November 12, 2019

The Honorable Anna Eshoo
Chairwoman
House Energy and Commerce Committee
Health Subcommittee
Washington, D.C. 20510

The Honorable Michael Burgess, M.D.
Ranking Member
House Energy and Commerce Committee
Health Subcommittee
Washington, D.C. 20510

Dear Chairwoman Eshoo and Ranking Member Burgess:

The undersigned organizations dedicated to improving maternal and child health, write to express our strong support for the *Maternal Health Quality Improvement Act* (H.R. 4995) and the *Helping Medicaid Offer Maternity Services Act* (H.R. 4996). We are grateful for your leadership and dedication to addressing the maternal mortality crisis in our country. These bills include critical next steps to build on Congress' previous work to prevent maternal deaths and improve maternal health outcomes.

Unlike every other industrialized country, maternal deaths in the United States are on the rise. From 2000 to 2014, the United States' maternal mortality ratio increased by 26.6%, from 18.8 maternal deaths per 100,000 live births in 2000 to 23.8 maternal deaths per 100,000 live births in 2014.[1] Each year, an estimated 700 women in the United States die as a result of pregnancy or pregnancy-related complications.[2] Of these maternal deaths, an estimated 60 percent are preventable.[3] Stark racial disparities in maternal health outcomes persist; Black and American Indian/Alaska Native women are roughly three times as likely to die from pregnancy-related causes as white women in the United States.[4]

With your leadership, the 115th Congress passed two important bills to address the rising rates of maternal mortality, H.R. 1318, P.L. 115-344, the *Preventing Maternal Deaths Act* and H.R. 315, P.L. 115-320, the *Improving Access to Maternity Care Act*. However, fully addressing the maternal mortality crisis, reducing severe maternal morbidities, and eliminating disparities in maternal health outcomes requires additional action and continued Congressional commitment. The *Maternal Health Quality Improvement Act* and the *Helping Medicaid Offer Maternity*

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[1] Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. MacDorman MF, Declercq E, Cabral H, Morton C. *Obstet Gynecol*. 2016;128(3):447–455. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/

[2] Pregnancy-related deaths. Atlanta, GA: US Department of Health and Human Services, CDC; 2019. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm

[3] Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Washington, DC: Review to Action; 2018. http://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdfpdf icon

[4] Vital Signs: Pregnancy-Related Deaths, United States Petersen EE, Davis NL, Goodman D, et al. , 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w

Services Act are critical next steps for the 116th Congress to build upon its previous work in addressing maternal mortality by:

Authorizing the Alliance for Innovation on Maternal Health (AIM) program, to help ensure implementation of best practices and eliminate preventable maternal mortality and severe maternal morbidity for every U.S. birth. The *Maternal Health Quality Improvement Act* would authorize the AIM program, an initiative of the Health Resources Services Administration (HRSA), and provide support to advance evidence-based practices to improve the quality and safety of maternity care throughout the care continuum.

Addressing racial and ethnic health disparities through implicit bias training and increasing the provision of culturally competent care. Research suggests that stereotyping and implicit bias on the part of health care providers can contribute to racial and ethnic disparities in health outcomes.[5] Providing support for training programs to eliminate and prevent discrimination in the provision of health care services can combat implicit biases and improve cultural competency in provider-patient communications and the provision of care.

Supporting state-based perinatal quality collaboratives working with providers, hospitals, and public health officials to implement best practices. With the *Preventing Maternal Deaths Act,* Congress made a significant commitment to discovering the drivers of maternal mortality and identifying opportunities to prevent future tragedies. However, the investment in state Maternal Mortality Review Committees (MMRCs) is only beneficial if the data gathered leads to meaningful and timely action. Perinatal quality collaboratives (PQCs) – networks of health care providers, systems, public health professionals and other stakeholders – translate MMRC recommendations into policy and health care practice changes that will save women's lives. For years, state-based PQCs have improved health outcomes for women and infants and lowered health care costs. For example, from 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.[6] Appropriately resourced, PQCs can provide the network and infrastructure to facilitate system-wide implementation of MMRC recommendations.

Improving access to obstetric care in rural areas through the creation of rural obstetric network grants, enhanced data collection, and telehealth programs. Women living in rural areas have less health care access and experience poorer health outcomes than women living in urban areas,[7] a trend exacerbated by the rapid rate of rural hospital closures and shuttering of obstetric units. Establishing rural obstetric networks, training providers in rural communities, and

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[5] Racial and ethnic disparities in obstetrics and gynecology. Committee Opinion No. 649. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e130–4. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Racial-and-Ethnic-Disparities-in-Obstetrics-and-Gynecology

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

[7] Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:384–8.

expanding access to telehealth services will help close the access gap for the approximately 500,000 women who give birth each year in rural hospitals. [8]

Allowing states the option to extend continuous Medicaid or CHIP eligibility for women for one year postpartum. Medicaid is the largest single payer of maternity care in the U.S., covering 42.6% of births.[9] However, Medicaid pregnancy coverage ends roughly 60-days postpartum. As many MMRCs have found, and the Centers for Disease Control and Prevention has confirmed, about 33% of pregnancy-related deaths occur during the time between 7 days to one year following childbirth, and greater than one third of those deaths occurred 43-365 days postpartum.[10] Deaths from preventable causes, including overdose and suicide, occur more frequently during this 12-month postpartum period.[11] Closing this critical gap in coverage during this vulnerable time can mean the difference between life and death for many mothers. The Helping Medicaid Offer Maternity Services Act represents a positive step forward, and we encourage Congress to continue to look for ways to close the postpartum coverage gap for all women in every state Medicaid program.

We appreciate your continued commitment to addressing our nation's maternal mortality crisis. The *Maternal Health Quality Improvement Act* and the *Helping Medicaid Offer Maternity Services Act* would create important policies to improve maternal health care and eliminate disparities in maternal health outcomes. We thank you for your leadership and urge passage of this critical legislation.

Sincerely,

American College of Obstetricians and Gynecologists
Association of Maternal and Child Health Programs
March of Dimes
Preeclampsia Foundation
Society for Maternal-Fetal Medicine

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[8] *As Rural Hospitals Struggle, Some Opt To Close Labor And Delivery Units.* Andrews, M. Kaiser Health News (2016, February 23). Retrieved from https://khn.org/news/as-rural-hospitals-struggle-some-opt-to-close-labor-and-delivery-units/

[9] *Births: Final Data for 2016*. National vital statistics reports; Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. (2018, January 31) vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

[10] *Vital Signs:* Pregnancy-Related Deaths, United States. Petersen EE, Davis NL, Goodman D, et al., 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: http://dx.doi.org/10.15585/mmwr.mm6818e1.

[11] *For Addicted Women, the Year After Childbirth Is the Deadliest.* Vestal, Christine. (2018, August 14) Pew Stateline. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-isthe-deadliest.