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3 **Title:** Perinatal Mental Health and Substance Use Disorder Services  
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5 **Introduced by:** Sara Jaber, MD, for the Michigan Section of the American College of  
6 Obstetricians and Gynecologists  
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8 **Original Author:** Sara Jaber, MD  
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10 **Referred To:** Reference Committee D  
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12 **House Action:** **APPROVED AS AMENDED**  
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15       Whereas, one in five women experience mental health or substance use disorders in the  
16 United States during pregnancy and the postpartum period, and  
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18       Whereas, 96 maternal deaths from 2012-2016 in Michigan were the result of substance use  
19 overdose, accounting for 26.1 percent of maternal deaths, and  
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21       Whereas, Michigan's rates of postpartum depression have been persistently higher than the  
22 national rate over the past few years, with the gap further widening in 2021 with postpartum  
23 depression in Michigan reported at 16.5 percent compared with 12.7 percent nationally, and  
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25       Whereas, untreated maternal mental health conditions result in annual cost of \$14 billion or  
26 \$32,000 per mother and infant, and  
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28       Whereas, mental health conditions during pregnancy and postpartum are associated with  
29 significant adverse outcomes including stillbirth, preterm birth, fetal growth restriction, low birth  
30 weight, impaired bonding, poor infant neurodevelopment, and higher rates of long-term health  
31 problems after delivery, and  
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33       Whereas, screening for mental health and substance use disorders are recommended at the  
34 first prenatal visit and then periodically during pregnancy and postpartum visits, and  
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36       Whereas, evidence shows that both non-pharmacological and pharmacological  
37 interventions are effective for preventing and treating perinatal mental health conditions, and  
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39       Whereas, the inpatient psychiatric admission of pregnant adolescents with suicidal ideation,  
40 or to provide more adequate psychiatric care, can lead to improved pregnancy outcomes, and  
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42       Whereas, only one intensive outpatient and partial hospitalization perinatal psychiatry  
43 program has been registered in Michigan, and  
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45       Whereas, although obstetric care providers play a critical role in the screening of mental  
46 health and substance use disorders in pregnancy and postpartum, most obstetric providers are not  
47 reimbursed for the time spent providing maternal mental healthcare services, and

48           Whereas, most states consider screening for mental health and substance use disorders as  
49 part of the “global obstetric code” rather than being reimbursed additionally for this service, and  
50 this was particularly correct if the physician screened every patient routinely, and  
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52           Whereas, some insurance payers provide reimbursement for services linked to a maternal  
53 mental health service only if the services are provided by psychologists and/or psychiatrists, and  
54

55           Whereas, only California, Colorado, and Tennessee have addressed and implemented  
56 Medicaid-related screening and billing/reimbursement protocols for obstetric care providers  
57 attending to pregnant and postpartum women; therefore be it  
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59           RESOLVED: That MSMS will support improvements in mental health and substance use  
60 disorder services during the pregnancy and postpartum period including access to non-  
61 pharmacotherapy, pharmacotherapy, outpatient services and inpatient psychiatric and medical  
62 services; and it be further  
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64           RESOLVED: That MSMS will advocate for inclusive private and public insurance coverage of,  
65 and sufficient payment for, all mental health services during pregnancy and the postpartum period;  
66 and it be further  
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68           RESOLVED: That MSMS will advocate for evidence-based, non-punitive, screening and  
69 treatment of mental health and substance use disorders as the standard of care during pregnancy  
70 and the postpartum period; and be it further  
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72           RESOLVED: That MSMS will encourage the expansion of mental health and substance use  
73 disorder treatment facilities that provide care during pregnancy and the postpartum period for  
74 those in need of inpatient and intensive outpatient disease management, including facilities that  
75 enable them to bring their minor children.  
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78   WAYS AND MEANS COMMITTEE FISCAL NOTE: \$12,000-\$24,000

## **Relevant MSMS Policy**

### **Support for Mental Health Reform in Michigan**

MSMS supports efforts to improve mental health services in Michigan, including those that address mental health disparities, promote interdepartmental coordination and shared accountability, and provide greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

### **Childcare Availability for Persons Receiving Substance Use Disorder Treatment**

MSMS supports the development of childcare resources for existing substance use treatment facilities and believes childcare infrastructure and support should be a major priority in the development of new substance use programs.

### **Eliminate Barriers to Medication-Assisted Treatment**

MSMS supports the elimination of insurance-related access barriers, including prior authorization requirements, to all forms of medication-assisted treatment for the medical treatment of substance use disorder.

### **Reimbursement for Postpartum Depression Prevention**

MSMS shall advocate for the following:

1. State Medicaid programs to reimburse applicable CPT codes that can be used for postpartum depression prevention by a broad range of health workers, with services currently covered under the Affordable Care Act.
2. An initiative to allow all qualified health care professionals to bill under a “pregnancy” diagnosis code, so that they can deliver perinatal and postnatal mental health preventive interventions.
3. State Medicaid programs to provide avenues for nurses, doulas, community health workers, and health educators trained in these programs as part of physician led health care teams to deliver these primary prevention interventions and be reimbursed.
4. States, payers, and health systems to make evidence-based postpartum depression prevention services the official standard of care and increase bundle payments accordingly statewide.

MSMS believes evidence-based postpartum depression prevention services should be the official standard of care for all federally-funded health care programs for pregnant women federally.

### **Relevant AMA Policy**

#### **Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953**

Our AMA will: (1) support improvements in current mental health services during pregnancy and postpartum periods; (2) support advocacy for inclusive insurance coverage of and sufficient payment for mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; (4) continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) advocate for evidence-based postpartum depression screening and prevention services to be recognized as the standard of care for all federally-funded health care programs for persons who are pregnant or in a postpartum state.

#### **Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991**

Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

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