Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers

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Last updated 2024-04-10.

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Please be advised that the paper was updated on April 10, 2024 to incorporate a revised analysis of state child abuse statutes and mandatory reporting policies issued in February 2024.

Full report available at https://end-overdose-epidemic.org/Improving-access-to-care-for-pregnant-and-postpartum-people-with-OUD.

Introduction

Over the past several years, the American Medical Association (AMA) and Manatt Health have partnered on recommendations that inform policymakers of best practices to eliminate barriers to care for opioid use disorder (OUD) through a national policy road map in December 2020; a comprehensive state toolkit in January 2022 expanding on the roadmap recommendations; and a compilation of profiles in December 2022 featuring leading physicians, policymakers and advocates who have implemented many of the recommendations. In light of the sharp increase in pregnancy and postpartum deaths linked to OUD,[1] the AMA and Manatt have developed a set of recommendations for state policymakers to improve access to care for pregnant and postpartum people with OUD with several strategies focused on improving care for justice-involved pregnant and postpartum individuals.

> "Improving care for pregnant people with substance use disorders must start with compassion and be based on the full slate of evidence-based medical care that reduces complications and supports long-term health for the newborn, mother and family. The AMA urges medical societies, state agencies and policymakers to carefully review and implement the recommendations and policies contained in this report because they are tangible examples of what leaders are doing today to improve maternal health and enhance outcomes."
>
> American Medical Association President
> Jesse M. Ehrenfeld, MD, MPH

The recommendations were informed by relevant research findings, interviews with physician experts, and an analysis of federal, state and local policies, and include examples where applicable. While this resource showcases numerous state and community-based best practices, we recognize that not all effective approaches in use throughout the country have been featured.

The AMA is grateful to the many physicians, policymakers and advocates who work to enhance access to care for pregnant and postpartum people with OUD.

Background

In recent years, opioid-related overdoses have become a leading cause of death associated with pregnancy and the postpartum period, with mortality rates rising more than 80% between 2017 and 2020.[2,3,4] This increase exacerbates a mounting maternal mortality and morbidity crisis and underscores the critical need to improve access to care for pregnant and postpartum people with OUD.[5] Left untreated, OUD during pregnancy can have severe medical and social consequences. It can destabilize a pregnancy and contribute to adverse outcomes such as low birth weight, preterm labor, and fetal distress and demise.[6] It can also increase the likelihood of newborns being separated from their families at birth, raising the risk of trauma to the mother and harms to the newborn.[7]

Fortunately, there are effective treatments for pregnant people with OUD. In particular, access to medications for OUD (MOUD)—including buprenorphine and methadone—has been demonstrated

to help improve the health outcomes of both pregnant people and their babies. For this reason, the US Centers for Disease Control and Prevention describes buprenorphine and methadone as "first-line therapy options for pregnant people with OUD."[8] Likewise, multiple clinical guidelines establish MOUD as the standard of care for pregnant people with OUD, and Department of Justice (DOJ) guidance extends federal protections to people who take MOUD.[9,10,11] As the American College of Obstetricians and Gynecologists (ACOG) notes, MOUD as the standard of care has better outcomes than medically managed withdrawal, which is associated with high relapse rates and worse outcomes.[12]

Despite the clear benefit of MOUD, pregnant people continue to face significant barriers to accessing it; only 50–60% of pregnant people in the United States receive MOUD.[13,14] Racial, ethnic and geographic disparities heighten access challenges, reducing treatment rates even further for certain populations.[15,16] Stigma related to perinatal OUD is pervasive and discourages many people from seeking any prenatal care. While all people with OUD face stigma, pregnant and postpartum people bear an even greater burden—they are assumed to be unfit parents, and their OUD is often treated as a basis for automatic removal of their child.[17] They may even face criminal charges for using medication to treat their OUD even though MOUD is strongly recommended under clinical guidelines.

Another challenge faced by physicians and pregnant people is the uncertainty about what federal and state laws may require. On one hand, federal law requires health care providers to *notify* the state if they are involved in the treatment or delivery of a substance-affected infant. Federal law, however, does not require automatic *reporting* to child welfare agencies, since an infant may be substance-affected for a variety of reasons, including that their parent is receiving MOUD.[18,19] While some states have adopted policies generally supporting treatment, more than 20 states and the District of Columbia have adopted punitive policies in excess of federal law, requiring providers to report the pregnant or postpartum person for alleged child abuse even if the person is receiving MOUD under a physician's supervision. For example, both Ohio's and Missouri's definitions of child abuse include newborns with any controlled substance in their system at birth, with no exceptions for MOUD.[20] Illinois law defines prenatal substance use as a *de jure* "neglected child" and requires reporting ultimately to the state attorney general.[21] These reports can result in family separation and—in some cases—arrest, criminal charges and incarceration. Media and other accounts highlight that these policies delay prenatal care, disrupt parent-child bonding, and exacerbate child mental health and educational challenges.[22,23]

Incarcerated pregnant and parenting people have even worse access to care, as many jails and prison systems do not—or will not—provide MOUD. A 2022 survey of jails across the country found that MOUD was available during pregnancy at only 60% of jails. Among the systems that did provide MOUD, a majority (near 55%) discontinued treatment following delivery through practices ranging from "abrupt cessation" in the hours after a person delivers their baby to tapering of medication.[24]

On the following pages, the AMA offers several recommendations to advance policies in support of evidence-based care for pregnant people with OUD to improve outcomes for the pregnant individual, newborn and family.

Recommendation 1

State policies should make clear that MOUD is the standard of care for OUD in pregnancy and should be available for all pregnant people throughout the prenatal, peripartum and postpartum periods.

> Guilt, shame and intersectional discriminations occur around drug use in pregnancy.[29]
>
> Mishka Terplan, MD

As detailed in the brief's background, pregnant people with OUD as well as the fetus, face adverse outcomes including preterm labor when OUD goes untreated.[25] The provision of MOUD significantly decreases these risks, leading to better outcomes for the pregnant person and newborn. Aligning with the standard of care for all individuals with OUD, every effort should be made to ensure that MOUD and supportive services such as counseling are easily available to pregnant and postpartum people.[26] Despite well-established evidence in support of MOUD during pregnancy and the postpartum period, several barriers limit access to care for pregnant and postpartum people. They face social, structural and economic barriers to accessing MOUD, in addition to stigma, the threat of criminalization and child welfare intervention even when they are receiving clinically appropriate treatment.[27,28] State policymakers can establish policies that expand access to MOUD and empower physician-led health care teams to offer MOUD during the perinatal, prepartum and postpartum periods.

Policy mechanisms to improve access to MOUD for pregnant and postpartum people

1. **Maximize the reach of Medicaid to expand access and coverage of MOUD.** Medicaid—the largest source of coverage and funding for OUD—acts as a linchpin for providing access to MOUD, covering nearly 40% of individuals with OUD nationwide.[30] The SUPPORT Act requires state Medicaid programs to cover all U.S. Food and Drug Administration (FDA)-approved forms of MOUD in addition to counseling and behavioral therapy through September 2025.[31,32] To better leverage Medicaid and establish a comprehensive system of care, states can:
   a. **Extend Medicaid and Children's Health Insurance Program (CHIP) coverage to pregnant people.** All states must provide Medicaid coverage to pregnant people who meet immigration standards and have household incomes at or below 133% of the federal poverty level (FPL).[33] While nearly all states extend coverage to pregnant people with incomes exceeding 138% of the FPL, Idaho, Louisiana and South Dakota have not yet done so.[34] Additional states can join the 20 states that elect to cover pregnant people regardless of their immigration status through CHIP's "unborn child option."[35,36]
   b. **Extend postpartum Medicaid coverage to 12 months.** Given the increased risk of overdose during the postpartum period, it is critical that states consider extending postpartum Medicaid coverage to better connect high-risk people to MOUD.[37] While states are required to extend coverage to 60 days postpartum, the American Rescue Plan Act and the Consolidated Appropriations Act of 2023 established and made permanent a pathway for states to extend pregnancy-related Medicaid coverage beyond the federal minimum of 60 days to 12 months

postpartum.[38,39] Forty-one states and the District of Columbia have implemented the 12-month coverage extension, and an additional six states have announced plans to do so.[40]

c. **Leverage Medicaid to support MOUD integration in obstetric and gynecological settings.** In recent years, states and policymakers have used Medicaid funding to integrate MOUD and substance use care in obstetric and gynecologic settings. In particular, states are participating in the Center for Medicare and Medicaid Innovation's (CMMI) Maternal Opioid Misuse (MOM) model to integrate MOUD and substance use care in obstetric and gynecologic settings. The MOM model aims to improve the integration of maternity care with behavioral health and OUD treatment. Participants receive ongoing support through 12 months postpartum and are connected with a case manager to facilitate access to care. Maryland has implemented the MOM model to expand coverage to pregnant and postpartum people with OUD through its Health Choice 1115 Demonstration.[41] To date, the MOM model is being tested in seven additional states: Colorado, Indiana, Maine, New Hampshire, Texas, Tennessee and West Virginia.[42]

   Colorado's Special Connections initiative also encourages providers to integrate and co-locate services, embedding MOUD and counseling services within other care settings (e.g., primary care practices, Federally Qualified Health Centers and pediatric practices) to expand care and address stigma. The program also deploys an extensive community outreach effort that encourages pregnant and postpartum people to seek care and affirms their self-worth.[43,44]

2. **Use federal grants and other funding sources to fill gaps in access.** States can also leverage alternative sources of funding, including Substance Abuse and Mental Health Services Administration (SAMHSA) grants and opioid settlement funds, to design and implement programs that improve access to MOUD for pregnant and postpartum people. SAMHSA provided West Virginia with a grant in 2021 to expand its Drug Free Mom and Babies Project. This program provides integrated and comprehensive substance use disorder (SUD) services, including MOUD, through collaboration with community partners. Recovery coaches conduct long-term follow-ups for two years after delivery and home visits as needed.[45]

3. **Increase education and training opportunities to address misconceptions about MOUD use in pregnancy.** States can encourage maternal and neonatal care providers to complete training courses on the treatment of OUD in pregnancy and birth, empowering physicians and other health care professionals to better identify, treat and support pregnant people with OUD. As part of this training, states can connect providers to evidence-based educational tools and trauma-informed training courses to address stigma, increase empathy and foster trust among people with OUD. For example, a Massachusetts program provided funding for hospital systems to offer trauma-informed care and addiction medicine trainings to maternal care providers. The health systems that participated in the program reported that it improved knowledge and skills among participants, as well as their attitudes toward treating pregnant people with OUD.[46,47]

   States can also cultivate knowledge sharing among providers. For example, the Washington State Opioid Response plan aims to improve systems of care for pregnant and parenting people through provider education initiatives.[48] As in Pennsylvania and Vermont, state practice guidelines and resources can also underscore the safety and efficacy of MOUD throughout the pregnancy and postpartum periods.[49,50]

Recommendation 2

State policies should ensure that pregnant and postpartum people with OUD are not punished for receiving MOUD and, instead, should be supported with family care plans.

Given that MOUD improves outcomes for pregnant, postpartum and parenting people with OUD, it is vital that they be offered MOUD and educated about the benefits to them and their family. Currently, however, pregnant individuals who receive MOUD face a significant risk that they will be reported to child protective services (CPS) and face potential removal of their baby (and other children). Heightening this risk, they could potentially receive care from uninformed and inexperienced health care professionals during the pre- or perinatal period, increasing the risk that they are inappropriately reported for receiving MOUD. Research shows that a majority (over 80%) of health care professionals are not familiar with the Child Abuse Prevention and Treatment Act (CAPTA),[51] the federal law that governs notification and reporting of substance-exposed newborns. While providers must notify the state when a newborn has been exposed to substances, they are not required to file a report of suspected child abuse or neglect unless stipulated by state law. This lack of awareness can lead to inappropriate referrals to child welfare agencies for alleged abuse and neglect when an individual is stable and receiving clinically recommended MOUD. It also perpetuates the stigma that accompanies pregnant and postpartum people with OUD and discourages others with SUD from receiving prenatal care.

Notification vs. Reporting

Notification: Health care providers are generally required to notify CPS of the birth of an infant affected by substance use. Notification requirements do not, however, require the health care provider to report child abuse or neglect to CPS and do not need to be processed by the same system as child abuse and neglect reports.

Reporting: Reporting the birth of an infant affected by substance use as suspected child abuse or neglect to CPS typically triggers an investigation of a named person or family by CPS. In some situations, this can lead to the provision of necessary services, but it also can lead to harmful consequences including heightened fear and trauma, treatment discontinuation and family separation, even in circumstances where there is no evidence of child mistreatment or risk to the infant.

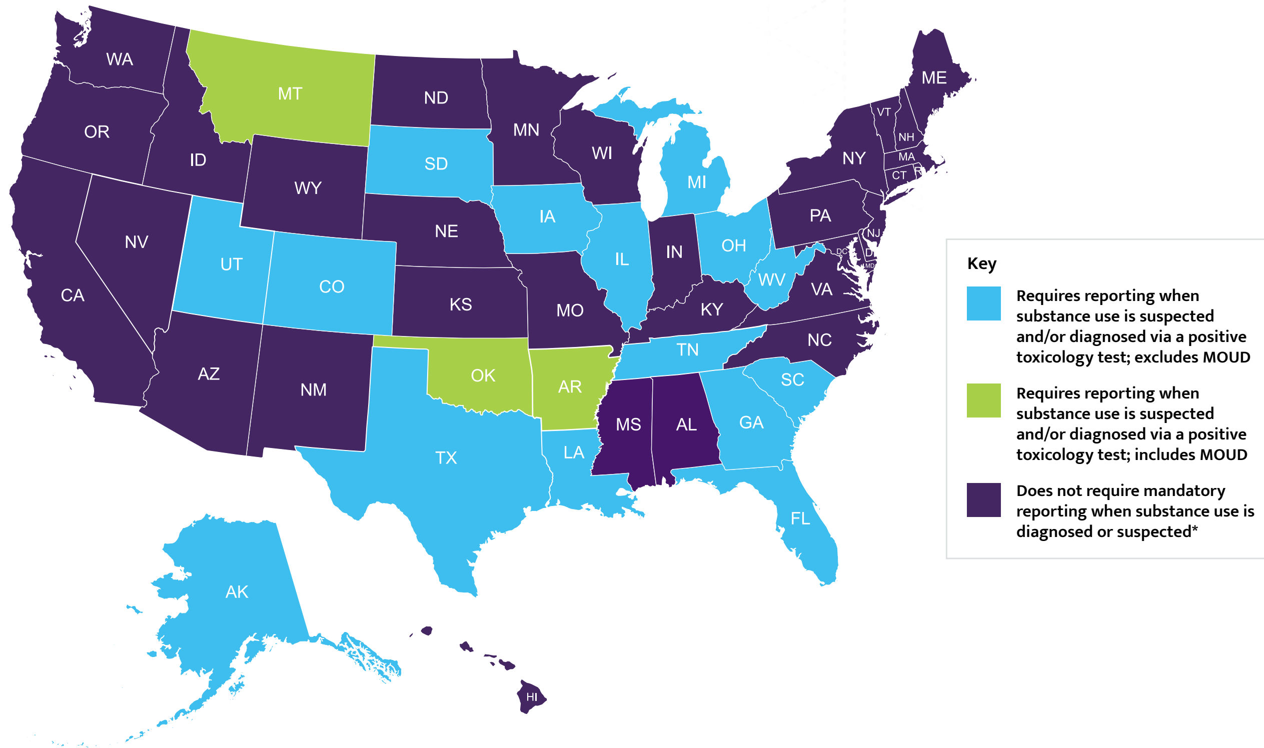
Federal and state notification and reporting obligations

Federal law generally requires health care providers to notify CPS and establish a plan of safe care (POSC) when a newborn is affected by illegal or legal substances, including MOUD.[52,53,54,55] This means that even pregnant individuals adhering to recommended medical treatment are subject to the notification requirement, although the notification does not need to include patient-identifying information. Many states have adopted additional requirements, however, that exceed these federal standards.[56] Nearly one-half of states consider substance use during pregnancy to be child abuse under civil child-welfare statutes and five states require health care providers to report

a positive toxicology test to CPS as child abuse even when it may be due to receiving MOUD.[57,58] However, the vast majority of states do not require health care providers to test pregnant or birthing people for substance use.[59]

Figure 1. State Notification and Reporting Policies on Substance Use During Pregnancy

Source: Based on an analysis of Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals by If When How. Last updated February 2024.



*While several states do not require mandatory reporting for suspected or diagnosed substance use during pregnancy, they may require mandatory reporting if the exposure occurs in combination with other actions that could endanger the fetus or infant.

The practical applications of these state requirements can have grave consequences for pregnant and postpartum individuals and their families. A *New York Times* investigative report found that since 2016, nearly 4,000 women were reported for receipt of MOUD alone during pregnancy in a sample of eight states and the District of Columbia.[60] Pregnant and parenting people reported to CPS for MOUD can end up losing custody of their child with little hope of short-term reunification. States can work to mitigate the impact of such policies through a variety of means, including by exempting MOUD from reporting requirements and supporting the development and implementation of family care plans.

> “It's like a sick game. They don't want you on illicit street drugs, so here, we're going to give you this medicine. But then if you take this medicine, we are going to punish you for it and ruin your family.[61]”
>
> **Caitlyn Carnahan, a mother in Oklahoma whose baby was taken for eight months in 2019**

> **A plan of safe care, or family care plan**, is a component of CAPTA that requires multidisciplinary care teams (e.g., physicians and other health care professionals, public health agencies, social workers, peer recovery specialists, home visitors) to develop, implement and monitor care plans that address and support the health and well-being of individuals and family members affected by substance use during pregnancy.

States can leverage family care plans to prevent unnecessary family separations, provide health and social services, and improve access to care for pregnant and postpartum individuals and their infants. Ideally, a family care plan is individualized to prioritize and address the needs of the parent-infant dyad; minimizes the involvement of child welfare agencies in cases where no neglect or abuse claims are suspected or substantiated; and coordinates family-focused treatment and social service provision.[62] The AMA and several other leading medical societies drafted state model legislation to help "increase access to evidence-based, non-judgmental or punitive maternal treatment." The proposal, "An Act to Create and Implement Family Care Plans for Infants, Children and Families," emphasizes the importance of establishing and defining "plans of family care" to establish "supportive care and fulfillment of needs for pregnant, postpartum and parenting individuals, newborns, children and families." The Legislative Analysis and Public Policy Association also has developed model legislation for states to use.[63]

State policies to enable pregnant and postpartum individuals to seek nonpunitive treatment and address the needs of families through family care plans

4. **Ensure state laws clearly distinguish between a "notification" and a "report" when there is a substance-exposed newborn or a pregnant or postpartum individual receiving MOUD.** Even if states may not be able to remove MOUD from notification requirements, they can distinguish and identify pathways that separate "notification" from child abuse reporting. Fourteen states have enacted statutes and policies that specifically do not require a report of potential child abuse and neglect based solely on an infant being exposed to a substance, but instead allow for notification when there is no evidence of maltreatment or risk of harm to the infant.[64,65] For example, New Mexico has a statute that distinguishes reports of infant exposure to substance use from a child abuse report that results in an investigation or a report to law enforcement.[66]

   Other states have taken a narrower approach, with legislation that specifically exempts prescription medications and medications taken under medical supervision from mandatory child abuse reporting policies.

   - Connecticut specifically defines "drug abuse" as the ingestion of controlled substances *without a prescription or other authorization*.[67]
   - Florida defines "neglect" as exposure to a controlled substance that is not the result of medical treatment administered to the mother or newborn.[68]
   - Indiana exempts exposure to controlled substances that are associated with valid prescriptions if the mother has made a good faith attempt to use the controlled substance according to prescription instructions.[69]

- Michigan exempts providers from mandatory reporting if the controlled substance or metabolite is the result of medical treatment administered to the newborn infant or the birthing person.[70]
- Connecticut and Rhode Island share aggregate and deidentified data on infants exposed to MOUD with federal epidemiological trackers and explicitly exclude perinatal MOUD from mandated child welfare reporting.[71]

5. **Establish separate and distinct pathways for notification and reporting.** Most states use the same pathways (e.g., child abuse hotline) for notifications and child abuse and neglect reporting. The absence of distinct pathways for notification can lead to unnecessary reports of child abuse even when a state has sought to distinguish the need for notification versus a report of potential child abuse or neglect. Connecticut has implemented a de-identified hospital notification system when no other safety concerns are present and reports to CPS are not warranted. Physicians and other health care professionals caring for a substance-exposed infant are required to file an online notification that includes a guided risk assessment of where there is a distinct maltreatment concern.[72] This empowers the health care team to involve CPS in cases of maltreatment or neglect independent from substance use alone. Vermont also established separate pathways for notification and reporting. Providers file reports of suspected child abuse to the Department for Children and Families (DCF) via the child protection hotline. These reports include identifying information to facilitate a subsequent investigation by DCF. Conversely, notifications remain de-identified and are made via secure fax or email.[73]
6. **Support education and training opportunities for the perinatal workforce.** States can provide education and training to health care professionals that distinguishes between a legally mandated "notification" of newborn exposure to substances and allegations of child abuse and neglect. Trainings can address the common misunderstanding among providers and others that there is no downside to "playing it safe" and being overly inclusive about who they report. In fact, unnecessary reports where a newborn is not at risk still expose families to separation from their baby and an often lengthy, traumatic and burdensome process to recover them. States, health systems and hospitals are further encouraged to review their maternal and birth center protocols to ensure they follow these guidelines.[74]
7. **Publicize and encourage nonpunitive clinical screening and treatment.** States can share screening and treatment practice guidelines for maternal and neonatal providers that care for pregnant or postpartum people with OUD and their infants. ACOG encourages the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to screen a pregnant person for an SUD as part of comprehensive obstetric care.[75] Specifically, ACOG recommends that screening be conducted universally with a validated verbal screening tool (e.g., 5Ps, NIDA Quick Screen, and CRAFFT for patients under age 26). ACOG's recommendations also stress the importance of performing screening when the pregnant person is alone to protect patient autonomy and confidentiality, as well as to foster communication with the patient.[76] States' guidelines can also highlight that screening remains voluntary and subject to the patient providing informed consent for the screening itself.

8. **Develop family care plans using a public health approach.** While CPS plays a role to help identify and protect newborns and children from neglect and abuse, CPS also undertakes considerable investigational and enforcement activities that can be overwhelming and fear-inducing for families. Public health agencies, by definition, are designed to take a different approach and often are better positioned to help establish cross-system care teams to address the needs of pregnant individuals and their families, including physicians and other health care providers, child welfare staff, individuals with lived experience, and social service providers. States can support the teams through perinatal care collaboratives and by engaging leading physicians from multiple specialties, including pediatrics, addiction medicine, family medicine and obstetrics and gynecology.

   For example, Colorado Hospital Substance Exposed Newborn Collaborative (CHoSEN) brings together hospitals and state agencies within the state's Rocky Mountain region to improve how they identify and respond to infants exposed to substances in utero. CHoSEN uses a multidisciplinary team composed of maternal and newborn providers to improve hospital care for these infants and family members. Member hospitals work to decrease hospital stays for infants impacted by withdrawal, build relationships with child welfare agency staff and sit on state collaborative teams focused on POSCs.[77] Research on CHoSEN shows demonstrated benefits to improve outcomes.[78]

   Oklahoma has required its publicly funded SUD treatment providers to develop family care plans with pregnant and postpartum individuals with SUD since 2021. These family care plans typically capture and track the family's needs for up to a year after the child's birth. The early results from Oklahoma are promising; county-based pilots are showing reductions in pharmacological interventions for newborns born with substance use exposure, as well as more infants discharged and safely remaining at home with their parents.[79]

9. **Collect and publish data to evaluate and improve the efficacy of family care plans.** Collaborative state teams can regularly evaluate the efficacy of family care plans. Consistent analysis and monitoring enable states to identify opportunities to improve care coordination and address cultural and ethnic disparities. For example, Nebraska's Department for Children and Family Services has used data on family care plans to identify necessary staff supports, target assistance to medical providers, and update forms to improve data collection on race and ethnicity, allowing it to determine if disparities exist in CPS reporting for parents and infants.[80]

   New Mexico's Plan of Safe Care Bill (H.B.230)[81] enacted in 2019 requires hospitals and birthing centers to notify the Department of Health that a substance-exposed newborn was born, and that the family has been referred for a POSC (this notification is not treated as a report of child abuse or neglect). The bill empowers the department to collect detailed epidemiological and social needs data regarding substance exposed infants, including substance exposure classification and distribution, family engagement data, Children Youth and Family Department (CYFD) history, provider bias, and gaps in service. The department publishes this report annually and shares it with key stakeholders to serve as a fidelity check and to inform policy recommendations and improvements.[82] The most recent report highlighted that while 3,770 plans of safe care were developed from 2020-2022, there remain continued needs to improve early referrals to treatment and ongoing monitoring.

Recommendation 3

Improve data collection and state partnerships to help support equitable access to treatment for all pregnant and postpartum individuals with OUD and their families.

Historically marginalized pregnant and postpartum people with OUD face persistent racial and ethnic disparities in access to care and treatment outcomes. Pregnant people with OUD face significant barriers in accessing care—only 50–60% of pregnant women with OUD receive treatment with MOUD.[83] Among this already vulnerable group, historically marginalized pregnant and postpartum individuals are less likely to receive MOUD (buprenorphine or methadone), are more likely to discontinue treatment during pregnancy and have lower rates of engagement in treatment.[84,85] Factors impeding access to care include social determinants of health (e.g., transportation, employment, child care and other barriers), stigmatization by providers, and punitive policies that disproportionately impact historically marginalized pregnant and postpartum people with OUD.[86]

Disparities are also well-documented across the perinatal continuum, with pregnancy-related mortality and morbidity rates among Black, American Indian and Alaska Native people more than double those of white individuals.[87,88] States can pursue equitable MOUD and SUD treatment policies, improved data collection standards, quality improvement programs, and culturally responsive provider trainings and incentives to help avert the increased rates of maternal morbidity and mortality during the pregnant and postpartum periods for individuals with OUD.

State policies to support equitable access to treatment

1. **Enact state legislation that requires access to evidence-based SUD care.** State legislatures can expand access to evidence-based care for pregnant and parenting individuals with an SUD by requiring state agencies to take specific action. For example, Connecticut recently required its departments of Mental Health and Addiction Services, Social Services, and Children and Families to work together to expand access and coordinate care for pregnant and parenting individuals with an SUD.[89] The state of Washington enacted a law that requires the state Department of Children, Youth, and Families and the Health Care Authority to take additional steps to expand access to "comprehensive prenatal exposure treatment" as well as develop ways to increase access to "diagnoses, treatment, services and supports" for pregnant individuals with an SUD.[90]
2. **Strengthen data infrastructure, collection and processes to better capture OUD and overdose rates, as well as treatment access and outcomes by race and ethnicity.** States can use data to develop a strategy to address health equity among pregnant and parenting people with OUD. Data analysis can help states understand the extent to which racial and ethnic disparities in access to MOUD and SUD treatment exist—as well as how to identify gaps in infrastructure and data collection.[91] For example, as part of a collaborative research study with Massachusetts General Health to understand racial disparities, Massachusetts' Department of

Public Health linked multiple state data sets to obtain a comprehensive analysis of racial and ethnic disparities in access to MOUD among pregnant women, including vital records, the all-payer claims database, state-funded addiction treatment data from the Bureau of Substance Addiction Services, acute care hospital records, and data from the state's prescription monitoring program.[92] Additionally, the Massachusetts Hospital Quality and Equity Incentive Program links payment to improved demographic data collection. It pays participating hospitals an incentive payment for meeting data collection requirements and achieving quality and equity improvement standards.[93]

3. **Build on statewide efforts to help identify opportunities to increase access and treatment outcomes for all pregnant and postpartum people with OUD.** States can work to identify and address disparities in access within their Medicaid programs. Tennessee, for example, uses multiple data sets to identify and conduct outreach to women of childbearing age about available resources and how to secure a variety of services, including primary care and treatment options for SUDs, such as MOUD when applicable.[94] Michigan showcases another instance of a state joining multiple programs to train and support primary care providers on how to recognize and treat SUDs, as well as providing behavioral health support to primary care providers.[95]

Recommendation 4

Correctional facilities and judicially-supervised diversion programs should provide all justice-involved people, including pregnant and postpartum individuals, with access to FDA-approved MOUD and universal screening for SUD.

Rates of SUD and OUD among incarcerated individuals are disproportionately high; the DOJ estimates that more than half of those incarcerated in state prisons and jails meet the criteria for an SUD, compared to one in 20 people in the general population.[96] Despite DOJ guidance that denial of MOUD in jails and prisons violates the Americans with Disabilities Act, and federal court decisions protecting the right to receive MOUD in carceral settings, jails and prisons still provide far less access to MOUD than do community providers.[97,98] It is contrary to all medical evidence to force individuals to undergo discontinuation or abrupt cessation of MOUD, leading to withdrawal, which is associated with painful physical and mental symptoms.

Access to MOUD for pregnant and postpartum people with OUD in U.S. jails[99,100]

OUD statistics

- Over a quarter of pregnant people admitted to prison, and 14% admitted to jail, had OUD

During pregnancy

- 60% of jails provide MOUD for pregnant people
- 52% of jails made both methadone and buprenorphine available for pregnant people

During postpartum

- 54% of jails did not continue MOUD
- 22% of jails that discontinued MOUD mandated abrupt discontinuation
- 60% of jails that discontinued MOUD called for discontinuation through tapering

Consistent with the DOJ guidance, the National Commission on Correctional Health Care recommends that carceral facilities establish MOUD programs that provide universal OUD screening, treatment with MOUD, and treatment continuity upon entry through release.[101] However, many jails and prisons cite structural and systemic barriers that limit MOUD program implementation, including regulatory constraints (i.e., methadone dispensing limitations[102]), reimbursement concerns, physical space restrictions, staff time limitations and security challenges.[103] While a growing number of correctional facilities are taking efforts to meet the standard of care for OUD, disparities in care still exist.

> “Withdrawal feels like the worst flu of your life, coupled with really bad insomnia … and on top of that you just had a baby.”
>
> Cara Poland, MD

State and local policymakers can promote access to MOUD for all incarcerated individuals, including pregnant and postpartum people, by enacting and implementing policies to support facilities’ efforts to implement MOUD programs.

State and local policies to ensure access to care for individuals in carceral settings

1. **Implement universal screening programs for SUD and pregnancy upon entry to all carceral settings.** While only 64% of people admitted to jails were screened for OUD,[104] the number of correctional facilities conducting universal screening is growing. As part of the District of Columbia's Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths, the district has implemented a universal screening strategy that has made screening available 24/7 at all correctional facilities.[105]

   The Franklin County House of Corrections in Massachusetts screens women under the age of 55 for pregnancy and SUD upon entry, according to Ruth Potee, MD, who serves as the facility medical director. Dr. Potee noted that they immediately provide pregnant people with inductions to treatment, including split dosing methadone and buprenorphine.

> "We have worked really hard in Kent County, [Michigan,] to ensure that people are screened for SUD as they enter jail regardless of gender or pregnancy status and are offered medication for addiction treatment."
>
> Cara Poland, MD

2. **Provide access to all three forms of MOUD.** Many states and correctional facilities have prioritized access to MOUD. For example, in 2016, Rhode Island launched the nation's first comprehensive treatment program that provides all three forms of MOUD—methadone, buprenorphine, and naltrexone—to incarcerated people and connects them to treatment upon release.[106] Massachusetts also has established access to care for incarcerated populations across facilities. The U.S. Attorney's Office worked in partnership with law enforcement officials in the Commonwealth to ensure that all three forms of MOUD are available to incarcerated individuals, regardless of whether they are held in local, state or federal facilities.[107] Other states like Vermont (see case study below) have facilitated partnerships between jails, prisons and community-based MOUD providers.

State case study: Vermont's Hub and Spoke model provides access to all three forms of MOUD

As a first step, Vermont enacted legislation affirming MOUD as a medical necessity for incarcerated people with OUD and directing facilities to implement universal screening and provide access to treatment in 2018.[108] To comply with the legislation, Vermont leverages its existing Hub and Spoke model to provide incarcerated populations with access to all forms of MOUD. Within Vermont's model, jails and prisons are considered spokes, and each facility employs multidisciplinary care teams composed of physicians, nursing staff, behavioral health providers and care managers. The care team partners with existing hubs (e.g., opioid treatment programs) to provide treatment support, including methadone assessments and inductions, dose adjustments, and reentry support. This model of care enables Vermont to provide comprehensive access to all forms of MOUD, including methadone, without facilities establishing their own methadone distribution systems.

Recommendation 5

Prior to release from jail or prison, all incarcerated individuals, including pregnant people, should receive Medicaid coverage and access to prerelease services, including detailed reintegration planning, medical referrals and linkages to essential services including childcare, housing and employment.

Substance-related overdose is a leading cause of death for people recently released from prison and jail.[109] People with OUD are particularly at risk during the first two weeks post-release, when the rate of overdose-related death is 12.7 times greater than in the general population.[110] In addition to the health risks associated with reentry, leaving incarceration is also associated with limited resources, economic uncertainty and social instability.[111] Upon reentry, newly released individuals often have limited financial and social supports. Pregnant and postpartum people with OUD may face even greater risks during re-entry due to the complexities associated with pregnancy.

Prerelease services stabilize physical and behavioral health conditions, improve care transitions, and reduce overdose-related morbidity and mortality for people with OUD.[112] It is critical that policymakers prioritize access to care, detailed reintegration planning and supportive services for all individuals leaving incarceration, including pregnant and postpartum people.

> "When we made MOUD available in Rhode Island, we set up a comprehensive program. We made all three medications available. We educated people, we screened people, we established connection to treatment upon release. In that first year, we documented a 60% drop in overdose deaths in the first few weeks after being released from incarceration."
>
> **Josiah Rich, MD**

State and local strategies to prioritize access to care and prerelease services for justice-involved populations, including pregnant and postpartum people

1. **Obtain federal approval and require correctional facilities to provide Medicaid covered prerelease services.** The "inmate exclusion" has historically prevented states from providing Medicaid financed prerelease health care services to justice-involved individuals who are inmates and otherwise eligible for Medicaid.[114,115] The Biden administration created a pathway for states to utilize Section 1115 Medicaid demonstrations to provide Medicaid financed pre-release services in state or local correctional facilities to support reentry to the community.[116] States have broad flexibility in designing justice-involved reentry demonstrations for Medicaid-eligible individuals but, at a minimum, must provide the following services:

Medicaid inmate exclusion

Federal law has historically excluded Medicaid payment to cover the cost of care for incarcerated people with the exception of inpatient hospital care.[113]

- Prerelease case management services;
- MOUD; and
- A 30-day supply of all prescription medications at the point of release.[117]

Additionally, states may provide family planning services, rehabilitative or preventive services, screening for chronic conditions that are likely to impact the carceral population (i.e., hypertension, diabetes, hepatitis C or HIV), treatment for hepatitis C, and durable medical equipment.

As of December 2023, both California and Washington have secured approval from the Centers for Medicare & Medicaid Services (CMS) to provide reentry services to justice-involved populations and 15 other states have submitted reentry demonstration requests.[118,119,120]

FIGURE 2. State Reentry Demonstration 1115 Waiver Requests as of January 2024

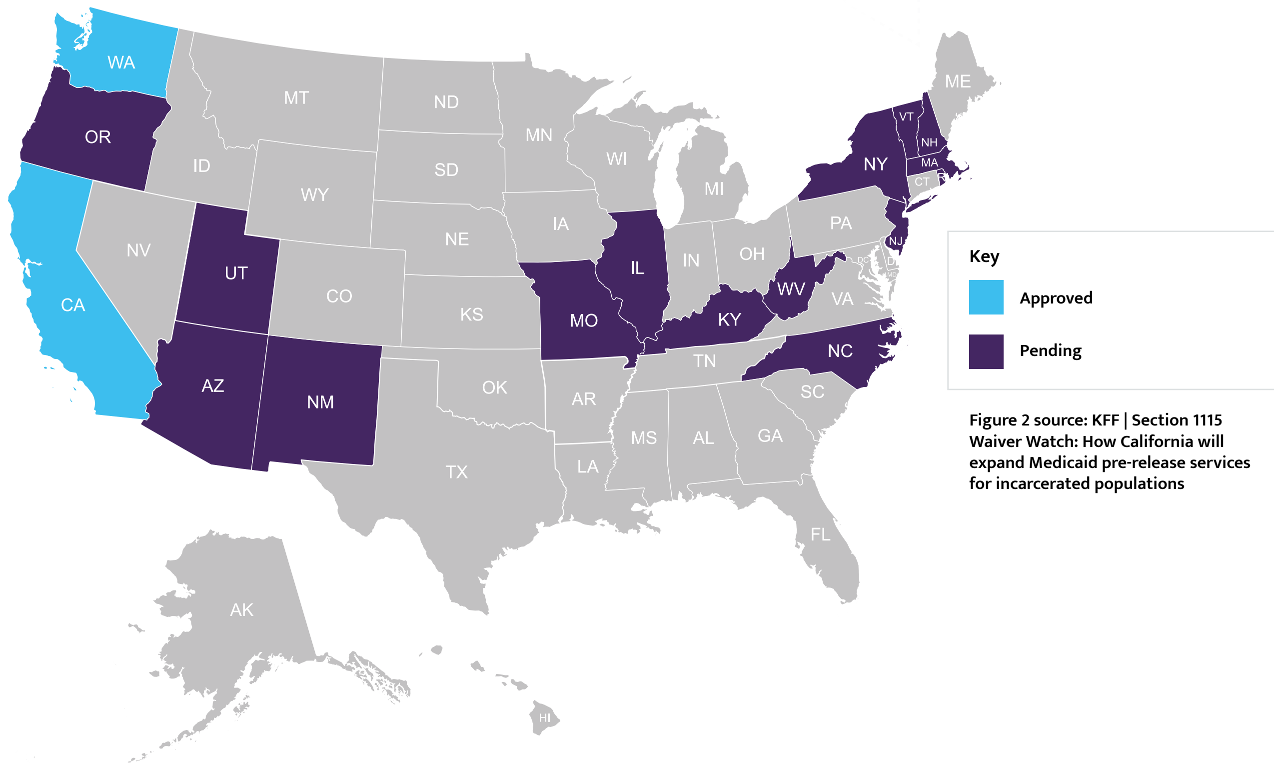


Figure 2 source: KFF | Section 1115 Waiver Watch: How California will expand Medicaid pre-release services for incarcerated populations

State case study: California advancing and innovating Medi-Cal (CalAIM) Section 1115 Demonstration[121]

In January 2023, California became the first state to secure a waiver to provide reentry services to justice-involved populations, allowing California to leverage Medicaid financing and provide targeted services to people in carceral settings.

Eligible facilities include:

- State prisons
- County jails
- County youth correctional facilities

Eligible populations include:

- Medicaid-eligible youth and adults in state prisons, county jails or youth correctional facilities
- Adults must meet one of the following health care criteria:
    - SUD
    - Pregnant or postpartum
    - Mental illness
    - Chronic conditions/significant nonchronic clinical condition
    - Intellectual or developmental disability
    - Traumatic brain injury
    - HIV/AIDs
- All youth in youth correctional facilities will be considered eligible without needing to meet the health criteria

Scope of covered services provided prerelease include:

- MOUD
- Pre- and post-release reentry care management with warm handoffs to community providers
- Physical and behavioral clinical consultation
- Lab and radiology services
- Community health worker services
- Medication and medication administration
- Medication and durable medical equipment to have in hand upon release

2. **Require correctional facilities to collaborate with multidisciplinary care teams to develop reentry programs tailored to meet the needs of pregnant and postpartum people and their families.** Some correctional facilities have begun to collaborate with providers and community-based organizations to develop comprehensive care plans for justice-involved populations. For example, the New Jersey Department of Corrections launched the Intensive Recovery Treatment Support (IRTS) Program in partnership with the Department of Mental Health and Addiction Services and Rutgers University Behavioral Health Care. The program employs support teams composed of case managers, nurses and peer navigators to provide supportive services to justice-involved individuals pre- and post-release. Participants are paired with peer navigators who have lived experience with incarceration and SUD and are at least five years post-release. The peer navigators begin to meet with participants six months prior to release and develop a reintegration plan in partnership with the incarcerated individual. Reintegration plans bridge the gap between incarceration and returning to the community and include access to MOUD, employment, housing and other reentry components. Peer navigators continue to provide support for one year post-release.[122]

   Some states and local governments have tailored their reentry programs to specifically meet the needs of pregnant and postpartum people. For example, Kent County, Michigan, has established a partnership between community-based care teams and care managers from the local jail. Both care managers collaborate to establish a reentry plan for the pregnant or postpartum individual, ensuring there are appropriate social supports in place prior to release. The community-based care manager continues to support the individual throughout the post-release period and is an integral part of the post-incarceration family engagement team, which encourages family-centered, strengths-based support throughout reentry to the community.[123]

   In California, the penal code established the Community Prisoner Mother Program (CPMP), which prioritizes reentry programming and reuniting incarcerated pregnant and parenting individuals to encourage parent-child bonding.[124] CPMP maintains a 24-bed facility that accommodates up to 24 participants and 40 children. The program aims to reintegrate soon-to-be-released individuals and their families into the community by developing individual treatment and reentry plans for the pregnant or parenting person. CPMP also provides families with SUD treatment, behavioral health services, prerelease planning, and targeted skills sessions to address employment, education and parenting needs.[125]

Conclusion

The escalating rise of opioid-related overdose morbidity and mortality among pregnant and postpartum people with OUD demands that state policymakers act urgently to improve access to care in both community and carceral settings. While some states have started to take a nonpunitive, public health approach to improve access to care, opportunities for improvement exist. Policymakers can use a variety of legislative and non-legislative approaches to eliminate barriers to care for pregnant and postpartum people with SUD regardless of their carceral status. The effectiveness of these measures rests on collaboration between policymakers, health care professionals, law enforcement, CPS agencies, advocates, and pregnant and postpartum people to expand access to evidence-based care, and enhance opportunities and outcomes for pregnant and postpartum individuals, newborns and families.

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117 CMS defines MAT as medication in combination with counseling/behavioral therapies, as appropriate and individually determined, and should be available for all types of SUD (e.g., both opioid and alcohol use disorders), as clinically appropriate. Coverage of MAT under a state plan includes all FDA-approved medications for opioid disorder, including buprenorphine, methadone and naltrexone, and acamprosate and naltrexone for alcohol use disorder.

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