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March 4, 2019

Via electronic submission

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education, Labor, and Pensions
Washington, DC 201510-6300

RE: Request for Information on Reducing Health Care Costs

Dear Chairman Alexander:

March of Dimes, a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers representing every state, the District of Columbia and Puerto Rico, appreciates the opportunity to comment on ways in which our nation can work to reduce health care costs while improving access and affordability of health care for all consumers. March of Dimes promotes the health of women, children and families across the life course, from birth through adolescence and the childbearing years, with an emphasis on preconception, prenatal, interconception and infant health. Ensuring that women, children and families have access to timely, affordable, and high-quality health care is essential to achieving our goals.

We applaud your efforts to identify ways to address our nation's health care costs.[1] As you seek to take a holistic look at where improvements can be made, **we would like to highlight three challenges facing maternal and child health care – *our nation's maternal mortality crisis, the rising preterm birth rate, and the opioid epidemic's impact on women and infants*.** Each of these issues – while challenging to families, providers, and policymakers – also present unique opportunities to improve health care outcomes for women and their children. We believe that, if addressed appropriately, there is the potential to translate key investments in these areas into cost savings as well as improved outcomes for patients.

As you examine the question of reducing health care costs, March of Dimes urges you to define "costs" broadly to include not only the dollars spent by the government, payers and providers, but also the financial, human, and emotional costs borne by patients, families and communities. In maternal and child health, the costs of health care can take the form of lifelong

[1] Sisko AM, et al., "National Health Expenditure Projections, 2018–27: Economic And Demographic Trends Drive Spending And Enrollment Growth," *Health Affairs*, 38, No. 3 (2019). Downloaded from HealthAffairs.org on February 26, 2019.

consequences for women, infants and families. For example, an infant born preterm may have medical conditions, special education needs, and other needs that persist for years or for their entire lives.[2] For women, the consequences of a high risk pregnancy and complications can include infertility or long-term health issues. Parents of a baby who requires weeks or months of care in the Neonatal Intensive Care Unit may experience significant mental health impacts,[3] loss of work time,[4] and the need for child care if they have other children alongside the health needs of their sick infant. Each of these represent critical costs inherent in our health care system that should be recognized as equally important to the dollars spent directly on services.

Background

Chronic Diseases Among Women of Child-bearing Age

Our nation cannot address health care costs without first understanding the prevalence of chronic disease and its impact on our health care system.[5] Six in every 10 adults in the U.S. have a chronic disease, and 4 in 10 have two or more.[6] Chronic conditions, such as high blood pressure, diabetes, heart disease, and obesity put women at higher risk of pregnancy complications.[7] According to recent CDC studies, nearly half of women are overweight or obese before they become pregnant, which is associated with a higher risk of pregnancy complications. One in four pregnancy-related deaths are related to heart conditions.[8] From 2005 to 2014, the prevalence of chronic conditions increased across all segments of the childbearing population, especially among women from rural and low-income communities and those with deliveries funded by Medicaid.[9] From 2008 to 2014, there was an increase in mental health conditions, including a 4.4% point increase in anxiety disorders.[10]

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[2] Raju, Tonse NK et al., Long-Term Healthcare Outcomes of Preterm Birth: An Executive Summary of a Conference Sponsored by the National Institutes of Health. Journal of Pediatrics, Volume 181, 309 - 318.e1

[3] Hua A et al. Comparison of PTSD Scores of NICU Parents Across Infant Gestational Age Categories, Pediatrics, Volume 141, Jan 2018.

[4] Stewart WF, Ricci JA, Chee E, Morganstein D. Lost productive work time costs from health conditions in the United States: results from the American productivity audit. J Occup Environ Med. 2003;45(12):1234-1246.

[5] Centers for Disease Control and Prevention, Health and Economic Costs of Chronic Disease. Available at: https://www.cdc.gov/chronicdisease/about/costs/index.htm

[6] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Infographic. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

[7] At A Glance 2016 Maternal Health Advancing the Health of Mothers in the 21st Century. Centers for Disease Control and Prevention, Division of Reproductive Health. Revised October 2017. Available at: https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-maternal-health.pdf

[8] Ibid.

[9] Admon, Lindsay K. MD; Winkelman, Tyler N. A. MD, MSc; Moniz, Michelle H. MD, MSc, et al.. Disparities in Chronic Conditions Among Women Hospitalized for Delivery in the United States, 2005–2014. Obstetrics & Gynecology, December 2017. Vol. 130, Issue 6 p 1319–1326. Available at: https://journals.lww.com/greenjournal/Fulltext/2017/12000/Disparities_in_Chronic_Conditions_Among_Women.19.aspx 9

[10] Multiple Chronic Conditions in the United States. Rand Corporation. Available at: http://www.fightchronicdisease.org/sites/default/files/TL221_final.pdf

The Maternal Mortality Crisis and Health Disparities

Despite the significant amount spent on maternity care in the U.S., the outcomes for our nation's mothers are poor and getting worse. An estimated 700 women die in childbirth each year.[11] [12] [13] More than 50,000 other women will experience life-threatening complications due to labor and delivery.[14] Despite the fact that many countries around the world have successfully reduced their maternal mortality rates since the 1990s, the U.S. rate is still higher than most other high-income countries,[15] [16] and it has doubled in the past 25 years.[17] A significant racial and ethnic disparity in maternal mortality exists in the U.S., with black women being three to four times more likely to die from pregnancy-related causes compared to white women.[18] [19] [20]

Preterm Birth Rates are on the Rise

In 2017, the preterm birth rate in the U.S. increased for the third year in a row, rising to 9.93% from 9.85 in 2016, a trend signaling an urgent health crisis for moms and babies. In the U.S., about 380,000 babies, or 1 in 10, are born prematurely each year.[21] Preterm delivery can happen to any pregnant woman, and often its cause is unknown. Preterm birth is the leading contributor to infant death, and those babies who survive are more likely to suffer from intellectual and physical disabilities. The U.S. preterm birth rate is among the worst of high-resource nations. Troubling racial disparities persist in our nation's preterm birth rates. The preterm birth rate among black women is 49% higher than the rate among all other women.[22]

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[11] Maternal Mortality Review Information Application. Report from Nine Maternal Mortality Review Committees. (2018). https://www.cdcfoundation.org/building-us-capacity-review-and-prevent-maternal-deaths

[12] Pregnancy-Related Deaths. Centers for Disease Control and Prevention, Division of Reproductive Health. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm

[13] For more information, see March of Dimes congressional testimony before the Energy and Commerce Health Subcommittee, September 27, 2018, available at: https://www.marchofdimes.org/materials/Stewart%20MOD%20maternal%20mortality%20testimony%20092718.pdf

[14] CDC. Severe Maternal Morbidity in the United States. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

[15] WHO. Trends in Maternal Mortality 1990-2015. Available at: http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/

[16] Creanga AA, Berg CJ, Syverson C, Seed K, Bruce FC, Callaghan WM (2015). Pregnancy-related mortality in the United States, 2006-2010. Obstet Gynecol 125(1):5-12.

[17] CDC. Pregnancy Mortality Surveillance System. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

[18] Creanga AA, Berg CJ, Syverson C, Seed K, Bruce FC, Callaghan WM. Pregnancy-related mortality in the United States, 2006-2010. Obstet Gynecol 2015;125(1):5-12. Available at: https://journals.lww.com/greenjournal/Fulltext/2015/01000/Pregnancy_Related_Mortality_in_the_United_States,.3.aspx

[19] Callaghan WM. Overview of maternal mortality in the United States. Semin Perinatol 2012; 36(1):2-6.

[20] The crisis in America's maternity wards, *Washington Post*, February 11, 2019, Available at: https://www.washingtonpost.com/health/2019/02/11/crisis-americas-maternity-wards/?utm_term=.c8a9e3468f0e

[21] March of Dimes, Premature Birth Report Cards, November 2018. Available at: https://www.marchofdimes.org/mission/prematurity-reportcard.aspx Preterm birth rates are from the National Center for Health Statistics, 2017 final natality data. Grades assigned by March of Dimes Perinatal Data Center.

[22] Ibid.

In addition to its human, emotional, and financial impact on families, preterm birth places a tremendous economic burden on our nation. A 2006 report by the National Academy of Medicine found the cost associated with preterm birth in the U.S. was $26.2 billion annually, or $51,600 per infant born preterm. Employers, private insurers and individuals bear approximately half of the costs of health care for these infants, and another 40% is paid by Medicaid.[23]

The Opioid Epidemic and Its Impact on Women and Infants

The opioid epidemic continues to exact a significant human and economic toll on the U.S. Some estimate the cost of prescription overdose, abuse and dependence to be as much as $78.5 billion each year,[24] a startling figure that does not account for the impact of illicit opioids. The opioid epidemic has highlighted our nation's shortcomings in preventing and treating substance use disorder and its consequences, especially among pregnant women. The impact on families and children is especially alarming given its ability to influence the health and well-being of multiple generations, including infants.

Infants born to mothers who used opioids during pregnancy often experience withdrawal symptoms after birth, known as neonatal abstinence syndrome (NAS). Among 28 states studied during 1999–2013, the overall incidence of NAS quadrupled from 1.5 per 1,000 hospital births in 1999, to 6.0 per 1,000 hospital births in 2013.[25] Infants can experience NAS whether a mother is using prescription opioids prescribed by her physician, receiving medication-assisted treatment, misusing opioid medications, or using illicit opioid drugs. Regardless of the reason for NAS, an infant experiencing symptoms often requires a prolonged hospital stay that leads to additional costs to the health care system, with a substantial proportion of that cost borne by state Medicaid programs. In 2012, Medicaid financed approximately 80% of the estimated $1.2 billion in NAS-related hospital charges.[26]

A mother's addiction to opioids may result in intrauterine growth retardation, premature birth and birth defects. Infants with NAS are more likely than all other hospital births to be born at low birthweight and to have respiratory complications, feeding difficulties, and seizures.[27] These health conditions are distinct from any of those suffered by the mother, and, thus, need to be addressed distinctly. The long-term consequences of such exposure to these pharmaceutical drugs in-utero for humans is largely unknown. All of these issues may result in

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[23] Preterm Birth: Causes, Consequences, and Prevention, Institute of Medicine of the National Academies, July 2006. Available at http://nationalacademies.org/hmd/reports/2006/preterm-birth-causes-consequences-and-prevention.aspx

[24] Curtis S. Florence et al. (2016). The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.Medical Care 54, no. 10 (2016): 901–6. https://www.ncbi.nlm.nih.gov/pubmed/27623005.

[25] Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802.

[26] Ibid.

[27] Hudak ML et al. Neonatal drug withdrawal. *Pediatrics*. 2012; 129(2):e540-e560 *attached hereto as Exhibit D.*

an entire generation of Americans with unexplained medical disorders and related consequences.

Recommendations for Reducing Health Care Costs

March of Dimes is pleased to offer a range of recommendations for federal policy interventions that promise to improve patient care and outcomes while also reducing costs across the health care system.

Increased Access to Maternity Care

Our nation must increase access to maternity care in in underserved areas. A recent March of Dimes' report, *Nowhere to Go: Maternity Care Deserts Across the U.S.,* revealed the unequal access to maternity care across the U.S., particularly in communities with higher poverty rates.[28] According to our findings, more than 5 million women live in maternity care deserts in 1,085 counties across the country that have no hospital offering obstetric care and no obstetric providers. An additional 10 million women live in counties with limited access to maternity care. With approximately 10% of births in counties with limited access to maternity, we must ensure women receive the quality care and support they need before, during, and after pregnancy.

In 2018, Congress took an important step in the right direction by passing the Improving Access to Maternity Care Act (P.L. 115-320). Congress should engage in oversight to ensure the energetic implementation of this law, and should explore additional opportunities to expand access to maternity and obstetric providers across the range of underserved areas and populations.

Expanded Access to Postpartum Coverage

Access to quality maternity care is a critical component of maternal health and positive birth outcomes. Medicaid covers roughly half of all births in the U.S., including many high-risk pregnancies. While the Affordable Care Act expanded the availability of maternity care coverage for women both through Exchange plans and Medicaid expansion, there remain significant limitations on coverage for postpartum care. Adequate postpartum coverage enables new mothers to obtain the services they need to ensure a full recovery and to ensure their next pregnancy, if any, can be healthy. This includes postpartum visits where their physical, emotional, and psychosocial wellbeing can be evaluated. March of Dimes supports efforts to expand Medicaid coverage of postpartum care by enacting policies to extend postpartum coverage to a full year after giving birth, rather than the current limit of 60 days that exists in many states.

Maternal Mortality Review Committees

[28] March of Dimes, "Nowhere to Go: Maternity Care Deserts Across the U.S.," 2018. Available at: https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf

Congress took an important step toward addressing the maternal mortality crisis in 2018 with the passage of the Preventing Maternal Deaths Act (P.L. 115-344), which will provide grants to states to create or improve their maternal mortality review committees (MMRCs). MMRCs are tasked with investigating maternal deaths, aggregating findings, and developing recommendations to prevent mothers from dying in the future. These state-specific recommendations are essential to preventing future deaths and other adverse outcomes women experience as a result of pregnancy, childbirth, and postpartum complications.

March of Dimes commends Congress for providing $12 million to the Centers for Disease Control and Prevention (CDC) in fiscal year (FY) 2019 to support the new grant program. March of Dimes encourages Congress to continue the investment in FY 2020 and beyond to sustain and expand the work of state MMRCs. Further, March of Dimes urges expanded funding for CDC's Perinatal Quality Collaboratives program to ensure the recommendations for state MMRCs are put into practice by providers, health systems, and public health professionals.

Perinatal Quality Collaboratives

Perinatal Quality Collaboratives (PQCs) are interdisciplinary teams of stakeholders that work to improve birth outcomes and reduce health care costs in communities and health care systems across the country.[29] PQCs help reduce preventable maternal mortality and severe maternal morbidity by promoting the adoption of best practices, such as eliminating elective deliveries before 39 weeks, adopting hospital safety bundles, and reducing c-sections among low-risk women. Improved outcomes in these areas will mean healthier moms, healthier babies, and cost savings for the entire health care system.

For example, during the period of September 2008 to March 2015, Ohio's PQC achieved an estimated cost savings of over $27,789,000 associated with a shift of 48,400 births to 39 weeks gestation or greater and a 68% decline in the rate of deliveries at less than 39 weeks gestation without a medical indication.[30] Tennessee's PQC is working on an Alliance for Innovation in Maternal Health (AIM) bundled care initiative to address maternal mortality and opioids during pregnancy.[31] These and similar efforts have tremendous potential to improve health and reduce costs with a modest investment of resources.

March of Dimes also supports the development and regular review of core "mother and infant care" quality measures that could be adopted throughout the health care system to gauge progress in improving perinatal health care quality as called for in the Quality Care for Moms and Babies Act.[32] While HHS currently has a core set of quality measures for adults and a separate one for children, there is a great need for a single, integrated core set for pregnant women and their babies.

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[29] Centers for Disease Control and Prevention, Status of State PQCs in the U.S. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html

[30] Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm#success

[31] Available at: https://tipqc.org/tennessee-aim-opioid-use-disorder/

[32] Available at: https://www.congress.gov/bill/115th-congress/senate-bill/2637

Group Prenatal Care

March of Dimes supports efforts to expand access to group prenatal care, an innovative model of prenatal care that has shown promise for improving both maternal and birth outcomes. [33] [34] Studies indicate that women in group prenatal care models are significantly less likely to have preterm births than women in standard care. Group prenatal care can also reduce rapid repeat pregnancy, or pregnancy within six months, by 50%, which is another risk factor for prematurity.[35] In Tennessee, women in March of Dimes' Supportive Pregnancy Care group prenatal care model were more likely to attend their postpartum visit and breastfeed, and less likely to utilize an emergency department during pregnancy.[36] In South Carolina, a CenteringPregnancy program led to improved birth outcomes for Medicaid eligible women, including reduced risk of prematurity, low-birth weight infants, and neonatal intensive care unit (NICU) stays with savings of nearly $457,842 per year from just one facility.[37]

March of Dimes strongly supports enhanced payment models to make group prenatal care more accessible. While group prenatal care has numerous benefits, the cost to implement a group prenatal care model in medical practices may be a barrier to implementation. Many programs rely on grant funding or state or federal resources to implement them. In states where implementation has been successful, the state Medicaid agency and Medicaid managed care organizations (MCOs) worked together to implement enhanced reimbursement regardless of payer, which contributed to stability and uptake among providers.

An enhanced reimbursement model encourages clinicians to adopt group prenatal care with the reassurance that their upfront implementation costs will be recovered, resulting in more care options for patients. Under this model, certified group prenatal care providers are reimbursed per patient, per visit, and are further incentivized when patients complete a series of visits. The state's Medicaid program, Medicaid MCOs, or commercial payers are responsible for accepting reporting and billing per visit to ensure payments.

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[33] Crockett, Amy et al., "Investing in CenteringPregnancy™ Group Prenatal Care Reduces Newborn Hospitalization Costs," *Women's Health Issues*, Volume 27, Issue 1, 60 – 66. Available at: https://www.whijournal.com/article/S1049-3867(16)30191-8/fulltext

[34] Zorrilla CD, Mosquera A, Silvia RD, Rivera-Viñas JI, Vega DIS et al. (2017) Cost Savings Related to Decreased Preterm Birth in a Program of Centering Pregnancy for Hispanic Women. *MOJ Womens Health* 5(1): 00108. DOI: 10.15406/mojwh.2017.05.00108. Available at: https://www.academia.edu/36821648/Cost_Savings_Related_to_Decreased_Preterm_Birth_in_a_Program_of_Centering_Pregnancy_for_Hispanic_Women

[35] Ickovics, J. R., Earnshaw, V., Lewis, J. B., Kershaw, T. S., Magriples, U., Stasko, E., Rising, S. S., Cassells, A., Cunningham, S., Bernstein, P., … Tobin, J. N. (2015). Cluster Randomized Controlled Trial of Group Prenatal Care: Perinatal Outcomes Among Adolescents in New York City Health Centers. *American journal of public health*, 106(2), 359-65.

[36] March of Dimes, unpublished evaluation study data.

[37] Gareau, S., Lòpez-De Fede, A., Loudermilk, B.L. et al., "Group Prenatal Care Results in Medicaid Savings with Better Outcomes: A Propensity Score Analysis of CenteringPregnancy Participation in South Carolina," *Matern Child Health J* (2016) 20: 1384. https://doi.org/10.1007/s10995-016-1935-y

March of Dimes also supports outcomes-based incentives for delivery of group prenatal care. This model of reimbursement uses incentive payments for certified providers who achieve any of the primary maternal and neonatal outcome measures for women, such as avoiding low birthweight and preterm births. Providers may also be able to receive additional incentive payments for meaningful achievements in secondary outcomes, such as smoking cessation or other appropriate measures.

Midwifery Care

March of Dimes has long supported increased access to midwifery care practiced by Certified Nurse Midwives (CNMs) and Certified Midwives (CMs), as part of a team-based system of care in the U.S. Many studies have found that women who received midwifery care were more likely to experience a low-intervention, spontaneous vaginal birth, more likely to be satisfied with their care, and less likely to have a first c-section (when compared to physician care for equally low-risk women),[38] [39] [40] thereby improving outcomes for subsequent births. Midwifery care also has a cost saving effect compared to other care models.[41] [42] Safely reducing primary c-sections can play a role in reducing maternal morbidity in initial and future pregnancies.

March of Dimes supports efforts to expand access to the services of CNMs/CMs and further integrate them into maternity care in all states. Expanded access to midwifery services has the potential to improve access to obstetric providers in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity in current and future pregnancies, lower costs, and improve the health of mothers and babies.

Doula Care

March of Dimes supports increasing access to doulas as a valuable supplement to appropriate medical care during pregnancy, childbirth, and postpartum recovery.[43] Doulas are non-clinical professionals who provide physical, emotional, and informational support to mothers before, during, and after childbirth, including continuous labor support. Studies suggest that increased access to doula care, especially in underserved communities, may improve birth outcomes,

[38] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2016 Apr 28;4:CD004667)
[39] ACNM. Midwifery: Evidence-Based Practice. Available at: www.midwife.org.
[40] Rosenstein MG, Nijagal M, Nakagawa S, Gregorich SE, Kuppermann M. The Association of Expanded Access to a Collaborative Midwifery and Laborist Model With Cesarean Delivery Rates. Obstet Gynecol 2015 Oct;126(4):716-23.
[41] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2016 Apr 28;4:CD004667)
[42] Vedam S, Stoll K, MacDorman M, et al. Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLoS One 2018;13(2):e0192523)
[43] March of Dimes Position Statement Doulas and Birth Outcomes, January 30, 2019. Available at: https://www.marchofdimes.org/materials/Doulas%20and%20birth%20outcomes%20position%20statement%20final%20January%2030%20PM.pdf

enhance the experience of care, and lower costs.[44] For example, access to doulas can reduce c-sections, which can play a role in reducing maternal morbidity in initial and future pregnancies.

Despite the growing body of evidence on the utility of doula care, only four states covered doula care under their Medicaid programs based on an April 2017 survey.[45] March of Dimes encourages the Committee to explore ways to enhance coverage for doula services under the full range of private and public insurance programs with payment levels sufficient to support the care provided.

Access to 17P

March of Dimes supports improving the availability and access to alpha-hydroxyprogesterone caproate (17P), when clinically appropriate, to help prevent preterm births. The hormone progesterone plays multiple roles in maintaining a healthy pregnancy. Studies have shown that for some women, treatment with progesterone can prevent either a first or subsequent preterm birth. 17P is a synthetic form of progesterone that has been shown to reduce the recurrence of preterm birth for women with a history of previous preterm birth. Women who have had a premature birth in the past are more likely to have a premature birth again. For these women, progesterone treatment increases the likelihood of having a full term baby in the next pregnancy by 33%.[46]

States have had success in increasing access to 17P through collaborative efforts with health plans to promote appropriate progesterone use to reduce preterm birth risk. For example, Louisiana linked to Medicaid data to help identify eligible women with a previous preterm birth for 17P treatment and created a pay-for-performance measure for Medicaid plans to improve 17P access.[47] The Puerto Rico Department of Health instituted a comprehensive 17P access program that sends nurses to administer 17P injections to eligible women, which contributed to a sizable reduction in the island's preterm birth rate.[48] Through provider education and streamlined ordering – such as removing preauthorization requirements for any type of progesterone and managed care plans offering home administration of 17P – barriers have been reduced and maternal and child health outcomes have improved.

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[44] Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev 2013 Jul 15;7:CD003766.

[45] Kaiser Family Foundation, Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey, April 27, 2017. Available at: https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/

[46] UNC Center for Maternal & Infant Health, "Preventing preterm birth: Progesterone treatment (17P) important information you need to know." Available at http://mombaby.org/PDF/17P%20Factsheet.pdf. Accessed 1-21-2014.

[47] State Story: Louisiana Public Health and Medicaid Team Up to Increase 17P Access and Reduce Preterm Birth Rate, Association of State and Territorial Health Officials, 2015. Available at: http://www.astho.org/Maternal-and-Child-Health/Louisiana-Public-Health-and-Medicaid-Team-Up-to-Increase-17P-Access-and-Reduce-Preterm-Birth-Rate/

[48] State Story: Public-Private Partnership in Puerto Rico Leads to Increased Access to 17P and a Lower Preterm Birth Rate. Association of State and Territorial Health Officials, 2016. Available at: http://www.astho.org/Programs/Maternal-and-Child-Health/Documents/Public-Private-Partnership-in-Puerto-Rico-Leads-to-Increased-Access-to-17P-and-a-Lower-Preterm-Birth-Rate/.

Expanded Use of Telemedicine

March of Dimes encourages the Committee to explore ways to increase the utilization of technology and telemedicine that could improve access to women's health, perinatal, and obstetric services. While there remains great variation in the extent of telemedicine use in the states and how it is being reimbursed,[49] we believe expanding on telemedicine services to supplement in-office care holds great promise for improving access to women's health and perinatal services, especially in underserved rural communities, where patients must often travel long distances for follow-up visits.[50] It is here that telemedicine can achieve savings for patients in accessing care. For example, telemedicine can be effectively utilized in providing postpartum care such managing medications, discussing lab results, and monitoring for postpartum depression[51] and gestational diabetes.

Maternal Opioid Use and Neonatal Abstinence Syndrome (NAS)

Congress already has a roadmap to address the maternal and child health aspects of the urgent and costly opioids epidemic. The Department of Health and Human Services (HHS) developed the Protecting Our Infants Act: Final Strategy (the Strategy) to satisfy its mandate under the 2015 law (P.L. 114-91). The Strategy outlines more than 40 recommendations to guide HHS in responding to maternal opioid use and NAS. In 2017, the Government Accountability Office (GAO) released a report entitled, "Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome." The GAO's only recommendation was, "HHS should expeditiously develop a plan for implementing the recommendations included in its strategy related to addressing NAS." In 2018, Congress responded to that recommendation by requiring HHS to submit a report to the Committee on its effort to implement the Strategy as part of the SUPPORT for Patients and Communities Act (P.L. 115-271). Unfortunately, HHS has not yet released that report. March of Dimes encourages the Committee to engage in active oversight with HHS to submit its report and to continue efforts to implement the recommendations included in the Strategy.

Each recommendation in the Strategy is essential to holistically address maternal opioid use and NAS; however, we would like to highlight two important recommendations for the Committee. First, the Committee should work with federal agencies on strategies to improve public health surveillance of NAS. A recent article in the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report,* informed by activities directed by March of Dimes in partnership with CDC, found that current surveillance methods to determine

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[49] State Telehealth Laws and Reimbursement Policies, Center for Connected Health Care Policy, The National Telehealth Policy Resource Center, Fall 2018. Available at: https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf

[50] Marsa L., "Labor pains: The OB-GYN shortage," special to *AAMCNews*, November 16, 2018. https://news.aamc.org/patient-care/article/labor-pains-obgyn-shortage/

[51] BenDavid D., Hunker D, Spadaro K, "Uncovering the Golden Veil: Applying the Evidence for Telephone Screening to Detect Early Postpartum Depression," The Journal of Perinatal Education, 25(1), 37–45. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4719105/pdf/JPE_Vol025-001_A6_037-045.pdf

the number of infants born with NAS are deficient.[52] In order to effectively address NAS, we must first understand the scope of NAS and measure its impact. Effective public health surveillance will allow policymakers to target resources appropriately to improve outcomes for infants born with NAS.[53]

Second, the Committee should support and encourage states to expand Medicaid coverage for women to a full year after pregnancy, particularly for women with substance use disorder (SUD). The postpartum period is a critical time to maintain appropriate treatment or intervene to help a women with SUD. While the months after pregnancy are a time when new mothers are vulnerable to continued drug use or relapse,[54] they are also a time when many women are highly motivated to establish a healthy lifestyle. Ensuring that postpartum women can access SUD treatment by extending Medicaid coverage postpartum will promote the health and wellbeing of mothers, infants and families impacted by the opioid crisis. As you are likely aware, Missouri policymakers passed legislation in 2018 expanding postpartum coverage for women with substance use disorder to one year, and other states are considering postpartum Medicaid expansion as well.

Health Care Cost Transparency

Finally, March of Dimes urges the Committee to consider ways it can improve consumers' access to meaningful and actionable information about health care costs. We are encouraged that Congress and the Centers for Medicare and Medicaid Services (CMS) are considering a variety of approaches to empower consumers to make more informed decisions about their health care. We support efforts to require all insurers to disclose health cost information to consumers in a user-friendly format that can be easily understood, such as the Affordable Care Act's Summary of Benefits and Coverage, which includes pregnancy and childbirth as one of the two standard examples.

Any attempt to address transparency within our health care system should be grounded in the consumer experience. This information could include a consumer's anticipated costs for services within a certain timeframe, and the anticipated cost for common services and coverage scenarios. However, attempts to address transparency must also take into consideration patients' or consumers' ability to act on this information. Narrow networks and other factors, may limit the ability for patients to select certain providers or take other steps that would help reduce costs.

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[52] Lind JN, Ailes EC, Alter CC, et al. (2019). Leveraging Existing Birth Defects Surveillance Infrastructure to Build Neonatal Abstinence Syndrome Surveillance Systems — Illinois, New Mexico, and Vermont, 2015–2016. MMWR Morb Mortal Wkly Rep 2019;68:177–180. http://dx.doi.org/10.15585/mmwr.mm6807a3.

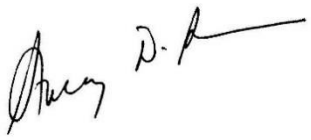
[53] Margaret A. Honein, Coleen Boyle and Robert R. Redfield. Public Health Surveillance of Prenatal Opioid Exposure in Mothers and Infants. *Pediatrics* 2019;143; DOI: 10.1542/peds.2018-3801 originally published online January 17, 2019. Available at: http://pediatrics.aappublications.org/content/143/3/e20183801

[54] Ariadna Forray et al. (2015) Perinatal substance use: a prospective evaluation of abstinence and relapse. Drug and Alcohol Dependence 150:147- 155. https://doi.org/10.1016/j.drugalcdep.2015.02.027.

In particular, March of Dimes supports ensuring that insurers provide consumers with access to an out-of-pocket cost calculator for covered services for both in and out-of-network providers, which would assist them in making decisions and help them shop for the most affordable services from the providers that are right for them. We also support increasing the transparency of claims data, so that health policy analysts can compare the number of denials for services in Marketplace plans compared to employer-based plans.[55] This analysis will be critical as we seek to guarantee that insurers are covering all Essential Health Benefits and are not denying coverage for these critical benefits in a systematic way under their plans. We look forward to working with the Committee to both improve the patient experience and decision-making process in addition to improving understanding about how health plans and providers are handling claims.

Once again, March of Dimes appreciates the opportunity to offer recommendations on ways our nation can reduce health care costs while improving access, affordability and health outcomes for all women, children and families. If we can provide further information or otherwise be of assistance, please contact KJ Hertz, Director of Federal Affairs at khertz@marchofdimes.org or 202-659-1800.

Sincerely,



Stacey D. Stewart
President

[55] Pollitz K, Cox C, Fehr R. Kaiser Family Foundation, Claims Denials and Appeals in ACA Marketplace Plans, Feb 25, 2019. Available at: https://www.kff.org/health-reform/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/?utm_campaign=KFF-2019-February-Health-Reform-Marketplace-Plans-Denial-Rates&utm_source=hs_email&utm_medium=email&utm_content=70230987&_hsenc=p2ANqtz-8cJiWGCGZSkF6HGbqe9txTIRS2uoy6wZMCSaxXO5-JVLLePOuukRORORFyowSfhulokG63sS8aT_7um4Sxm4rxsFtH_nA&_hsmi=70230987