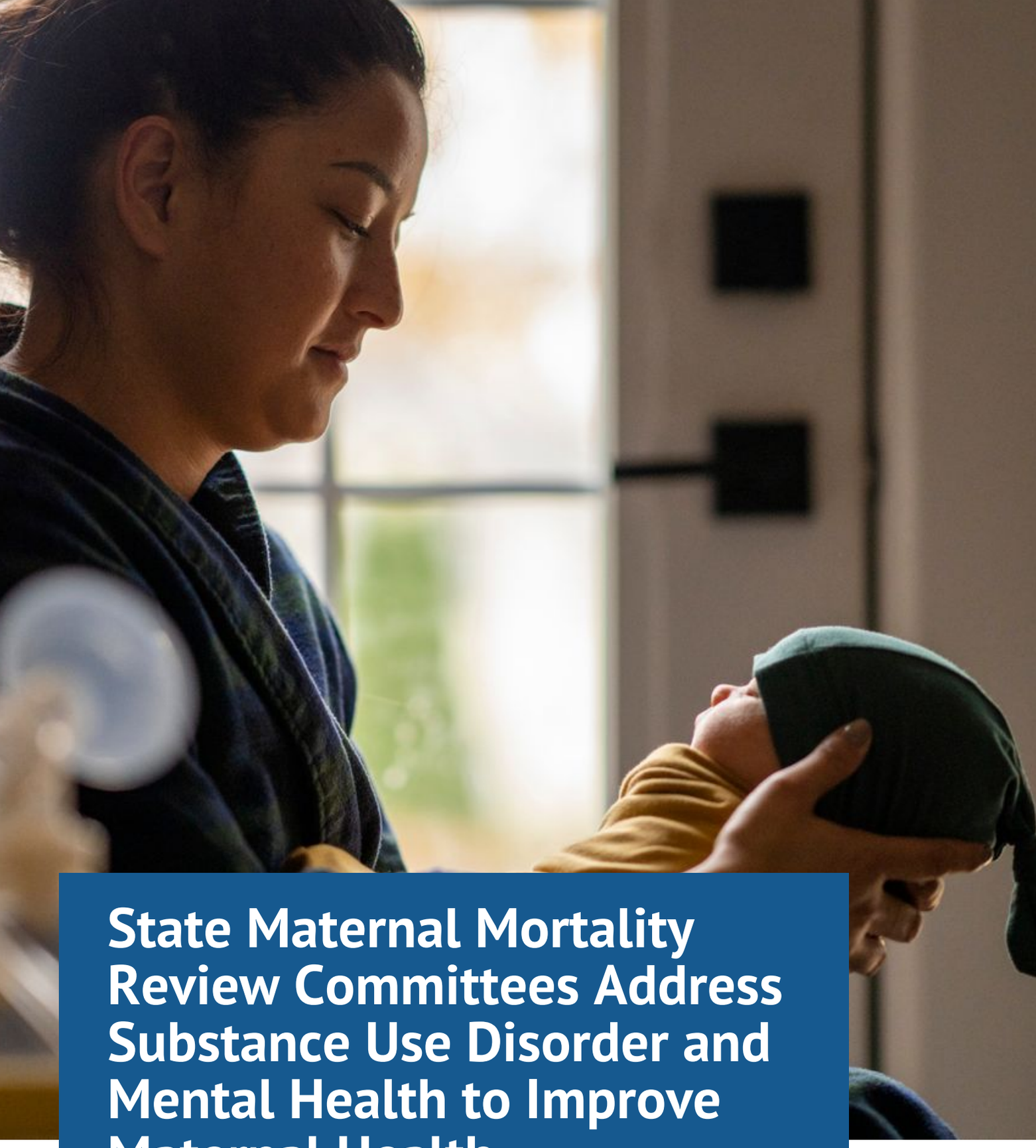

State Maternal Mortality Review Committees Address Substance Use Disorder and Mental Health to Improve Maternal Health

By Taylor Platt and Carrie Hanlon

August 2021

Background

The United States is facing a maternal mortality crisis. Maternal mortality rates have not been improving[1] and the United States currently has the highest rate among Organization for Economic Co-operation and Development (OECD) nations.[2] In 2019, the overall maternal mortality rate in the United States was 20.1 per 100,000 live births, with a rate of 44.0 for non-Hispanic Black women and 17.9 for non-Hispanic white women.[3] Deeply rooted systemic racism in health care and other systems serving maternal and child populations is a significant factor in the racial and ethnic disparities in maternal deaths.[4] Many states have been actively working to improve maternal health outcomes by leveraging the work of Maternal Mortality Review Committees (MMRC). Many MMRCs have recommended that states place greater priority on substance use disorder (SUD) and mental health conditions, which contribute to maternal mortality, to improve overall health outcomes. Facilitating access to perinatal behavioral health services is critical in addressing maternal mortality and morbidity, particularly considering the COVID-19 pandemic, which has exacerbated SUD and mental health needs, along with existing health inequities.

Racial Differences in Cause of Maternal Deaths

- The leading cause of pregnancy-related death varies by race. A Centers for Disease Control and Prevention (CDC) review of 14 Maternal Mortality Review Committee (MMRC) reports showed that the leading cause of death for non-Hispanic White women was mental health conditions (including SUD and overdose) while the leading cause for non-Hispanic Black women was cardiovascular-related conditions.
- In its most recent report, the Illinois MMRC found that Black women were more likely to die from a pregnancy-related medical condition whereas white women were more likely to die from a pregnancy-related mental health condition.

MMRCs are multidisciplinary committees in states and cities that perform comprehensive reviews of pregnancy-related deaths occurring within a year of the end of a pregnancy. MMRCs analyze these deaths that occur in their state each year and make recommendations to prevent them.[5] These suggested changes often target individuals, hospitals, providers, and the broader health care system. Improving maternal health outcomes has always been a priority, however, many states, motivated by increases in maternal mortality rates, are placing greater emphasis on the strategies identified by MMRCs to improve health outcomes and avoid unnecessary human and financial costs.

In a review of MMRC data in 14 states, mental health conditions, including suicide and overdose, were the underlying cause of 8.8 percent of pregnancy-related deaths.[6] Additionally, the COVID-19 pandemic has had negative ramifications for maternal health. Pregnant women are at a higher risk for more severe symptoms of COVID-19. Due to the pandemic, prenatal care visits decreased and maternal mental health conditions increased.[7] Early identification of SUD and mental health conditions may be missed due to the effects of COVID-19.

State Morbidity and Mortality Review Committees (MMRCs) at-a-Glance

- 48 states and the District of Columbia have MMRCs.
- The Centers for Disease Control and Prevention fund 25 states through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) and provide guidance and support to MMRCs through Review to Action.
- Title V Maternal and Child Health (MCH) Services Block Grants fund and support MMRCs.
- MMRCs may be led by the state or another entity (e.g., provider groups).
- MMRC membership varies by state but typically includes providers (e.g., obstetricians and gynecologists, cardiologists, nurses, and nurse midwives), state Medicaid, public health, behavioral health agencies, and community-based stakeholders (e.g., community organizations and family members affected by maternal loss).
- MMRCs, including membership and public report timelines, may be legislatively mandated.
- Frequency and availability of public reports vary by state.

For more information on state MMRCs click here for NASHPs 50-state scan.

MMRC Behavioral Health Policy Recommendations

MMRCs identified SUD and mental health conditions as drivers of pregnancy-related deaths. Based on a review of publicly available MMRC recommendation reports as of February 2021, improving SUD and mental health services for pregnant women in the prenatal and postpartum periods is a common policy recommendation for states. Access to behavioral services is an important component in improving maternal health outcomes. Because state MMRCs review each pregnancy-related death that occurs, they can identify policy changes that can improve overall maternal health outcomes. Nearly every state that reviews pregnancy-related deaths has recommendations focusing on:

- Ensuring adequate insurance coverage and payment,
- Increasing early identification and referrals,
- Ensuring referrals and follow-up care, and/or
- Increasing access to specific services.

Ensuring adequate Medicaid coverage and payment for SUD and mental health related services:
Medicaid covers more than 40 percent of births in the United States and covers approximately 65.9 percent of Black non-Hispanic births.[8] Inadequate coverage of services remains a barrier for many women seeking treatment and maintenance of care for behavioral health conditions. Many state MMRCs identify policy recommendations related to Medicaid coverage and reimbursement of substance use and mental health treatment during pregnancy.

To ensure Medicaid coverage and adequate reimbursement, many MMRCs commonly recommend three strategies as outlined below. (For specific state recommendations see Table 1). Providing coverage for SUD and mental health related services can help pregnant women to overcome barriers to receiving care.

- **Offer provider incentives to complete maternal behavioral health screenings.** States can use financial incentives to encourage providers to make screening, brief intervention, and referral to treatment for behavioral health conditions part of routine perinatal care and promote the use of evidence-based screening methods or tools in care settings.[9] In 2021, **Louisiana** began allowing separate Medicaid reimbursement for perinatal depression screenings of an enrolled caregiver during a well-child visit from birth to 1 year of age.[10]
- **Increase reimbursement for behavioral health related services.** Adequate reimbursement rates for behavioral health services can ensure that pregnant and postpartum women have access to the services. **Washington State** recommends increasing funding to the state Medicaid program to adequately reimburse hospitals for inpatient perinatal SUD care at the time of delivery and increasing reimbursement for caregiver depression screening by pediatric and family care providers.[11]

- **Expand Medicaid coverage for postpartum women.** States can extend Medicaid coverage beyond the standard 60 days postpartum for women and can also expand coverage to include inpatient and outpatient treatment. **Illinois** recently received approval for a Medicaid Section 1115 demonstration to extend postpartum coverage from 60 days after delivery up to one year postpartum, with the goal of reducing maternal morbidity and pregnancy-related mortality.[12] Illinois' 1115 demonstration allows for full Medicaid benefit coverage and includes continuous eligibility to address individuals losing coverage and help reduce racial disparities in maternal health outcomes. Similarly, **California** has extended Medicaid eligibility to a period of one year following the last day of pregnancy for a pregnant individual who is receiving health care coverage under the Medi-Cal program, and who has been diagnosed with a maternal mental health condition.[13] This postpartum coverage extension is supported through state dollars and may expire at the end of 2021. California, like other states, is considering the state plan amendment option offered under the Biden American Rescue Plan to extend postpartum coverage from 60 days to 12 months.[14] States electing this option must provide full Medicaid benefits during and throughout the 12-month period.

Increasing early identification of SUD and mental health conditions: Identifying behavioral health conditions as soon as possible during and after pregnancy is critical to providing the necessary treatment and services to ensure healthy outcomes for mothers and their babies. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends screening pregnant women for SUD in multiple settings, including the emergency department, OB/GYN visits, primary care visits, and well-child visits.[15] States are also encouraging screening for mental health conditions in a variety of settings including well-child, prenatal, postpartum, and emergency department visits. Maternal mental health conditions are the most common complications of pregnancy and childbirth.[16] Additionally, postpartum depression is common and has been shown to negatively impact maternal and infant health outcomes.[17] Currently, Medicaid programs in 43 states and Washington, DC recommend, require, or allow maternal depression screening as part of a well-child visit.[18] However, depression in pregnant and non-pregnant women of reproductive age often goes undiagnosed.[19]

To increase early identification, MMRCs commonly recommend three strategies (For specific state recommendations see Table 2.)

- **Provide adequate insurance coverage for screening. Virginia's** BabyCare program provides behavioral risk screening for pregnant Medicaid enrollees. The behavioral health risks tool screens for tobacco use, alcohol and other drug use, emotional health, and intimate partner violence.[20]
- **Use data systems and medical record review to monitor risk factors and track patterns.** In **Illinois**, the MMRC notes that health care providers must, by state law, use the Illinois Prescription Monitoring Program to review patients' past prescriptions and identify potential dependence and drug-seeking behavior. The Illinois MMRC now recommends hospital obstetric and emergency departments train providers on best practices for treating patients with SUD, including how to integrate the Illinois Prescription Monitoring Program into the electronic medical record.

- **Implement universal screening of pregnant women** for behavioral health conditions using validated tools (e.g., SBIRT)[22] in multiple health settings, including emergency rooms and pediatric primary care. Considering its MMRC recommendations, **New Jersey** recently rolled out new Medicaid initiatives, including requiring providers to complete the Perinatal Risk Assessment (PRA) form during the first prenatal visit for all enrollees.[23] The PRA form identifies demographic, medical, and psychosocial factors, including impacts of COVID-19, SUD, and mental health conditions, to help determine case management plans for pregnancies.

Ensuring appropriate referrals and follow up for women with SUD and mental health related needs: Referrals and linkage to follow up services are key components to ensuring pregnant women receive needed care. Linking pregnant women to behavioral health related services is challenging due to several issues, including stigma, lack of resources, and coverage.[24] One policy area that MMRCs identified for states to improve is working with providers to make sure pregnant women are referred to services and ensuring links to these services through appropriate follow-up coordination after the referral is made.

MMRCs commonly recommend two strategies to ensure appropriate follow-up occurs. (For specific state recommendations see Table 3.)

- **Implement standard protocols in multiple settings for referrals to services after a positive screening.** States can develop and share standard protocols for referral processes in hospitals, labor and delivery settings, emergency departments, well-visits, and home visits when a pregnant or postpartum woman has screened positive for a behavioral health condition. Referral processes can include protocols for pain management, consults with social workers or case managers, and connections to services like home visiting programs. These protocols can include mechanisms to ensure care coordination and connection to referred services. The Louisiana Department of Health has partnered with hospitals in implementing the Alliance for Innovation on Maternal Health (AIM) patient safety bundle on obstetric care for women with OUD.25 These bundles are designed to improve maternal health outcomes through education, care coordination, and patient safety protocols.
- **Ensure access to referred services** by coordinating behavioral health services with obstetric care, working with managed care organizations to guarantee members have access to specialists and treatment, addressing social determinants of health, and providing enabling services such as child care and transportation. Implementing a warm handoff during the referral process or care transition, as **Maryland** and **Ohio** MMRCs recommend, allows pregnant women and their families to experience continuous care and engage with their entire care team. A warm handoff occurs when a transfer of care between members of the health care team is done with the patient and their family.[26] A warm handoff can be implemented between OB/GYNs, primary care providers, pediatricians, case managers, care coordinators, and behavioral health providers. States can implement a warm handoff during the postpartum period to help with care transitions.

Increasing access to specialized treatment plans and specific services for perinatal populations: Medication Assisted Treatment (MAT) for SUD and telehealth services for mental health needs. MAT is the use of medications, along with counseling and behavioral therapies, to provide a whole patient approach to SUD treatment.[27] MAT has been shown to significantly reduce the need for inpatient detoxification and improve birth outcomes for pregnant women who have SUD.[28] Because of the effectiveness of MAT in preventing overdose and treating SUD, state MMRCs recommend these types of policy changes to ensure pregnant and postpartum women have access to this treatment. (For specific state recommendations see Table 4.).

- **Link women to MAT immediately** during the visit where OUD is identified.
- **Expand MAT** distribution and **ensure coverage of MAT** without prior authorization.
- **Provide more MAT resources** and treatment programs for women.

Telehealth services have demonstrated effectiveness in treating a range of behavioral health issues, from depression to SUD.[29] The Health Resources and Services Administration (HRSA)'s Screening and Treatment for Maternal Depression and Related Behavioral Disorders program currently funds seven states to support integrating behavioral health into maternal health care via telehealth. During the COVID-19 pandemic, there has been a rapid expansion of telehealth services to treat pregnant and postpartum women and to address their behavioral health needs.[30] Prior to the implementation of telehealth flexibilities during the public health emergency, many state MMRCs identified these policies to address the mental health needs of pregnant and postpartum women and to improve health outcomes.

- **Expand telehealth services** to provide SUD and mental health screening and treatment in rural areas and areas with provider shortages.
- **Offer behavioral health screenings via telehealth during the postpartum period** to help identify mental health needs as soon as possible.

When the public health emergency ends, states may consider keeping in place telehealth flexibilities to ensure access to mental health services for pregnant and postpartum women.

Key Considerations

As states continue to implement policies to improve maternal health, they can consider several themes that emerged from NASHP's review of state MMRC recommendations.

- **Having diverse MMRC member composition can lead to comprehensive and inclusive recommendations.** According to the CDC, MMRCs are meant to have multi-disciplinary committee members to provide different perspectives when reviewing pregnancy-associated[31] and identifying recommendations. Most states have state public health agency representation on their MMRCs, whereas less than half of state MMRCs have Medicaid agency representation.[32] Including Medicaid agency representation and community voices may lead to successful integration of recommendations related to Medicaid and community programs.
- **Collaborating across systems serving maternal populations to support blended program funding and data sharing agreements can help ensure pregnant and postpartum women have access to quality SUD and mental health services.** MMRCs recommend states take a cross agency, two-generation systems[33] approach to serving pregnant and postpartum women with behavioral health needs. To provide quality services to pregnant and postpartum women, state Medicaid, public health, behavioral health, social service, and housing agencies will want to work closely to coordinate policy and program changes and ensure proper data sharing agreements are in place. In addition to cross agency collaboration, states may work closely with hospital systems, providers, and community members to ensure policies are implemented successfully. In order to maximize funding for policies and programs to support this population, states may braid multiple funding streams such as Medicaid, Title V Maternal and Child Health (MCH) Services Block grant, state dollars, and other grants (e.g. The Maternal Opioid Misuse Model).
- **Incorporating implicit bias trainings that are part of staff and hospital training requirements can help combat bias in treating pregnant and postpartum women with behavioral health needs.** Most MMRCs recommend integrating implicit bias trainings at multiple levels to help combat racial bias and stigma related to mental health conditions and SUD. Recommendations focus on requiring training for providers, hospital staff, state policy makers, and staff that work with pregnant and postpartum women. States and stakeholders can consider embedding these trainings in onboarding protocols and continuing education to help improve maternal health.
- **Addressing social determinants of health can assist in meeting behavioral health needs during pregnancy.** MMRCs identify needs like housing, food insecurity, transportation, and child care as key components in improving health outcomes for pregnant women with behavioral health needs. When designing policy changes for this population, it is important to consider social determinants of health.
- **Integrating mental health and SUD screening into multiple settings, such as emergency departments and well-child visits, as well as different points of service throughout pregnancy-related care, can help states identify needs and provide essential services to pregnant and postpartum women in a timely way.** States can support screening in multiple settings by implementing provider trainings and incentives.

- **Building referral networks with accessible care coordination services that target high-risk pregnancies is an important component of comprehensive programs for pregnant and postpartum women.** Once a pregnant woman screens positive for substance use or a mental health condition, connecting her to services is a key step in improving outcomes. Building these referral networks for women with behavioral health needs can help to improve care coordination and prevent pregnancy-associated deaths.

Conclusion

MMRC recommendations can inform state-specific policies to improve maternal health outcomes and reduce disparities for women with behavioral health needs. The policy recommendations identified by MMRCs include increasing screening for SUD and mental health conditions in multiple settings, providing adequate coverage and reimbursement for behavioral health services, addressing social determinants of health, and ensuring referrals and care coordination services. By implementing these policy recommendations through cross systems collaboration, states can build infrastructure to help support women with behavioral health needs throughout the perinatal period. Because of the impact of COVID-19 on behavioral health, it is more important than ever to ensure pregnant and postpartum women have access to behavioral health resources, and states may look to MMRC recommendations for key policy options and considerations.

Acknowledgements

This policy brief was written by Taylor Platt and Carrie Hanlon. The National Academy for State Health Policy would like to thank the state officials who reviewed the information in the brief as well as Project Officer Michael Sauter and his colleagues at the Health Resources and Services Administration for their feedback and guidance. The authors also wish to thank Hemi Tewarson, Karen VanLandeghem, and Eddy Fernandez for their contributions to the paper. This project is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under the Supporting Maternal and Child Health Innovation in States Grant No. U1XMC31658; $398,953. This information, content, and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the US Government.

Appendix

Table 1: MMRC Recommendations to ensure adequate Medicaid coverage and payment Ensuring adequate Medicaid coverage and reimbursement for SUD and mental health related services

Ensuring adequate Medicaid coverage and reimbursement for SUD and mental health related services	SUD	Mental Health
	Louisiana: Incentivize provider screening and integration of substance use treatment into prenatal and postpartum care. Ensure coverage (without prior authorization) by all payers of medication assisted treatment for opioid use disorder, including methadone and buprenorphine.	California: Support incentives to routine screening of pregnant and postpartum women for mental health conditions by both obstetric providers and pediatricians during well-child visits.
	Virginia: Coverage for women enrolled in the Virginia Family Access to Medical Insurance Security (FAMIS) program during pregnancy should be expanded to provide increased access to comprehensive coverage for chronic disease management, including substance abuse treatment (both residential and outpatient), mental health services and family planning.	Washington: The Health Care Authority should increase reimbursement for and create reimbursement mechanisms when necessary: • Reimburse for additional caregiver depression screenings by pediatric and family providers through the first year of an infant's life. Currently, these screenings are only reimbursed through the first six months of the infant's life. • Provide billing codes that allow enhanced reimbursement for group prenatal and postpartum care.
	Washington State: Increase funding to the state Medicaid program so it can adequately reimburse hospitals and providers for inpatient perinatal substance use care at hospitals of birth at the time of delivery and for up to 14 days after delivery.	

Table 2: MMRC Recommendations to increase early identification of behavioral health conditions

	SUD	Mental Health
Increasing screening for behavioral conditions in a variety of settings (emergency department, OB/GYN, primary care, well-child)	Illinois: Providers should follow best practices for the identification and treatment of substance use disorders among pregnant and postpartum women. Providers treating pregnant and postpartum women in obstetric or emergency care should: • Adopt a universal, validated, self-reported screening tool for substance use at the first prenatal care visit, on admission for delivery, and during postpartum visits.	Ohio: Optimize treatment for pregnant and postpartum women with mental health issues. Ensure that anyone with mental health concerns (e.g., history of suicide attempt) has an evaluation during pregnancy, prior to discharge at any hospital admissions and the postpartum period.
	Louisiana: Offer universal substance use screening, brief intervention, and referral during pregnancy. Screening should include alcohol use disorders, rather than isolated emphasis on routine urine drug screening.	Michigan: Advocate for emergency department reimbursement for regular depression/suicide screenings.
	New Jersey: Use of the Pregnancy Risk Assessment (PRA) tool by all healthcare providers who care for pregnant women in NJ. Screening of pregnant women for prescription or illicit drug use throughout pregnancy and at the time of delivery.	New Jersey: Universal screening for postpartum depression • Each hospital develops policies to ensure that women who experience a pregnancy loss are appropriately screened for PPD. • Scheduling of a psychiatric or mental health consultation for all women who have a history of PPD in a previous pregnancy or delivery, regardless of current Edinburgh score. • Including a postpartum depression screening checkbox on all fetal death certificates to be completed in the Vital Information Platform (New Jersey's web based registration system).
	Ohio: Develop a statewide surveillance system of perinatal substance abuse.	
	Virginia: All providers of care to women of childbearing age should be trained in and engage in SBIRT for substance misuse, mental illness, domestic violence and trauma at the initiation of care.	Virginia: Provide coverage through the Medicaid program for comprehensive coverage and screening for mental illness

Table 3: Referrals and appropriate follow up to services

	SUD	Mental Health
Increasing screening for behavioral conditions in a variety of settings (emergency department, OB/GYN, primary care, well-child)	Illinois: Hospitals should establish policies and protocols to ensure appropriate treatment of pregnant and postpartum women with substance use disorders and to support opioid overdose prevention. Hospital obstetric and emergency departments should train providers on best practices for treating patients with substance use disorder, including how to: • Start patients on medication-assisted recovery (MAR) and link patients to outpatient treatment and to recovery services. • Create policies to ensure appropriate postpartum pain management and opioid prescribing practices. • Prescribe naloxone for patients who use opioids and counsel these patients and their families on the use of naloxone.	Illinois: Health insurance plans, including Illinois Medicaid, should cover intensive case management and outreach and non-medical support services (such as doulas) for women with complex medical and mental health conditions while pregnant and up to one year after delivery.
	Michigan: Require social work consults for all pregnant or postpartum patients with Substance Use Disorder, Intimate Partner Violence, past trauma and/or mental health disorders. Including referrals to appropriate follow up care and support such as Maternal Infant Health Program (MIHP).	Maryland: Prior to discharge after delivery, mechanisms should be put in place to coordinate a warm hand-off for patients needing primary care and specialty follow-up as well as those needing behavioral health treatment, including appointments and referrals and addressing needs such as transportation and childcare.
	New Jersey: Provision of referral opportunities to all healthcare professionals providing direct care to women of childbearing age. Provision of referral opportunities to all hospital emergency rooms and labor and delivery departments.	Washington: Ensure continuity of care by developing policies and procedures for a "warm hand off" for transferring or sharing care between prenatal and postpartum provider, and primary care or behavioral health provider. This includes building relationships and connecting with the provider who will be participating in the patient's care, helping the patient schedule appointments, addressing barriers like transportation or cost, and sending pertinent records to the participating provider before the patient's appointment.
	Ohio: Improve coordination of medical care and substance abuse / mental health treatment. Partner with Ohio Department of Health, WIC, and the Ohio Department of Mental Health and Addiction Services regarding WIC's brief intervention model to evaluate alcohol use in pregnancy and making referrals.	

Table 4: Increasing access to behavioral health services

Increasing access to behavioral health related services for pregnant and postpartum women	Increase Access to MAT	Increase Telehealth
	Louisiana: Maintain linkages to evidence-based, decriminalized medication assisted therapy for opioid use disorder in women of reproductive age at the point of care, without delay. Recommends coverage by all payors for MAT without prior authorization.	Iowa: Consider expanding telehealth to increase access to mental health professionals in rural areas.
	New Jersey: Wider distribution of all drug addiction resources throughout the state among all healthcare providers as well as the public.	Mississippi: Expand access to substance use and mental health services for pregnant and postpartum women including community-based, telehealth and faith-based care.
		Missouri: Recommended increased opportunities for mental health screenings during the postpartum period and expanded telehealth options for mental health care.

Notes

[1] “First Data Released on Maternal Mortality in Over a Decade.” Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, January 30, 2020. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2020/202001_MMR.htm.
[2] Tikkanen, Roosa, Munira Z Gunja, Molly FitzGerald, and Laurie Zephyrin. “Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries.” Maternal Mortality Maternity Care US Compared 10 Other Countries | Commonwealth Fund. Commonwealth Fund, November 18, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.
[3] Hoyert DL. Maternal mortality rates in the United States, 2019. NCHS Health E-Stats. 2021. DOI: https://doi.org/10.15620/cdc:103855.
[4] Taylor, Jamila K. “Structural Racism and Maternal Health Among Black Women.” Journal of Law, Medicine & Ethics 48, no. 3 (2020): 506–17. https://doi.org/10.1177/1073110520958875. https://journals.sagepub.com/doi/full/10.1177/1073110520958875
[5] “Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM).” Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, February 26, 2020. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html.
[6] “Enhancing Reviews and Surveillance to Eliminate Maternal Mortality.” Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, September 4, 2019. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html#table1.
[7] Kotlar, Bethany, Emily Gerson, Sophia Petrillo, Ana Langer, and Henning Tiemeier. “The Impact of the COVID-19 Pandemic on Maternal and Perinatal Health: a Scoping Review.” Reproductive Health. BioMed Central, January 18, 2021. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-021-01070-6.
[8] “Medicaid’s Role in Maternal Health .” Medicaid and CHIP Payment and Access Commission, June 2020. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf.
[9] Ashcroft, Rachelle, Jose Silveira, Brian Rush, and Kwame Mckenzie. “Incentives and Disincentives for the Treatment of Depression and Anxiety: a Scoping Review.” Canadian journal of psychiatry. Revue canadienne de psychiatrie. The Canadian Psychiatric Association, July 2014. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4086319/.
[10] “Developmental Screening, Autism Screening and Perinatal Depression Screenings.” Louisiana Department of Health Informational Bulletin 21-3, 2021. https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2021/IB21-3.pdf.
[11] “Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016.” Washington State Department of Health. Prepared by the Prevention and Community Health Division, October 2019. https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-010-MMRPMaternalDeathReport2014-2016.pdf.
[12] “Illinois Continuity of Care and Administrative Simplification.” Centers for Medicare and Medicaid Services . Accessed April 6, 2021. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81586.

[13] “California Budget Summary .” California Health and Human Services . Department of Health Care Services , May 2020. http://www.ebudget.ca.gov/2020-21/pdf/Revised/BudgetSummary/HealthandHumanServices.pdf.
[14] Ranji, Usha, Alina Salganicoff , and Ivette Gomez. “Postpartum Coverage Extension in the American Rescue Plan Act of 2021.” Kaiser Family Foundation, March 18, 2021. https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/.
[15] Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and
Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville,
MD: Substance Abuse and Mental Health Services Administration, 2018. https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf
[16] “ Fact Sheet: Maternal Mental Health.” Maternal Mental Health Leadership Alliance. July 2020. https://www.mmhla.org/wp-content/uploads/2020/07/MMHLA-Main-Fact-Sheet.pdf
[17] Ko JY, Rockhill KM, Tong VT, Morrow B, Farr SL. Trends in Postpartum Depressive Symptoms — 27 States, 2004, 2008, and 2012. MMWR Morbidity Mortal Weekly Rep 2017;66:153–158. DOI: http://dx.doi.org/10.15585/mmwr.mm6606a1External.
[18] “Maternal Depression Screening.” Healthy Child Development State Resource Center. National Academy for State Health Policy, April 5, 2021. https://healthychild.nashp.org/maternal-depression-screening-2/#toggle-id-1.
[19] Ko, Jean Y, Sherry L Farr, Patricia M Dietz, and Cheryl L Robbins. “Depression and Treatment among U.S. Pregnant and Nonpregnant Women of Reproductive Age, 2005-2009.” Journal of women's health (2002). U.S. National Library of Medicine, August 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4416220/.
[20] Lent, Megan. “Virginia’s Babycare Program: Working to Improve Birth Outcomes Through Medicaid.” National Academy for State Health Policy, 2018. https://www.nashp.org/wp-content/uploads/2018/12/Babycare-VA-Fact-Sheet.pdf
[21] “Illinois Maternal Morbidity and Mortality Report.” State of Illinois. Department of Public Health, October 2021. https://www.dph.illinois.gov/sites/default/files/maternalmorbiditymortalityreport0421.pdf.
[22] “Screening, Brief Intervention, and Referral to Treatment (SBIRT).” Substance Abuse and Mental Health Services Administration (SAMHSA). US Department of Health & Human Services , 2017. https://www.samhsa.gov/sbirt.
[23] “Perinatal Risk Assessment (PRA) Required for Reimbursement of Prenatal Care.” State of New Jersey Department of Human Services. Division of Medical Assistance & Health Services, November 2020. https://bit.ly/3dyQqQE.
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5871558/
[25] “Obstetric Care for Women with Opioid Use Disorder .” Council on Patient Safety in Women's Health Care, 2017. https://safehealthcareforeverywoman.org/wp-content/uploads/Obstetric-Care-for-OUD-Bundle.pdf.

[26] Warm Handoff." AHRQ. Agency for Healthcare Research and Quality. Accessed May 27, 2021. https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html#:~:text=A%20warm%20handoff%20is%20a,of%20the%20patient%20and%20family.
[27] "Medication-Assisted Treatment (MAT)." SAMHSA. US Department of Health & Human Services, January 4, 2021. https://www.samhsa.gov/medication-assisted-treatment.
[28] ibid
[29] Warren, Jacob C, and K. Bryant Smalley. "Using Telehealth to Meet Mental Health Needs During the COVID-19 Crisis." Commonwealth Fund, June 18, 2020. https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis.
[30] "COVID-19 Telehealth Coverage Policies." Center for Connected Health Policy , 2020. https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies.
[31] Pregnancy-associated death:A death during or within one year of pregnancy, regardless of the cause. These deaths make up the universe of maternal mortality; within that universe are pregnancy-related deaths and pregnancy-associated, but not related deaths. (Review to Action)
Pregnancy-related death: A death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. (Review to Action)
Pregnancy-associated, but not related deaths: A death during or within one year of pregnancy, from a cause that is not related to pregnancy.
[32] "State Maternal Mortality Review Committee Membership and Recommendations." The National Academy for State Health Policy, 2021. https://www.nashp.org/state-maternal-mortality-review-committee-membership-and-recommendations/#tab-id-2.
[33] National Academies of Sciences, Engineering, and Medicine. 2019. Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25466.