women engaged in treatment can be challenging due to the various ways in which they can be covered by public and private insurance, the stigma associated with SUD, and social and logistical barriers to treatment (e.g., availability of child care, lack of transportation, etc.).

Supporting early identification of women with SUD

Early identification of pregnant women with SUD is key to facilitating access to services and improving outcomes

for mothers and infants. However, early identification of pregnant women with SUD can be challenging. Women are often reluctant to report substance use due to fear of child protective services involvement or potential legal ramifications. Providers also need education and training about SUD screening, as well information about available treatment services for women with positive screenings.

Colorado's Department of Health Care Policy and Financing (HCPF), which administers the state's Medicaid program, reimburses providers for administering Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent risky use of alcohol and drugs.[52] However, despite increasing provider reimbursement and hiring a contractor to educate providers on SBIRT, SBIRT utilization rates have not significantly increased. Anecdotally, providers have reported discomfort with screening women for SUD when they are not familiar with referral and SUD service options for those with positive screens. HCPF is expanding provider networks and increasing care coordination between physical and behavioral health services to ensure the appropriate supports for positive screens are available and that providers are aware of them. In July 2018, the state launched the second iteration of its Accountable Care Collaborative (ACC Phase II), which joined physical and behavioral health under one accountable entity — a regional accountability entity (RAE). The new delivery system is designed to improve the relationship between primary care providers who screen for behavioral health diagnoses and behavioral health providers who treat behavioral health conditions. Additionally, the RAEs are eligible to receive additional payments for improving members' behavioral health engagement.

Texas's Medicaid program also reimburses for SBIRT,[53] and the state's Health and Human Services Commission (HHSC) supports early identification and access to treatment through the Pregnant, Postpartum Intervention (PPI) Program. PPI provides community-based, gender-specific outreach and intervention services for pregnant and postpartum women who have or are at risk of developing SUD. PPI providers conduct substance misuse screening and assessment, provide counseling services, and manage referrals.[54] They also provide targeted outreach to engage high-risk women early in perinatal care and SUD treatment.[55]

Providing coverage for SUD treatment beyond 60 days postpartum

As previously noted, women with SUD are particularly vulnerable in the postpartum period, yet women who qualified for Medicaid due to their pregnancy may lose coverage at 60 days postpartum. Many states have SUD treatment programs designed for pregnant women or give pregnant women priority access to state-funded treatment, however, the benefits may not be available to postpartum and parenting women after 60 days postpartum. Both Colorado and Texas are implementing a variety of mechanisms to facilitate access to and continuity of care after childbirth for women enrolled in Medicaid, beyond 60 days postpartum.

Colorado HCPF, in partnership with the Colorado Office of Behavioral Health (OBH), administers Special Connections, a program for pregnant women enrolled in Medicaid who have alcohol and drug abuse problems. Special Connections provides a comprehensive range of SUD treatment services to pregnant women for up to twelve months postpartum, including residential treatment, case management, individual counseling, group substance misuse counseling, group health education, and referral to aftercare and ongoing support.[56] In order to implement Special Connections, Colorado submitted and received approval for a state plan amendment and 1915(b) Waiver.[57] The state plan amendment allows the state Medicaid program to provide extended services to pregnant women up to 60 days postpartum. The 1915(b) waiver then allows the state to continue to cover SUD treatment services for between two to twelve months postpartum.[58] While women must be enrolled in Special Connections prior to delivery in order to receive services postpartum, the state is able to provide continuity of care for pregnant and postpartum women with SUD.

Texas, as a non-Medicaid expansion state, experienced the challenge of women with SUD who became eligible for Medicaid due to their pregnancy but were no longer eligible after giving birth. The women also no longer received priority access to state-funded treatment because they were no longer pregnant. To address this issue, Texas DSHS expanded SUD treatment slots for pregnant and parenting women, which includes women with infants up to 18 months old or women who have been referred to the Texas Department of Family and Protective Services and have children under the age of 6.[59] As a result, when a woman's Medicaid coverage ends, she seamlessly transitions to state-funded treatment. Financing changes take place behind the scenes, but women experience no changes or disruptions to their providers or services.[60]

Facilitating transitions between care settings

Pregnant and parenting women with SUD may access care in various settings, depending on their treatment needs. These transitions can begin with the initial screening and referral to appropriate treatment, and then care at different intensity levels, such as from residential to community-based care when they "step down" through treatment. Care transitions can pose risks to women in recovery as they create opportunities for disruptions in care.[61] Ensuring connections between the various care settings, including when a woman is initially referred to treatment, or as she transitions to less intensive services over time, can help keep her engaged in treatment.

Pennsylvania's Centers of Excellence (COE) program uses a "hub and spoke" model of care, through which the "hub" serves as a central and coordinating source of specialty SUD services and the "spokes" are primary care and community-based providers that provide additional supporting services. The hub and spoke approach in Pennsylvania is designed to coordinate care for individuals with OUD, and ensures that treatment is team-based and "whole person" focused.[62] Currently, there are 45 COEs throughout the state, six specifically target pregnant and postpartum women. COEs manage referrals and facilitate warm handoffs to ensure that individuals are connected to the medical and behavioral health services they need to treat their OUD. For the COEs supporting pregnant and parenting women, this can include getting women into gender-specific SUD treatment and ensuring that they receive appropriate obstetrics services. In addition to the COEs, the Pennsylvania Department of Drug and Alcohol Programs (DDAP) has established warm hand-off processes for emergency departments to use in order to facilitate a seamless transition from emergency medical care to SUD treatment for individuals who experienced an overdose.[63] While not specific to pregnant and parenting women, the warm hand-off processes are part of the state's overarching strategy that can provide a key opportunity to identify pregnant and parenting women with SUD and connect them to treatment.

In **Colorado**, women served by the Special Connections program are also enrolled in regional accountable entities (RAEs), which coordinate the physical and behavioral health for Medicaid enrollees in their specific region. Colorado Medicaid is leveraging RAEs to improve coordination and delivery of services for special populations, including those transitioning between residential and community SUD treatment programs.[64] As a woman prepares to transition out of the residential care provided through Special Connections, the RAE will ensure she is connected to the appropriate outpatient and community-based care. To further support transitions between settings, the Colorado Office of Behavioral Health oversees a peer support specialists program. Peer support specialists, also referred to as peer navigators, are individuals with lived SUD experience who are formally trained to engage others in the recovery process and help them navigate the behavioral health system.[65] Colorado engages peer support specialists to assist individuals, including pregnant and parenting women, transitioning from residential treatment. Peer support specialists also connect and engage clients in community-based care, particularly in rural areas where treatment providers tend to be harder to access.[66]

Continuity of care for incarcerated women

Incarcerated women are more likely than incarcerated men to have SUD and co-occurring mental health issues, and two-thirds of incarcerated women are the primary caretakers of children.[67,68] Incarcerated pregnant women also may experience barriers to receiving appropriate prenatal care and SUD treatment services. Pregnant and parenting women with SUD who are incarcerated are especially vulnerable to disruptions in care due to their transitions between systems.[69] Additionally, incarceration can present stressors that pose risks to their recovery, such as the separation from their children and transitioning back into the community.[70,71] States are considering not only how to connect incarcerated women with SUD to services and ensure they continue to receive care while incarcerated, but also how to connect women to services upon community re-entry.

In **Colorado**, HCPF has implemented a statewide data-sharing program with the Colorado Department of Corrections in order to streamline Medicaid enrollment for criminal justice-involved populations in the prison system, including women, and better coordinate transition services. The department hopes this proof-of-concept at the state level can provide impetus, incentive, and support at the county level for similar arrangements because there is variation among county jails' policies for providing services to pregnant women with SUD. Some county jails facilitate access to medication-assisted treatment if a woman was receiving it in the community prior to incarceration. Others only allow for a three-day detoxification, which is an intervention to manage withdrawal.[72] However, detoxification for pregnant women with OUD is not recommended due to the high-risk of fetal distress or death.[73] Instead, experts recommend slow detoxification for pregnant women in conjunction with obstetrical support. Colorado's Office of Behavioral Health is working with county jails to increase access to clinician support and medication-assisted treatment in an effort to prevent three-day detoxification for pregnant women.[74] HCPF also requires RAEs to provide care coordination for Medicaid-eligible individuals, including pregnant women with SUD, transitioning out of the criminal justice system to help ensure continuity of care. Additionally, HCPF is exploring opportunities for data sharing with the Colorado Division of Criminal Justice in order to streamline Medicaid enrollment for criminal justice-involved populations, including women, and better coordinate transition services.

Implementing Care Delivery Models that Recognize the Unique Needs of Women and Families

Effective treatment programs for pregnant and parenting women with SUD address the comprehensive needs of women, including reproductive health and perinatal care, social services supports, and parenting skills, as well as their children.[75] Such comprehensive approaches to care can help address the underlying causes of SUD and help promote long-term recovery and the well-being of the whole family. Historically, the systems within states (e.g., primary and obstetric care, behavioral health care, community-based services and supports, etc.) that can play key roles in supporting pregnant and parenting women have been fragmented. Colorado, Pennsylvania, and Texas are implementing and expanding a variety of care delivery models designed to break down historical siloes between agencies and systems and promote a holistic approach to care for this population.

Coordinating and integrating reproductive health care and SUD treatment

OUD is linked to a high rate of unintended pregnancy and unmet contraceptive needs. More than 80 percent of women with SUD reported lower contraceptive use than women without SUD. Furthermore, over 86 percent of pregnant women with OUD reported that their pregnancies were unintended[76] and 20 percent of the postpartum women became pregnant again within 18 months.[77] Pregnant women with SUD often do not access timely and adequate prenatal care due to the fear of legal ramifications, functional impairment associated with substance use, and transportation or childcare issues.[78] Inadequate prenatal care can lead to adverse outcomes for the mother and infant.[79] Coordinating or integrating reproductive health services with SUD treatment can support

the overall health and well-being of pregnant and parenting women. Models for coordination and integration include creating referral pathways between SUD and family planning providers to co-locating MAT and obstetric care.

Pennsylvania's COEs that serve pregnant women provide care coordination services for SUD treatment needs, including MAT, support services that help mother and child, and perinatal care. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) is also working to improve bi-directional referrals between family planning and SUD services. This initiative will target obstetric providers to promote the use of SUD screening and referrals as part of prenatal care and also train SUD providers to ask women about their pregnancy intentions and refer them to additional reproductive health care services as needed. The Department of Health's Bureau of Family Health is also leading an effort using Opioid State Targeted Response funds to address unintended pregnancy rates among individuals with OUD utilizing the Alliance of Family Planning Councils. The alliance is a statewide network of clinics that provide maternal and reproductive health services. The project will include training, a pilot and an evaluation of the education, outreach, and development of referral pathways.

Colorado's Office of Behavioral Health (OBH) is developing pilots to co-locate SUD treatment and perinatal care. These pilots are modeled after similar initiatives underway in other states, such as Project Nurture in Oregon,[80] that are designed to provide prenatal care, maternity care, and postpartum care for women with SUD all in one setting. The co-location of these services is intended to improve access to all of the services a woman may need to promote recovery and the overall health and well-being of the woman and her child.

The role of the safety net

The health safety net plays a key role in supporting vulnerable and low-income populations. Health centers are statutorily required to provide primary, preventive, and enabling health services, which include the delivery of or referrals to behavioral health services. While many states' SUD strategies focus on specialty providers and hospital-based systems, safety net providers can expand the reach of SUD programs, particularly in rural communities where specialty providers are less accessible.

Pennsylvania's COEs use a "hub and spoke" approach to care, with the COE serving as the "hub," or central source of care that oversees referrals and coordination among the various "spokes" (e.g., physical, behavioral, and maternal health providers). Currently, eight of the COEs are federally qualified health centers (FQHCs) and six are safety net hospitals. In cases where COEs are based in non-safety net hospitals, they are required to work with a network of community resources, which include nurses, social workers, certified recovery specialists, telemedicine psychiatry providers, family members, and other community relationships to serve as spokes in COEs' systems of care.

Denver Health, a FQHC in **Colorado**, has established a family practice clinic that administers MAT next to an obstetrics practice in order to facilitate access to both SUD treatment and perinatal care for pregnant women with SUD. Early findings from this pilot indicate that this model may promote increased adherence to treatment among pregnant women.

Promoting family-centered care models

Parental substance use can lead to negative outcomes among children. Prenatal exposure to substances can cause an infant to experience withdrawal symptoms and may have long-term effects on an infant's development, and physical, behavioral, and emotional health. Children of parents with SUD may also experience developmental, behavioral, and emotional challenges.[81] Treatment models that support women within the context of their families and meet the needs of their children have been shown to improve outcomes for both women and children.[82] Family-centered treatment – a comprehensive approach that addresses the array of challenges faced by women with SUD, their children, and other family members – can take a variety of forms, including both residential and community-based.[83]

Texas's Mommies program is an integrated model of care for pregnant and parenting women with OUD or polysubstance use involving opioids, which is designed to meet the needs of the women and their children. Participants receive an individualized care plan, counseling specific to substance misuse, crisis intervention

services, case management, individual therapy, family therapy, and group therapy. Depending on their needs, women can also receive a variety of evidence-based interventions for trauma recovery and parenting skills.[84] Additionally, Texas created the Statewide Pregnancy Stabilization Center, a residential treatment program for pregnant and postpartum women with SUD. This center provides a full continuum of services for women and their children, ranging from clinical services to recovery support services (e.g., recovery housing), and allows mothers and their children to remain together during treatment.[85] Texas reports this program and other residential treatment programs serving women and their children across the state are underutilized due to hesitancy among referring entities to support children entering residential treatment environments with their mothers.

The **Pennsylvania** Department of Human Services is expanding its evidence-based home visiting program in response to the opioid epidemic. Home visiting programs use a family-centered approach to provide a comprehensive set of social, health, and educational services to parents and young children. All 50 states and Washington, DC are implementing home visiting programs for targeted populations with support from the federal Maternal, Infant, and Early Childhood Home Visiting Program.[86] By expanding home visiting, Pennsylvania aims to reach communities with higher rates of SUD in order to provide in-home supports that can engage pregnant and parenting women in SUD treatment, help prevent child abuse and neglect, and screen children for potential issues associated with parental substance use.[87] Pennsylvania is also training home visiting staff to screen for SUD among parents and identify signs of substance exposure among infants.

Addressing social determinants of health for women and their families

Women with SUD tend to face additional barriers to care, as compared to men, since they are more likely to be primary caretakers for their children. In order to achieve long-term recovery, women may also need services and supports beyond SUD treatment services, such as housing, transportation, childcare, and employment services. Addressing these social determinants of health can be complex both to implement and finance; however, states recognize that these services are key to promoting the health and well-being of women and families.

For example, **Pennsylvania** incorporated a focus on social determinants of health in its COE program, with COEs overseeing referrals to housing, transportation, and other social services.[88] **Texas's** Mommies program provides free transportation and childcare services for participating women, as well as support in coordination other benefits.[89] **Colorado's** OBH is exploring strategies to improve childcare options for parenting women with SUD, including contracting with a mobile licensed childcare provider who can move among various treatment locations and establishing multi-provider childcare centers.[90]

Leveraging Funding Streams and Coordination across Systems

With numerous systems — from health care to criminal justice -- potentially involved in the care of pregnant and parenting women with SUD, states emphasize the importance of coordinating strategies across state agencies. By coordinating strategies, the various state agencies can promote consistent policies and approaches to support this population and facilitate long-term recovery. Additionally, coordination creates opportunities to provide a comprehensive range of SUD services and supports to pregnant and parenting women that one system alone cannot cover.

Aligning policies and improving programming through formalized cross-system collaboration

To improve the coordination of SUD strategies across systems, states have formalized their cross-system collaboration through mechanisms such as interagency agreements, task forces, and perinatal quality collaboratives. These mechanisms are designed to align policies across agencies to:

- Facilitate data collection and analysis to inform policy and program implementation, and
- Coordinate services to improve care for populations affected by SUD, including pregnant and parenting women.

In **Colorado**, HCPF and OBH have an interagency agreement that formalizes their partnership in the implementation of Special Connections. The interagency agreement enables OBH to contract with licensed women's treatment programs in order to provide Medicaid-eligible services and delineates the roles and responsibilities of each agency.[91] Additionally, the Colorado General Assembly established the Substance Abuse Trend and Response Task Force, which subsequently formed the Substance-Exposed Newborn (SEN) Steering Committee in 2008 to "identify and implement strategies for reducing the number of families impacted by substance use during pregnancy in Colorado and for improving outcomes for impacted women, children, and families across the lifespan."[92,93] The SEN Steering Committee is convened by a community partner, but it includes representatives from OBH, the Colorado Department of Justice, and the state child welfare agency. The SEN Steering Committee's efforts have included establishing the SEN Hospital Learning Collaborative to improve care for newborns exposed to substances and their caregivers and advance policies that promote access to care for pregnant women with SUD.[94]

As part of Gov. Tom Wolf's opioid disaster declaration, **Pennsylvania** established an Opioid Command Center to coordinate the state's response to the opioid epidemic. The center convenes leaders from the state Department of Health (DOH), Department of Drug and Alcohol Programs, Department of Human Services, Emergency Management Agency, the Pennsylvania Commission on Crime and Delinquency, Department of Corrections, Department of State, Department of Aging, Insurance Department, Department of Education, Department of Military and Veterans Affairs, Department of Labor and Industry, Office of the State Fire Commissioner, and the Pennsylvania State Police. The Command Center is implementing initiatives across all populations, including, but not limited to, pregnant and parenting women. It is collecting and analyzing data in order to understand the scope of the problem and target interventions and resources where they are most needed. As part of this data collection effort, the center has made NAS a reportable condition to the DOH. Currently, more than 80 percent of hospitals and birthing centers report NAS cases.[95] **Pennsylvania** has integrated the NAS data into its Opioid Data Dashboard, which enables the state to determine where prevention and treatment are needed.

Texas DSHS oversees the Maternal Mortality and Morbidity Task Force, a multidisciplinary task force charged with studying maternal mortality and morbidity in the state. The task force found that drug overdose accounted for 17 percent of all maternal deaths in the state, and nearly 80 percent of those maternal deaths occurred after 60 days postpartum.[96] DSHS is using this data to implement targeted prevention and intervention efforts, including developing a patient safety bundle on obstetric care for women with OUD and partnering with another agency, the Texas Health and Human Services Commission, to increase access to behavioral health and SUD services for pregnant and postpartum women.[97]

Leveraging multiple state and federal funding streams

The use of multiple funding streams is key to states' programs supporting pregnant and parenting women with SUD. States and the federal government have made significant investments into combatting the opioid epidemic. While some of this funding must go specifically towards addressing OUD, many states leverage other various funding streams to develop and enhance their broader SUD policies and initiatives to prevent and mitigate the impact of substance misuse overall. Colorado, Pennsylvania, and Texas use Medicaid, state general funds, and federal investments to support pregnant and parenting women. (For an overview of federal investments related to pregnant and parenting women with SUD, see the Appendix.)

Colorado's Special Connections program uses Medicaid, Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), and state general revenue dollars to provide medical and social services to its enrollees. Medicaid dollars support Medicaid eligible services, including residential treatment, case management, group substance abuse counseling, group health education for pregnant women, risk screenings, and individual counseling. SABG and state

general revenue funding support the costs of room and board for residential treatment, as well as program administration (e.g., managing the request for proposal for treatment sites, certifying providers, providing technical assistance, etc.).

In addition to supporting Special Connections, Colorado Medicaid also covers the care coordination and transition services provided by the RAEs to Medicaid enrollees with SUD, including pregnant and parenting women. Colorado OBH uses SABG and the State Targeted Response to the Opioid Crisis Grant to support other initiatives that provide services to this population. For example, OBH is developing a pilot program to co-locate medication-assisted treatment and obstetric services. OBH is also exploring mechanisms to improve access to childcare while a woman is in treatment. Options include: mobile childcare to provide childcare services to multiple treatment sites in one day; polices giving women in SUD treatment priority access to childcare services; and multiprovider childcare sites, in which participating treatment providers would share financial responsibility with supplemental funding from the state.

Pennsylvania supports COEs through state general revenue and Medicaid funding. Medicaid managed care organizations are required to contract with COEs in order to cover Medicaid-eligible treatment services, while state dollars support the upfront costs of becoming a COE and case management activities that go beyond the scope of Medicaid. While initially grant-funded, the COEs will begin billing Medicaid for the enhanced care management services they provide in 2019 in order to sustain their efforts. Pennsylvania is leveraging its State Targeted Response to the Opioid Crisis Grant to improve bidirectional referrals between SUD treatment and family planning for pregnant women. The state uses its Title V Maternal and Child Health (MCH) Services Block Grant and Maternal, Infant, and Early Childhood Home Visiting Grant (MIECHV) to support its evidence-based home visiting program. However, Pennsylvania is expanding its home visiting program through state general revenue funds.

Similar to Pennsylvania and Colorado, **Texas** supports PPI, the Mommies program, and the Statewide Pregnancy Stabilization Center by leveraging Medicaid reimbursement for Medicaid-eligible treatment services. PPI, which houses the Mommies program, draws from multiple funding streams, including SABG and state general revenue funds. SABG funds support general services provider through PPI, while the general revenue funds supports the Mommies programing. The state also uses state general revenue funds to support the Statewide Pregnancy Stabilization Center.

Table: Overview of Funding Streams by State

State	Initiative	Funding Stream
Colorado	Special Connections	• Medicaid • Substance Abuse Prevention and Treatment Block Grant • State General Revenue
	Regional Accountable Entities (RAEs)	• Medicaid
	Co-location Pilots and Child Care Initiatives	• State Targeted Response to the Opioid Crisis Grant • Substance Abuse Prevention and Treatment Block Grant
	Centers of Excellence	• Medicaid • State General Revenue
Pennsylvania	Bi-directional Referrals and Family Planning Services	• State Targeted Response to the Opioid Crisis Grant
	Home Visiting	• Maternal, Infant, and Early Childhood Home Visiting Grant • State General Revenue
Texas	Pregnant, Postpartum Intervention (PPI) Program (including Mommies Program)	• Medicaid • Substance Abuse Prevention and Treatment Block Grant (SABG) • State General Revenue
	Statewide Pregnancy Stabilization Center	• Medicaid • State General Revenue

Key Considerations for Meeting the Needs of Pregnant and Parenting Women

Meeting the needs of pregnant and parenting women with SUD in order to promote their long-term recovery is complex. Not only do women require comprehensive SUD treatment, but they also typically need services to support them in as caregivers, to address their other physical and behavioral health needs, and to coordinate care between the various systems that serve them. Below are key considerations that states are using to develop and implement their SUD policies and initiatives for pregnant and parenting women.

- *Provide community-based supports to meet the unique needs of women with SUD.* Because women are often the primary caregivers of their children, facilitating access to community supports enables parenting women to fully engage in SUD treatment. For example, providing childcare in residential and outpatient settings alleviates some of the challenges of parenting while in treatment. Other supports, such as housing for the entire family, family-strengthening programs, and employment services, can also empower women as caregivers and give them skills and tools that will contribute to the overall health and well-being of their families.
- *Implement workforce and other strategies that increase access to SUD care in rural areas.* To ensure access to care for pregnant and parenting women, states are exploring ways to strengthen the provider workforce in rural communities by implementing changes to provider licensing, leveraging peer support specialists, and expanding access through telehealth. They are also incorporating transportation benefits into their SUD programming by providing shuttle services or covering the costs of public transportation or ride-sharing services.
- *Educate providers and patients to reduce stigma associated with pregnant and parenting women accessing SUD treatment.* The stigma associated with SUD during pregnancy can serve as a significant barrier to providing care for a woman and her infant. Pregnant and parenting women may be reluctant to seek SUD treatment or seek prenatal and postpartum care, which are linked with improved maternal and infant health outcomes,[98] due to the fear of criminal justice or child welfare involvement. The stigma among the provider community can lead to discrimination and further discourage women from receiving care. There is also a persistent stigma against MAT for pregnant women despite evidence that MAT improves maternal and infant outcomes.[99] Education and training for providers and women with SUD are key to reducing these stigmas.
- *Coordinate and align health care and child welfare policies.* States recognize the importance and benefits of keeping families together for both children and their parents. Through cross-system collaboration, states can work to ensure that their policies are consistent in approaches to care and standards for treatment (e.g., aligning SUD treatment timelines with child welfare timelines), and promoting coordination between providers and child welfare professionals to improve outcomes for women and children.
- *Involve parenting women who are in long-term recovery in the design and implementation of SUD policies and programs.* Parenting women in long-term recovery can provide valuable insights into how to structure programs to effectively meet the needs of pregnant and parenting with SUD and engage women in treatment based on their lived experience. Additionally, states can train women in recovery as peer support specialists. In this capacity, women in recovery can help others with SUD navigate SUD services and community supports, as well as help keep them engaged in treatment.

Conclusion

Pregnant and parenting women with SUD are a particularly vulnerable population due to their complex needs and the significant barriers that impede access to care and long-term recovery. The opioid epidemic has brought pregnant and parenting women with SUD to the forefront of state policymaking due to significant financial and long-lasting intergenerational costs. States are strengthening their SUD policies and programming to address the unique and comprehensive needs of pregnant and parenting women by:

- Improving care, access, and coverage:
- Supporting care delivery models that break down siloes between systems and provide care for the whole family; and
- Maximizing limited resources by using multiple funding streams and partnering across systems.

Colorado, Pennsylvania, and Texas demonstrate how states can leverage a variety of policy options and strategies to ensure this population receives holistic and coordinated care.

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Appendix: Selected Federal Funding Sources to Address Substance Use Disorders

The following table provides an overview of select federal funding sources available to states to support their opioid and substance use disorder (SUD) treatment and prevention efforts targeting pregnant and parenting women.

Agency	Title	Description	FY 2019 Funding	First Authorized
	New Funding Sources Targeting SUD			
Centers for Disease Control and Prevention (CDC)	Opioid Prescription Drug Overdose Prevention	Provides funds to all states for prescription drug overdose prevention activities, including improving data collection and analysis, strengthening interventions that improve prescribing practices, and expanding prescription drug monitoring programs. The appropriation also includes $10 million for an opioid awareness campaign.	$475.6 million	Injury Prevention Act of 1986
Health Resources and Services Administration (HRSA)	Rural Communities Opioids Response Program	Supports the treatment and prevention of SUD in high-risk, rural communities. In FY 2018, it offered planning grants to consortiums of public and/or private entities in rural counties at high risk of SUD, hepatitis C, and HIV.	$120 million	Consolidated Appropriations Act of 2018
	Health Center SUD-MH Supplemental Funding	Provides supplemental awards to health centers to improve and expand access to mental health and SUD prevention and treatment services. In FY 2018, funding was available to all community health centers (CHCs) based on a formula, which included a base amount and additional funds for CHC patients currently receiving medication assisted treatment (MAT). CHCs could also receive one-time funding for infrastructure investments.	$200 million	Special Health Revenue Sharing Act of 1975
Substance Abuse and Mental Health Services Administration (SAMHSA)	Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction Program	Confers grants to states, local governments, nonprofits, and tribes to increase access to MAT in states hardest hit by the opioid epidemic. $10 million is set aside for tribes and tribal organizations.	$89 million	Children's Health Act of 2000
	Treatment for Pregnant and Postpartum Women (continued)	Provides grants to support treatment for pregnant and parenting women with SUD. Two grant programs are available under this line item: • The Services Grant Program for Residential Treatment for Pregnant and Postpartum Women is available to public and private nonprofit entities to expand access to residential treatment for low-income pregnant and postpartum women (within 12 months postpartum) and their children.	$29.9 million	Alcohol, Drug Abuse and Mental Health Services

Agency	Title	Description	FY 2019 Funding	First Authorized
	New Funding Sources Targeting SUD			
Substance Abuse and Mental Health Services Administration (SAMHSA)	Treatment for Pregnant and Postpartum Women	This is a longstanding grant program that was first authorized in the Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act of 1992. • The State Pilot Grant Program for Treatment for Pregnant and Postpartum Women is available to single state agencies to support a family-centered continuum of care for pregnant and postpartum women with SUD, including opioid use disorder (OUD). In grants made in FY 2017, at least 75% of funds had to be used for services, and no more than 15% of the funds could be used for residential treatment. This new pilot program was first authorized in the Comprehensive Addiction and Recovery Act of 2016.		Administration Reorganization Act of 1992/Comprehensive Addiction and Recovery Act of 2016
	State Opioid Response Grants	These grants are available to states, territories, and tribes to increase access to OUD treatment, prevention, and recovery support services, with $50 million designated for tribes and 15% for states with the highest age-adjusted OUD mortality.	$1.5 billion	Consolidated Appropriations Act of 2018
	Existing Funding Sources Addressing SUD			
Centers for Medicare & Medicaid Services (CMS)	Medicaid and Medicare	Reimburses for SUD treatment services for Medicaid and Medicare enrollees. This is the largest federal investment in SUD treatment.	$5.8 billion in FY 2018	Social Security Amendments of 1965
Department of Justice (DOJ)	Adult Drug Courts	Provides grants to state, local, and tribal governments to develop or enhance drug court programs. Drug courts divert some people with SUD accused of crimes from the traditional criminal justice system into a court setting managed by a multidisciplinary team that includes drug treatment.	Not yet final ($75 million in FY 2018)	Violent Crime Control and Law Enforcement Act of 1994
	Residential Substance Abuse Treatment for State Prisoners	Assists states in developing and implementing SUD treatment programs for people who are incarcerated or have reentered the community from incarceration. Funding is distributed using a formula, which includes a base amount and takes into account the number of incarcerated individuals in a state.	Not yet final ($30 million in FY 2018)	Violent Crime Control and Law Enforcement Act of 1994
HRSA	Title V Maternal and Child Health Block Grant	These state block grants support maternal and child health. States have significant flexibility in how to use the funds. Most funding is distributed through a formula based on the number of low-income children in a state. States must match $3 for every $4 of federal funding provided.	$677.7 million	Social Security Act of 1935

Agency	Title	Description	FY 2019 Funding	First Authorized
	New Funding Sources Targeting SUD			
HRSA and Administration for Children and Families (ACF)	**Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)**	Provides funds to states and tribes to develop and implement evidence-based home visiting programs that provide professional support to at-risk parents throughout pregnancy and early childhood by providing services in the home. Most MIECHV funds are distributed to states through a formula or a competitive cooperative agreement program. In three states, funding goes to nonprofit organizations instead of state government agencies.	$400 million	Patient Protection and Affordable Care Act of 2010
Indian Health Service (IHS)	**Alcohol and Substance Abuse Programs**	Funds IHS alcohol and substance abuse treatment programs, including comprehensive care in IHS facilities.	Not yet final ($227.8 million in FY 2018)	Snyder Act of 1921
SAMHSA	**Substance Abuse Prevention and Treatment Block Grant**	Flexible funding is available to all states to implement and evaluate substance abuse prevention and treatment activities. Funding is distributed based on a formula calculated on measures of the population at risk, the cost of services, and the state's fiscal capacity.	$1.85 billion	Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act of 1992
	Screening, Brief Intervention, and Referral to Treatment	Provides grants to implement screening, brief intervention, and referral to treatment (SBIRT) services for substance misuse and SUD. In FY 2018, grants were directed to states, tribes, or public or private health care systems for patients in primary care and community health settings.	$30 million	Children's Health Act of 2000
	Treatment Drug Courts	Grants to promote drug courts, which provide treatment for people with SUD and divert them from the traditional criminal justice system. In FY 2018, it provided grants for state, local, and tribal governments to expand SUD treatment services, including recovery support, screening, and case management in existing drug courts.	$70 million	Children's Health Act of 2000