MARCH OF DIMES

OFFICE OF GOVERNMENT AFFAIRS

T (202) 659-1800
E advocacy@marchofdimes.org
MARCHOFDIMES.ORG

April 6, 2020

Via electronic submission

The Honorable Charles Grassley
Chairman
Senate Committee on Finance
Washington, DC 201510-6200

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
Washington, DC 201510-6200

RE: Request for Information on Improving Maternal Health Outcomes

Dear Chairman Grassley and Ranking Member Wyden:

On behalf of March of Dimes, the leading non-profit organization fighting for the health of all moms and babies, thank you for the opportunity to submit information on ways to improve maternal health outcomes across the nation. 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, infants and families have access to quality care is essential to achieving our goals.

THE NATION'S MATERNAL AND INFANT HEALTH CRISIS

Virtually every measure of the health of pregnant women, new mothers, and infants living in the United States is going in the wrong direction. In 2018, the nation's preterm birth rate rose for the fourth year in a row.[i] In many communities, infant mortality rates exceed those in developing nations.[ii] Approximately every 12 hours, a woman dies due to pregnancy-related complications.[iii] This has led to an urgent crisis that demands a comprehensive response by policymakers at every level of government.

Maternal Health

An estimated 700 women die from complications related to pregnancy each year.[iv,v,vi] More than 50,000 other women experience life-threatening complications due to labor and delivery.[vii] 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, and it has doubled in the past 25 years. [viii,ix,x]

The threat of maternal mortality and morbidity is especially acute for women of color. Black mothers of all ages are three times more likely to die from pregnancy-related complications than their white peers.[xi] The rates of pregnancy-related death for Black and American Indian/Alaska Native women over the age of thirty are four to five times higher than their white

peers.[xii] Black women are 27 percent more likely to experience severe pregnancy complications than white women.[xiii] These disparities cannot be explained by differences in age or education. According to the latest data from the Centers for Disease Control and Prevention (CDC), maternal mortality rates among Black women with a completed college education or higher was 1.6 times that of white women with less than a high school diploma.[xiv]

Maternal mortality is also significantly higher in rural areas, where obstetrical providers may not be available,[xv] and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage.[xvi] In October 2018, March of Dimes released a report showing that 5 million women live in "maternity care deserts," which are communities without a hospital offering obstetric services or providers.[xvii] Each year, 150,000 babies are born to mothers living in maternity care deserts.[xviii]

Preterm Birth

The health of our nation's infants health mirrors that of their mothers. Health outcomes are getting worse and those worsening outcomes are driven by disparities. In 2018, the preterm birth rate in the United States increased for the four year in a row, rising to 10.02 percent from 9.63 percent 2015, a trend signaling an urgent health crisis for moms and babies. In the United States, about 380,000 babies, or 1 in 10, are born prematurely each year.[xix] 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 percent higher than the rate among all other women.[xx]

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 percent is paid by Medicaid.[xxi]

POLICY RECOMMENDATIONS TO IMPROVE MATERNAL HEALTH

March of Dimes is pleased to offer a range of policy recommendations that could lead to improved health outcomes for mothers and, by extension, their babies. These recommendations focus on improving access to care, improving the quality of maternity care, and addressing social determinants of health.

<u>Access to Care</u>

March of Dimes recognizes that ensuring access to continuous care for women before, during, and in the months following pregnancy is critical to addressing our nation's growing rates of maternal mortality and severe maternal morbidity. To achieve this, policymakers must expand access to health insurance coverage, address workforce issues, and improve access to telehealth.

Extending Postpartum Medicaid Coverage

Access to quality maternity care is a critical component of maternal health and positive birth outcomes. Uninsured mothers and newborns are more likely to have poor birth outcomes than moms and babies with insurance coverage.[xxii]

Medicaid covers roughly half of all births in the United States, and women with Medicaid coverage are more likely to have had a prior preterm birth, low birthweight baby, and experience certain chronic conditions (e.g., diabetes) – putting them at higher risk of maternal morbidity and mortality.[xxiii] While the Affordable Care Act expanded the availability of maternity care coverage for women through Exchange plans and Medicaid expansion, there remain significant limitations on coverage for postpartum care. For many new moms across the country, Medicaid's pregnancy coverage lapses 60 days after birth, ending at a critical time for the health of new moms. Studies show that that approximately 55 percent of women covered by Medicaid for their delivery were uninsured at some point in the following six months.[xxiv] Too many new moms are losing coverage at a critical time. The data show that approximately 30 percent of pregnancy-related deaths – not counting those that were caused by suicide or overdose – occur 43 to 365 days postpartum.[xxv] State analyses of pregnancy-associated deaths, which include behavioral health-related causes, often find that 50 percent or more of deaths occur beyond the 60-day period.[xxvi]

March of Dimes supports efforts to extend Medicaid's postpartum coverage to a full year after giving birth, rather than the current limit of 60 days that exists in many states.

Facilitating access to midwifery services

Certified nurse midwives (CNMs), certified midwives (CMs) or midwives whose education and licensure meets the International Confederation of Midwives (ICM) Global Standards for Midwifery Education all provide a full range of primary health care services for women, including gynecologic and family planning services; preconception care; and care during pregnancy, childbirth and the postpartum period.[xxvii,xxviii] Higher rates of maternal mortality and morbidity and other adverse birth outcomes among women of color, and black women in particular, have prompted interest in models of care that can improve outcomes including midwifery and specific evidence-based supportive and preventive care programs developed and led by midwives.[xxix] March of Dimes supports efforts to increase the number of midwives of color and diversify the maternity care workforce with individuals who represent the lived and cultural experiences of the patients they serve. [xxx]

Promoting Doula Services

As non-clinical professionals who provide physical, emotional and informational support to mothers before, during and after childbirth, doulas also provide continuous labor support.[xxxi] A 2017 Cochrane review of 26 trials of continuous labor support and doula care involving over 15,000 women in 17 different countries in high and middle-income settings found some improved outcomes for women and infants including: "increased spontaneous vaginal birth, shorter duration of labor, and decreased caesarean birth, instrumental vaginal birth, use of any

analgesia, use of regional analgesia, low five-minute Apgar score and negative feelings about childbirth experiences. We found no evidence of harms of continuous labour support."[xxxii] Increasing access to doula care, especially in under-resourced communities may improve birth outcomes; improve the experience of care, and lower costs by reducing non-beneficial and unwanted medical interventions. Studies suggest doula access can decrease maternal anxiety and depression and help improve communication between low-income, racially and ethnically diverse pregnant women and their healthcare providers. March of Dimes supports Medicaid and other payers providing coverage for doulas services as one tool to help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States.

Telehealth

March of Dimes supports increasing access to telehealth services for pregnant and postpartum women. Telehealth is increasingly used across a range of health care specialties, including obstetrics, maternal-fetal medicine, and mental health.[xxxiii] There is reason to focus specifically on telehealth in maternity care, as in recent years, telehealth has been incorporated into many aspects of women's health care, including: virtual patient consultation with specialists, remote observation of ultrasound recordings by maternal-fetal medicine experts, postpartum blood pressure monitoring using Wi-Fi connected devices, and fertility tracking with patient-generated data.[xxxiv] Additionally, a robust and growing body of evidence shows largely positive outcomes associated with the provision of telehealth services in maternity care.

Evidence on a range of services and telehealth domains suggests telehealth services provide comparable outcomes to traditional methods of healthcare delivery. A 2020 systematic review of telehealth interventions in the journal *Obstetrics & Gynecology* found that that a number of telehealth interventions were associated with outcomes known to improve the health of moms and babies. In particular, telehealth interventions were associated with improvements in obstetric outcomes related to perinatal smoking cessation and breastfeeding.[iii]

Maternal Immunization

A critical component of prenatal care is delivery of recommended vaccines to expecting mothers as some vaccine-preventable diseases can pose a serious risk to the health of a pregnant woman and that of her unborn baby. Further, a pregnant woman can pass on antibodies to vaccine-preventable diseases, which helps protect babies until they receive their recommended immunizations.

Currently, there are two vaccines recommended during pregnancy: influenza and Tdap. Unfortunately, coverage with Tdap and influenza vaccines during pregnancy has been low, with approximately one half of women receiving each vaccine and only one third receiving both.[xxxv] While there are a number of factors that influence our nation's low maternal immunization rate, there are steps policymakers can take to increase coverage, including:

- **Eliminate cost-sharing for maternal immunizations**: Recent studies have shown that cost-sharing requirements can decrease vaccination rates among pregnant women.[xxxvi]

March of Dimes strongly urges policymakers to require all state Medicaid plans to cover all maternal immunization recommended by the Advisory Committee on Immunization Practices with no cost-sharing. Additionally, Congress should commission a study on coverage and access to maternal immunization services for pregnant and postpartum women in the Medicaid program.

- **Improve provider billing for maternal immunization services:** Maternal care providers face unique barriers to administering vaccines to the patients they serve, including reimbursement challenges and difficulties in stocking vaccines in their offices. Congress should direct the Department of Health and Human Services, in coordination with the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration to develop a plan and proposed budget to facilitate billing, coding and payment for maternal immunizations, as well as make recommendations to address challenges around vaccine purchase, storage and handling for maternal care providers.

<u>Improving Quality of Care</u>

Despite the significant amount spent on maternity care in the United States, the outcomes for our nation's mothers are poor and getting worse. Policymakers must focus reform efforts on ensuring that care is delivered in a way that optimizes maternal health outcomes.

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. [xxxvii, xxxviii] Studies indicate that women in group prenatal care models are significantly less likely to have preterm births than women receiving standard care. Group prenatal care can also reduce rapid repeat pregnancy, or pregnancy within six months, by 50 percent, which is another risk factor for prematurity.[xxxix]

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 or Medicaid MCOs are responsible for accepting reporting and billing per visit to ensure payments.

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.

Quality Care for Moms and Babies Act
Clinical quality measures are tools for assessing observation, treatment, processes, experiences, and/or outcomes of patient care. They are used by public and private payers, as well as providers like hospital systems, to help improve health care and achieve better outcomes. Quality measures reflect how well a health care system is performing in a certain field at any given time, promote the adoption of best practices, and identify areas of care that need improvement. Existing quality measures for maternity and newborn care are not widely used or reported.

March of Dimes 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* (S. 1960).[xl] This legislation ensures funding for maternity and infant care quality collaboratives focused on improving the care and creates a core set of maternal and infant healthy measures to better track the quality of care delivered to pregnant women and infants throughout the country.

Implicit Bias Training for Maternal Care Providers
March of Dimes strongly supports implicit bias training for healthcare professionals providing maternal care. Implicit bias refers to the unconscious attitudes and beliefs that influence understanding, decisions and behaviors towards people based on certain characteristics, such as race, gender, ethnicity, religion, sexuality, etc. Although every person across society has unconscious bias, unchecked negative biases and stereotypes can foster misplaced narratives about a patient's background or a group of patients, and contribute to poor decision-making. Knowledge and behavior change are the first steps to ensuring better patient-provider communication and improving the quality of care, which can help narrow gaps in maternal and infant outcomes. A recent study showed nearly half of all providers practicing in obstetrics and gynecology admit to having some bias. [xli] Implicit bias trainings for healthcare providers could work to mitigate adverse health experiences across every care delivery setting to create and sustain a culture of equity within health care institutions and improve birth outcomes.

Maternal Mental Health Screenings
March of Dimes supports measures to help identify and treat maternal mental health disorders, including universal screening and treatment, education and surveillance. We are supportive of the *Moms MATTER Act of 2020* (H.R.6143), which establishes a Maternal Mental and Behavioral Health Task Force to improve mental and behavioral health outcomes for women throughout pregnancy and up to one year postpartum, and appropriates support over five years for innovative approaches to improve maternal health, including group prenatal and postpartum group care models.[xlii] Mental health screenings are critical components to identifying and

treating maternal mental health disorders. Depression and maternal stress screenings can be incorporated into well-woman visits, prenatal appointments, well-child visits and during postpartum check-ups, which can be administered by OBGYNs, pediatricians, and family physicians. Some Neonatal Intensive Care Units have incorporated screening of parents for PTSD into their protocols. Symptoms of postpartum mood disorders are sometimes misattributed to normal pregnancy changes, and go under- or unreported. It is important that providers and the public are educated to recognize maternal mental mood disorder symptoms. Finally, adequate funding to support services tracking maternal mental health disorders are needed to support research and treatment initiatives for mothers suffering from maternal mental health disorders.

<u>Addressing Social Determinants of Health</u>

While access to health insurance and quality health care services is essential to promoting healthy pregnancies and healthy infants, we cannot address the nation's maternal and infant health crisis by focusing exclusively on doctor's offices and hospitals. We must also address barriers to health in our communities and neighborhoods. Increasing access to voluntary home visiting is a proven tool to improve health for moms and babies. Home visiting can improve maternal health outcomes by:

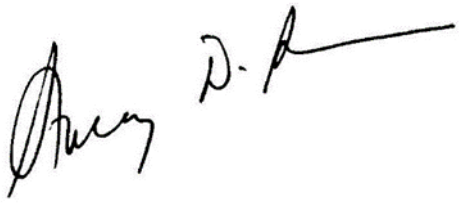
- Reducing pregnancy induced hypertensive disorders, pre-term birth, and maternal depression;
- Facilitating connections and breaking down barriers between mothers and health practitioners in the community;
- Providing screening for maternal depression in the prenatal and postnatal period;
- Providing referrals for mothers when certain risk factors, including trauma or domestic violence, are present in the home; and
- Addressing the social determinants of health affecting families, such as social supports, parental stress, access to health care, income and poverty status, and environmental conditions.

Because of the positive impact of home visiting on families served, March of Dimes is proud to support the *Home Visiting to Reduce Maternal Mortality and Morbidity Act* (H.R. 4768). This legislation would double Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) funding from $400 million to $800 million over two years and double the tribal set-aside from 3 percent to 6 percent. This increase in funding will allow MIECHV's evidence-based programs to reach more families. Currently, the program is only able to serve approximately 150,000 of the 18 million families that could benefit from home visiting. March of Dimes strongly urges Congress to advance legislation that will increase funding for home visiting services.

Once again, March of Dimes appreciates the opportunity to offer both information and recommendations on ways our nation can improve maternal health outcomes. If we can

provide further information or otherwise be of assistance, please contact KJ Hertz, Director, Federal Affairs at khertz@marchofdimes.org or 571.969.8655.

Sincerely,



Stacey D. Stewart
President & CEO

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