The Honorable Chuck Grassley
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

April 3, 2020

Dear Chairman Grassley and Senator Wyden,

We, the undersigned consumer-led organizations committed to the development of the strongest possible policies to support the health and wellbeing of moms and babies, appreciate the opportunity to respond to the Senate Finance Committee's March 3, 2020 request for information (RFI) to help address our nation's maternal health crisis. Even during the current coronavirus (COVID-19) pandemic, maternal health remains an urgent issue and we are grateful for your efforts to understand the factors contributing to poor maternal health outcomes in the United States and to develop legislation based on specific, evidence-based solutions to address those factors and improve maternal health. We respectfully submit our comments below.

Background

Before the COVID-19 pandemic hit, the U.S. maternal mortality rate was the highest of any high-resource nation despite spending far more on maternity care than any other country. The U.S. is one of just two countries in the world where maternal deaths are actually increasing.[1] Every year in the U.S., approximately 700 women die of complications related to pregnancy and childbirth.[2,3] Even more alarming, Black and Indigenous women are more than twice as likely to die from complications of pregnancy and childbirth as white women.[4] The CDC has also found that three in five of these deaths were preventable.[5] Beyond mortality, nearly 50,000 women a year experience severe maternal morbidities including hemorrhage[6] — and 1 in 10 pregnant people in the United States experience depression or anxiety after childbirth,[7] but lack the support and treatment services necessary to face these challenges. The rate of maternal deaths has more than doubled in the past two decades, and maternal morbidity is increasing at an even faster rate. Because maternal health is a key indicator of a country's overall health system, the rapid rise of maternal mortality and morbidity signifies that the U.S. health system is broken and failing to meet the needs of women and families.

Prior to the pandemic, Congress had considered a myriad of initiatives aimed at improving maternal health outcomes particularly for vulnerable women and families, including the more than 43% of births that are covered by Medicaid.[8] Today, with COVID-19 overtaxing the health care systems, states and health care providers have closed Labor and Delivery units, restricted labor support and visitation policies, and diminished outpatient care including prenatal, postpartum, fertility, and contraception

care. These policies will have the unintended consequences of long-term harm to families and women who were already at risk for poor maternal health outcomes. Now, more than ever, there is a need to enact long-term, stabilizing policies that better support growing families, especially for our most vulnerable populations. The following evidence-based strategies (provided below with the data to support them) would provide needed help to women and families to not only address persistent inequities but also to prevent the exacerbation of health disparities for women and families during the COVID-19 pandemic. We offer the following recommendations below structured by the topic categories requested by the committee.

Topic 1: Coverage and Standards to Improve Maternal Health

Health insurance coverage, continuity of that coverage, and access to quality medical care are foundational to improving maternal health outcomes. We strongly support expanding coverage for pregnant and postpartum women.

Recommendation 1: Permanently extend Medicaid coverage for all postpartum women for at least 12 months after giving birth with increased FMAP at 100% for the first five years, reduced to 90% thereafter.

Medicaid provides essential coverage for women while they are pregnant, during delivery and up until 60 days postpartum. However, according to the Centers for Disease Control and Prevention, one in three pregnancy-related deaths occur one week to one year after delivery, and most are preventable.[9] In some states, more than 50% of pregnancy related deaths occurred after 60 days postpartum.[10] These deaths are the canaries in the coal mines – countless women suffer life-threatening complications, trauma, and significant mental health issues during this vulnerable phase of life between two months and 1 year postpartum.[11] The American College of Obstetricians and Gynecologists recommends that women have access to uninterrupted care during this critical period to increase preventive care, reduce avoidable adverse obstetric and gynecologic health outcomes, increase early diagnosis of disease, and reduce maternal mortality.[12]

It is better for women's health outcomes to have continuous coverage through Medicaid than to have them move onto the state's Exchange Marketplace at 60 days postpartum. Research has shown that mothers accessed outpatient postpartum care at lower rates when they had to move onto Marketplace plans whereas women who were able to stay on Medicaid accessed more postpartum care. Further, continuity of Medicaid is the most helpful for women with severe complications at birth: they accessed 50% more care if they were able to continue their Medicaid coverage.[13]

Beyond the effect on mortality, morbidity and inequities, the administrative efficiencies and cost-saving potential of continuing Medicaid coverage through one-year postpartum for moms cannot be overstated. The average monthly Medicaid expenditure for these individuals falls as the months of enrollment rise. Each month of Medicaid enrollment reduced Medicaid expenditures an additional $6.49 per month. As a result, it is estimated that the second six months of Medicaid coverage costs about 30 percent less than the first six months of coverage in a year.[14]

Recommendation 2: Ensure that all pregnant and postpartum women have full Medicaid coverage through one year postpartum, including full oral health coverage, rather than limited pregnancy-related coverage or limited behavioral health coverage postpartum. This is particularly important to standardize care across states and reduce disparities.

Ensuring women have access to full-scope Medicaid through one year postpartum is critical because the conditions that are killing women during this period extend beyond those considered pregnancy-related. For example, for maternal deaths that occur between 42 days and 1 year postpartum, the first leading cause was cardiovascular issues (32%) and the second leading cause was behavioral health-related conditions (30%).[15] In some states, where Medicaid coverage for pregnant women is restricted to "pregnancy-related services," pregnant women may have trouble accessing services for these underlying conditions that may not be directly associated with pregnancy. For example, there are instances where women with pregnancy-related service coverage are unable to access treatment for broken bones, a brain tumor, heart disease, or the seasonal flu.[16] Further, without dental coverage, pregnant women are more likely to experience poor oral health. Poor oral health raises a pregnant woman's risk of high blood pressure, which can lead to major complications and even death. It also increases her risk of poor birth outcomes, such as low birth weight or premature birth.[17]

Ensuring full-scope Medicaid services also has cost-savings implications. The utilization of emergency and inpatient services and Medicaid expenditures significantly increased for beneficiaries with depression or ambulatory-case sensitive conditions such as heart failure, diabetes and COPD when they returned to Medicaid after experiencing a temporary loss in coverage.[18,19] For mothers that experience postpartum depression, there are both health outcome and cost savings benefits when women are able to access integrated care.[20]

Topic 2: Use of Non-Physician Clinicians and Continuity, Coordination of Care

We strongly support expanding access to and integration of midwives, peer perinatal support workers, and other non-physician health professionals into the maternal health landscape, and building continuity and coordination of care to improve health outcomes.

Recommendation 3: To amend title XIX of the Social Security Act to provide coverage under the Medicaid program for services provided by community-based doulas, perinatal community health workers, and other peer support service providers.

Community-based doula programs engage and educate trusted members of their communities to serve as birth doulas and home visitors who can provide childbirth education, breastfeeding support, and support navigating the health care system, as well as continuous support during labor and birth. The benefits of community-based doulas in maternity care are well-supported and demonstrated by research showing improved health outcomes for both women and babies including: fewer low birthweight babies, fewer preterm births, fewer cesarean sections, lower rates of postpartum depression, increased breastfeeding, and more positive birth experiences.[21] A large Cochrane systematic review found that women who receive continuous support during labor from a doula were more likely

to have several positive outcomes, including: increased rate of spontaneous vaginal birth; shorter duration of labor; decreased rates of cesarean birth, instrumental vaginal birth, and use of any analgesia; decreased rates of low 5-minute Apgar scores; and less negative feelings about their childbirth experiences.[22] Additionally, doula care has been found to be incredibly cost-effective, reducing overall costs by avoiding unnecessary medical interventions and the potential complications and chronic conditions that may result.[23],[24],[25] Medicaid coverage of doula care has been found to reduce spending by as much as $1,450 per birth, a figure that focuses solely on the cost savings that are easiest to track and realized in the short term.[26] Despite the demonstrated benefits of doula care, lack of reimbursement by Medicaid acts as a significant barrier to accessing doula support.[27] Medicaid coverage of these doula care services would not just facilitate access to this care for those who need it most; it would also improve short and long-term outcomes for both moms and babies.

Perinatal community health workers (CHWs) serve as bridges between their communities and the health care system, fostering greater trust and enhancing the health system's ability to provide higher quality, culturally centered care. Due to their intimate knowledge of their communities' needs and resources, CHWs are particularly effective at addressing the social determinants of health.[28] By reducing avoidable utilization of hospital and emergency department visits, community health worker programs can reduce unnecessary spending, resulting in net savings and positive returns on investments for health systems and payers.[29,30,31]

Recommendation 4: Require reimbursement parity under Medicaid for maternity care services provided by midwives at 100% of identical services provided by physicians to match requirements for Medicare under the ACA.

Considerable evidence demonstrates that the midwifery model of care achieves excellent outcomes for women and infants, and shows no area where their care is worse than other models. Research has found that the midwifery model results in fewer medical interventions such as cesareans, episiotomies, and epidurals, fewer serious lacerations, a higher likelihood of breastfeeding, and greater patient satisfaction.[32,33,34] In the Center for Medicare and Medicaid Services' (CMS) Strong Start Study, midwife-led care was found to significantly improve outcomes for Medicaid-enrolled clients across indicators of population health, experience of care, and value of care.[35]

Expanding midwifery care has the potential to significantly reduce Medicaid and private insurance spending on maternity care and can enhance the value of care provided. Midwifery care lowers costs by avoiding the overuse of interventions, which also eliminates avoidable short- and long-term complications and chronic conditions for women and newborns that sometimes result from unnecessary medical procedures.[36,37] Increased rates of breastfeeding and decreased use of epidural pain relief associated with midwifery care also achieve cost savings.[38,39] Under the Affordable Care Act, certified nurse-midwives are guaranteed equitable Medicare reimbursement as physicians for maternity care services, yet in many states, services provided by midwives are still covered at lower rates than those provided by physicians under Medicaid fee-for-service and managed care plans.[40] Payment parity in

Medicaid for midwives would increase availability of these effective models and ensure that women have access to these high-quality services.

Recommendation 5: Direct CMS to implement a demonstration program for freestanding birth centers in order to develop innovative and sustainable payment models for low-risk maternity care.

In the U.S., women with low-risk pregnancies who give birth at home or birth centers, as compared to those who have chosen a hospital birth, have consistently lower rates of intervention and intervention-related maternal complications.[41] In the CMS Strong Start program study, participants who received prenatal care in Strong Start birth centers were found to have lower rates of low birth weight, preterm birth, and C-sections and higher rates of vaginal birth after cesarean (VBAC) than other Medicaid beneficiaries. Each mother-infant dyad was also found to have healthcare cost savings of $2,010 through birth and into the following year.[42] Birth center care has also been found to have the potential to save Medicaid an average of $11.6 million per 10,000 births per year and reduce costs per birth by 16 percent as compared to hospital care.[43]

Topic 3: Addressing Disparities and Disparate Outcomes

Maternal mortality rates for Black, Native American, and Alaska Native women are strikingly higher than those of white women[44] and similarly Black infant mortality rates are more than twice that of non-Hispanic white infants.[45] We strongly support addressing these stark disparities.

Recommendation 6: Implement a grant program to promote community-based, community-led perinatal care programs, particularly those led by Black and Indigenous women that have shown promising outcomes on reducing racial and ethnic disparities.

In order to holistically meet the needs of pregnant women facing complex social, economic, and environmental issues, as well as structural and interpersonal racism and implicit bias, community-based, community-led perinatal care programs are critical to provide culturally-competent, trauma-informed maternity care.

The added support of doula care is beneficial to women of color most affected by health disparities as a result of structural racism and implicit bias. Because community-based doulas share the same background, culture, and language with their clients, they are able to serve as a key resource for addressing discrimination and disparities. Doulas allow questions, preferences, and values to be addressed by facilitating positive communication between pregnant women and their care providers. As liaisons, doulas provide non-clinical emotional, physical, and informational support before, during, and after labor and birth that ultimately incorporates cultural sensitivity and awareness into quality maternity care, resulting in improved childbirth experiences for women of color.

Factors associated with these positive experiences of care include the midwifery model's emphasis on client engagement in care decision-making and a "relationship-based" model of care that fosters trust, respect, and emotional support.[46] Communities of color in particular benefit from the midwifery model's

prioritization of establishing trusting relationships and respect for culture, values, dignity, and privacy throughout the pregnancy and childbirth process.

One example, HealthConnect One, an evidence-informed home visiting and community-based doula program was found to lead to higher rates of breastfeeding and lower rates of cesarean section among participants. In 2012, an expert panel on the "Promotion and Support of Community-based Doula Programs" that evaluated HealthConnect One's model emphasized that the Health Resources and Service Administration should promote similar community-based doula programs with federal funding based on the model's maternal health outcomes and implications for perinatal workforce development.[47]

Recommendation 7: Direct HHS to implement a maternity care demonstration project that includes doulas, CHWs and midwives, and is focused on reducing racial and ethnic disparities and improving health outcomes.

Maternity care homes are another high-value care model that integrate comprehensive care and show promise in reducing racial disparities in maternal health outcomes.[48] Through maternity care homes, pregnant women are paired with care coordinators who can connect them to essential perinatal health care, as well as social and community services. This model addresses the social determinants of health in order to reduce complications by providing coordinated, comprehensive, and culturally appropriate services and care, including mental health services and access to housing and food assistance.

Topic 4: Data Collection and Effective Evaluation to Improve Outcomes and Quality

Although there are numerous quality measurement initiatives, measurement remains an underused tool for reducing health disparities. We strongly support initiatives to not only measure and stratify data by race and ethnicity, but also to incentivize outcomes based on that stratified data.

Recommendation 8: Direct the HHS Center for Medicare and Medicaid Innovation (CMMI) to require the stratification and public reporting of quality measures by race and ethnicity and to implement payment incentives for the reduction of disparities in any maternity-focused model.

Data show disparities can persist despite improvements in health care quality. For example, state-level data show that some states that rank in the top quartile (that is, highest quality) for overall quality of care also rank in the bottom quartile (worst disparities) for disparities in quality of care for Black, Hispanic, and Asian people compared to whites.[49] However, implementing equity-focused measurement can accelerate reductions in health inequities. Quality measures first must be stratified by race and ethnicity at a minimum, as well as by language, disability, and other important factors. Delivery system and payment transformation efforts must directly incentivize the reduction of disparities by basing financial incentives not only on overall performance on quality measures, but directly on the reduction of existing disparities in these quality measures.[50] In addition, CMMI should prioritize innovating payment models to incentivize high-quality maternity care and continuity of coverage from pregnancy through on year postpartum.

Topic 5: Social Services Aimed at Supporting Mother and Child Wellbeing

Research shows that health outcomes are driven by an array of factors, including underlying genetics, health behaviors, social and environmental factors, and health care. We strongly support implementing interventions, like home visiting, that can broadly support women and families and reduce racial and ethnic disparities.

Recommendation 9: Make home visiting a mandatory Medicaid benefit.

Home visiting programs, which serve women and families during and after pregnancy, can promote maternal and child health by connecting mothers to postpartum medical care, mental health and substance use disorder treatment, and community-based resources; providing parenting education; and bringing clinical services into the home.[51] In addition, evidence-based home visiting programs reduce costs. Research has shown that home visiting programs reduce NICU stays and the costs associated with them and for every dollar invested in a home visiting program there is a return of up to $5.70 in savings and benefits. In turn, the success of home visiting programs ultimately saves money for states and the federal government by lowering costs for programs such as Medicaid.[52] Ultimately, Medicaid reimbursement for home visiting services would both improve health outcomes for pregnant women, babies and families, and provide meaningful cost savings to the health care system.

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We are grateful for the Committee's interest in this important issue that affects families across the country and appreciate this opportunity to provide feedback in response to your Request for Information. We welcome the opportunity to work with you in the coming days, weeks, and months as you develop policy solutions to address the maternal mortality crisis and improve maternal health. This work has never been more important. If you have any questions, please contact Kelly Murphy, Director of Early Childhood Initiatives at Families USA, at KMurphy@familiesusa.org. We look forward to partnering on this and other issues to meet the critical health needs of women and families, indeed the needs of everyone in America.

Sincerely,

Every Mother Counts
Families USA
March for Moms

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