January 2022

ASPE ISSUE BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

INTEGRATING OB/GYN AND SUD CARE POLICY CHALLENGES AND OPPORTUNITIES

Background

Over the past two decades, the United States has experienced a public health crisis related to substance use disorders (SUDs). This crisis is especially pronounced with regard to opioid use disorders (OUDs), to which women are increasingly vulnerable. Between 1999 and 2016, the rate of deaths from prescription opioid overdoses increased 507% among women, compared with an increase of 321% among men.[1] Also, between 1999 and 2014, the national prevalence of OUDs among pregnant women increased 333%.[2] This increase among women who are pregnant can have far-reaching impacts on quality of life and health care costs for mothers and their infants. Maternal SUDs can cause several birth-related complications that can increase hospital costs and length of stay.[3] However, expanded insurance coverage and increased interaction with health care professionals during pregnancy provide opportunities to link pregnant women experiencing SUDs to treatment services in order to reduce the impacts of SUDs on mother, child, and health care spending. This brief is based on findings from an environmental scan of peer-reviewed and grey literature and a technical expert panel meeting that RTI held on behalf of ASPE in July 2019 to discuss policies on integrating Obstetrics and Gynecology (OB/GYN) and SUD services.

Defining Integrated OB/GYN and SUD Care

Integrated OB/GYN and SUD services may be a viable option for providing access to SUD care for women of child-bearing age. Although models for integrated primary and behavioral health care in general are well known[4,5] and their effectiveness[6] is established, models for integrating OB/GYN and SUD care are less researched. This issue brief seeks to define integrated OB/GYN and SUD care, describe promising models, and describe barriers to and opportunities for expanding integrated care. Building upon existing definitions of integrated care,[7] we define integrated OB/GYN and SUD care as follows:

> *The clinical and non-clinical care that results from a practice team of OB/GYN and SUD clinicians, case managers, and care coordinators working together with woman, infant, and family, using a systematic and cost-effective approach to provide family-centered care. This care may address OB/GYN needs, substance use conditions, mental health conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, impact of traumatic experiences, ineffective patterns of health care utilization, and systematic barriers to seeking and utilizing physical and behavioral health care.*

Models of Integrated Care

Established and emerging models of care meeting the definition of integrated OB/GYN and SUD care include collaborative systems of care, patient-centered teams, evidence-based models, trauma-informed care, co-located corrections treatment, reverse co-located treatment, hub-and-spoke centers, and teleconsultation and telehealth models. These models of care can be categorized using the Center for Integrated Health Solutions' Standard Framework for Levels of Integrated Health Care.[7] This framework provides a classification of the levels of collaboration and integration to promote planning, financing, and stakeholder engagement efforts around integrated care. Select models and example programs are depicted in ***Exhibit 1***, which also shows the relationship between each model and the level of integration.

Implementation Challenges and Policy Options

Despite the existence of several models of integrated OB/GYN and SUD care, there are barriers to implementation.

Funding. Limited reimbursement and provider confusion about reimbursement can serve as barriers to implementing and expanding integrated care.[8] This includes lack of reimbursement within a standard maternity payment bundle for SUD-related services such as screening, counseling, or referral that an OB/GYN may provide, or providers' confusion around what they can and cannot bill. Providers report difficulties with simultaneous billing for physical health and mental health care for the same visit, double co-pays for patients, and lack of coverage for necessary non-clinical services such as childcare, transportation, and housing support.

Opportunity for policymakers:

- States can allow providers to use care coordination billing codes with flexibility for reimbursing non-clinical, essential services such as childcare, transportation, and provide gap funding for postpartum services.
- Policymakers can incentivize the adoption of innovative payment models that compensate OB/GYN providers and the primary care workforce for treating patients with SUD, such as pay for performance or prospective, population-based payments.[9]

Stigma. Unfortunately, pregnant and postpartum (or parenting) women (PPW) with SUD can experience both individual stigma (from providers) and structural stigma (from mandatory reporting). Some health care professionals may be hesitant to treat PPW with SUD due to lack of comfort or understanding of appropriate treatment modalities. This can limit access to integrated care. In addition, state laws mandating that health care providers report substance use during pregnancy may discourage some from treating this population. Fear of disclosure and child welfare involvement, as well as judicial system barriers, may also be a disincentive for pregnant women with SUD to seek health care.[10,11]

Opportunity for policymakers:

- Embedding SUD treatment within behavioral health care more broadly may reduce stigma associated specifically with SUD.
- Changes in state statutes on reporting and notification may incentivize women to seek treatment for SUD.[12]

Locus of treatment. Clinical experts have noted that the primary treatment provider (obstetrics vs. SUD treatment provider) may change depending upon the needs of the woman and where she is in her pregnancy. Experts have also noted that access to services can be largely dependent upon the geographic location of patients. Although integrated models provide optimal care, access to fully-integrated services may vary by geographic location (urban versus rural) or need for services.

Opportunity for policymakers:

- Tailoring models to serve the geographic area and the specific needs of the population could improve access to critical treatment. Telemedicine and hub-and-spoke models may serve to meet this need.

Pregnancy timeline. Experts emphasized that postpartum SUD treatment is critical. Women with OUD are least likely to overdose during pregnancy and most likely to overdose in the postpartum period--peak risk is around 7-12 months after delivery.[13] However, states are required to provide pregnancy-related Medicaid eligibility through 60 days postpartum, at which point women ineligible for Medicaid through another pathway may not be able to access SUD treatment services when coverage ends. It is important that women are connected to appropriate care throughout this critical postpartum period.

Opportunity for policymakers:

- The postpartum period for the year after birth is important for preventing overdose among women. Previously states have used the 1115 Waiver authority, Medicaid 1915(b) Waivers or state-only funds to extend postpartum coverage.[14] In 2021 the American Rescue Plan allowed states to extend postpartum coverage up to 12 months for 5 years in both Medicaid and CHIP plans. CMS has released guidance to states on expanding postpartum coverage through this option.[15] If passed, the pending Build Better Back Act will make the postpartum coverage in Medicaid and CHIP permanent and mandatory for all states.
- Policymakers can incentivize pediatric providers to provide screening and support services for postpartum women with or at risk for SUD to increase stability for women and their families.

Integrated OB/GYN and SUD models of care could provide more comprehensive treatment services for women, thereby serving as an important benefit for pregnant women and newborns. There are many opportunities to expand and refine existing and emerging models of integrated care to combat this significant public health concern. The pending Build Back Better Act, if passed, can further expand access to integrated care models for pregnant and postpartum women that incorporate mental health and substance use services for sustained recovery and reduced morbidity and mortality.

Endnotes

1. National Institute on Drug Abuse. (2019). Overdose death rates. Retrieved July 18, 2019, from https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

2. Haight SC, Ko JY, Tong VT, Bohm MK, & Callaghan WM. (2018). Opioid use disorder documented at delivery hospitalization--United States, 1999-2014. *Morbidity & Mortality Weekly Report*, 67(31), 845-849. doi.org/10.15585/mmwr.mm6731a1.

3. Patrick SW, Davis MM, Lehmann CU, & Cooper WO. (2015). Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. *Journal of Perinatology*, 35(8), 650-655. doi:10.1038/jp.2015.63.

4. Cohen D, Davis M, Hal J, et al. (2015). A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration Observations from Exemplary Sites. Agency for Healthcare Research and Quality. Retrieved June 24, 2021, from https://integrationacademy.ahrq.gov/sites/default/files/2020-06/AHRQ_AcademyGuidebook.pdf.

5. Gerrity M. Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. *Milbank Memorial Fund*. Retrieved June 24, 2021, from https://www.milbank.org/wp-content/uploads/2016/04/Integrating-Primary-Care-Report.pdf.

6. Gold S, Green L, Peek CJ, et al. (2017). From Our Practices to Yours: Key Messages for the Journey to Integrated Behavioral Health. *Journal of the American Board of Family Medicine*, 30(1), 25-34.

7. Heath B, Wise Romero P, & Reynolds K. (2013). A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions. Retrieved June 24, 2021, from https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56.

8. For more information see ASPE report "Integrating SUD and OB/GYN Care: Policy Challenges and Opportunities".

9. Center for Healthcare Strategies. Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care. Retrieved June 24, 2021, from https://www.chcs.org/media/VBP-for-SUD_Final_June-2018.pdf.

10. Guttmacher Institute. Substance Use During Pregnancy as of June 1, 2021. Retrieved June 24, 2021, from https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy.

11. Office of the Assistant Secretary for Planning and Evaluation. Medication-Assisted Treatment for Opioid Disorder in the Child Welfare Context: Challenges and Opportunities Research Brief. Retrieved January 28, 2022, from https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//185086/MATChildWelfare.pdf.

12. National Center on Substance Abuse and Child Welfare. How States Serve Infants and Their Families Affected by Prenatal Substance Exposure: Brief 1--Identification and Notification. Retrieved November 29, 2021, from https://ncsacw.samhsa.gov/files/prenatal-substance-exposure-brief1.pdf.

13. Schiff DM, Nielsen T, Terplan M, et al. (2018). Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. *Journal of Obstetrics & Gynecology*. 132(2), 466-474. doi:10.1097/AOG.0000000000002734.

14. Seibert J, Stockdale H, Feinberg R, Dobbins E, Theis E, & Karon SL. (2019). State Policy Levers for Expanding Family-Centered Medication-Assisted Treatment. Retrieved on June 24, 2021, from https://aspe.hhs.gov/basic-report/expanding-access-family-centered-medication-assisted-treatment-issue-brief.

15. Centers for Medicare & Medicaid Services. (2021). Improving Maternal Health and Expanding Postpartum Coverage in Medicaid and the Children's Health Insurance Program, State Health Official Letter. Retrieved on December 9, 2021, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

RTI International Authors: Julie Seibert, Erin Dobbins, Elysha Theis, Madeline Murray, Holly Stockdale, Rose Feinberg, Jesse Hinde, and Sarita L. Karon

This brief was prepared under contract # HHSP233201600021I between the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy and RTI International. For additional information about this subject, you can visit the BHDAP home page at https://aspe.hhs.gov/about/offices/bhdap or contact the ASPE Project Officers at HHS/ASPE/BHDAP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201; Kristina.West@hhs.gov.

EXHIBIT 1. Example Models of Integrated OB/GYN and SUD Care by Level of Integration	
Model	**Example Program Name and Description**
Level 1 -- Minimal Collaboration. Providers work at separate facilities and communication is rare. Referrals are made based on past collaboration and communicate only when needed.	
This level of collaboration may exist when formal programs are not in place.	
Level 2 -- Basic Collaboration at a Distance. Providers work at separate facilities and view each other as resources. They communicate periodically about shared patients and patient care when specific issues arise.	
This level of collaboration may exist when formal programs are not in place.	
Level 3 -- Basic Collaboration Onsite. Providers are co-located in the same facility but may practice in different spaces. Though systems are separate, regular proximity increases communication.	
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**Project Link** is a standalone hospital-based program in Providence, Rhode Island that delivers SBIRT training to OB/GYN providers to refer patients to the in-house intensive outpatient substance use treatment program within the hospital.
Level 4 -- Close Collaboration with Some System Integration. Collaboration among providers is closer due to co-location, shared practice space, and some shared systems. Typical models are found in hospital OB/GYN departments delivering limited outpatient SUD care.	
Centering Pregnancy Group	**Summa Health System** is a regional health system in Ohio that uses the *Centering Pregnancy* model to provide care, education and support in 10 group sessions lead by a provider.
Level 5 -- Close Collaboration Approaching an Integrated Practice. Providers begin to function as a care team, with frequent direct communication and integration of a range of services.	
Maternal/Pregnancy Health Home	**Perinatal Assistance and Treatment Home** is a statewide program in Kentucky that integrated SUD treatment with OB/GYN care through available group counseling and peer support network that prepare women for labor, delivery and infant care.
Level 6 -- Full Collaboration in a Transformed/Merged Practice. Integrate care blurs into a single program. Providers work closely with patients and each other. A case manager or social worker coordinates external support services as directed by providers.	
Integrated Care	**Moms in Recovery** is a standalone program in New Hampshire that employs a team of OB/GYN physicians, a clinical psychologist, and nurse care coordinator for PPW to receive group prenatal care and education by OB/GYN physicians as well as group counseling led by a psychologist.