

## **Federal Public Policy and Legislative Solutions for Improving Maternal Health**

Maternal health is a top priority for the AHA and our member hospitals and health systems, and our initial efforts are aimed at eliminating maternal mortality and reducing severe morbidity. As hospitals work to improve health outcomes, we are redoubling our efforts to improve maternal health across the continuum of care and reaching out to community partners to aid in this important effort. The AHA continues to support a strong federal response to the current COVID-19 pandemic. Vulnerable populations, such as pregnant women, should remain a key priority in our concerted effort to address this health care crisis.

The causes of maternal mortality and morbidity are complex, including lack of consistent access to comprehensive care and persistent racial disparities in health and health care. To help improve maternal health, we support the federal public policy and legislative actions discussed below.

### **Initiatives and Accreditation**

At the federal level, a number of legislative initiatives specific to maternal mortality have been introduced. The AHA supported legislation enacted in 2018, the Preventing Maternal Deaths Act, which provides funding through the Centers for Disease Control and Prevention (CDC) for states and other entities to develop maternal mortality review committees (MMRCs). While some states and cities already have established MMRCs, participation by all states will allow for the collection of additional data that will aid in better understanding the causes of maternal mortality and ways to improve treatment. The CDC is awarding more than \$45 million over five years to support MMRCs through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality program. This investment will provide about \$9 million a year to 24 recipients representing 25 states.

Regarding legislation introduced in the 116<sup>th</sup> Congress, AHA supports provisions of the Mothers and Offspring Mortality and Morbidity Awareness Act (S. 916/H.R. 1897) that would improve state maternal mortality data, provide funding to promote safety practices and cultural competency, and extend health coverage and services for low-income postpartum women, including by extending Medicaid and Children's Health Insurance Program (CHIP) coverage for a year postpartum.

The AHA supports the Maternal Health Quality Improvement Act (H.R. 4995), which would help hospitals and health systems improve maternal health by authorizing grants to improve care in rural areas and funding to promote best practices and educate health care professionals on implicit bias, and the Helping Medicaid Offer Maternity Services

Act (H.R. 4996), which would give states the option to extend Medicaid and CHIP coverage for pregnant and postpartum women from the current 60 days to one year after birth, with a 5% increase in the Federal Medical Assistance Percentage for the first year a state opts to extend the coverage. It also would require the Medicaid and CHIP Payment and Access Commission (MACPAC) to issue a report on access to doula care in Medicaid. Both bills passed the House Energy and Commerce Committee in November.

The AHA also expressed support for the Black Maternal Health Momnibus (S. 3424/H.R. 6142), introduced in March, which seeks to end preventable maternal mortality and severe maternal morbidity in the United States and reduce disparities in maternal health outcomes.

Regarding efforts to address social needs for mothers, the AHA supports the Social Determinants Accelerator Act (H.R. 4004/S. 2986), which would provide planning grants and technical assistance to help states and communities address the social determinants of health for high-need Medicaid beneficiaries.

In addition to legislative activity at the federal level, The Joint Commission, which accredits more than 21,000 U.S. health care organizations and programs, including hospitals and health systems, recently adopted standards for perinatal safety. The standards take effect July 1, 2020 and hospitals' compliance will be evaluated during accreditation surveys. The AHA supports the Commission's focus on evidence-based procedures and responses that will ensure the most medically appropriate and effective course of treatment for women diagnosed with either maternal hemorrhage or severe hypertension/preeclampsia. We also support the requirement for education of staff, and believe conducting complication-specific training and drills will better prepare providers to act effectively and efficiently when these situations arise. Further, we support standards to provide patients and their families with the necessary educational materials to recognize symptoms that require immediate attention as another important safeguard.

## Recommendations

The AHA suggests the following actions that could be taken at the federal level, including:

**Continue efforts to expand Medicaid in non-expansion states and extend postpartum coverage for women enrolled in Medicaid and CHIP.** We support providing the enhanced federal matching rate to any state, regardless of when it expands. This would give newly expanded states access to three years of 100% federal match, which would then scale down over the next several years to the permanent 90% federal match. Access to health care throughout a woman's reproductive years, especially before pregnancy, is important to detect any underlying conditions that may

place women at higher risk of pregnancy-related complications.<sup>1</sup> Recent studies have shown that Medicaid expansion could be contributing to lower maternal mortality rates in those states that extended their programs under the Affordable Care Act and could also contribute to decreasing racial disparities in maternal mortality<sup>2</sup>. Studies also have found that Medicaid expansion led to a decline in infant mortality, with greater declines seen among African American infants.<sup>3</sup>

Current law provides a federal match for 60 days postpartum for women in Medicaid and CHIP. We support increasing this period to one year, which would provide coverage for new mothers, who may remain at high-risk for maternal morbidity and mortality, and allow providers to better coordinate services for them across the continuum of care. In addition to complications such as cardiovascular disease and hypertension, in the postpartum period, women may experience behavioral health issues or have a substance use disorder.

Postpartum depression (PPD) is the most common complication after pregnancy, affecting one in seven new mothers, or 400,000 births per year, according to the American Psychological Association. Giving clinicians the ability to treat women for PPD during the postpartum period by ensuring coverage is an important tool for improving women's health during this critical time.<sup>4</sup>

**Provide federal subsidies for more lower- and middle-income individuals and families.** Many individuals and families who do not have access to employer-sponsored coverage earn too much to qualify for either Medicaid or marketplace subsidies and, yet, struggle to afford coverage. This is particularly true for lower-income families who would be eligible for marketplace subsidies except for a “glitch” in the law that miscalculates how much families can afford. We support both expanding the eligibility limit for federal marketplace subsidies to middle-income families and fixing the “family glitch” so that more lower-income families can afford to enroll in coverage.

**Require state Medicaid programs to cover telemedicine for maternal care.**

Telehealth could be used to provide access to care for urban and rural areas that do not have providers, both for regular care throughout the perinatal period as well as consultations with specialists. Only a small number of state Medicaid programs mention obstetrical care in their telemedicine reimbursement law and only 19 state Medicaid programs reimburse for telemedicine services delivered to the patient in their home, which limits reimbursement of services, such as lactation assistance and in-home monitoring during and after pregnancy.<sup>5</sup> A study in the CDC's Morbidity and Mortality

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<sup>1</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6090644/>

<sup>2</sup> [https://www.whijournal.com/article/S1049-3867\(20\)30005-0/fulltext](https://www.whijournal.com/article/S1049-3867(20)30005-0/fulltext); <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>

<sup>3</sup> <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304218>; <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>

<sup>4</sup> <https://www.ajmc.com/conferences/acog-2018/obstetricians-are-well-positioned-to-diagnose-treat-postpartum-depression-speakers-say>

<sup>5</sup> <https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/>

Weekly Report (MMWR) examined work done by 13 state MMRCs to identify contributing factors and strategies to prevent future pregnancy-related deaths, which included addressing personnel issues at hospitals by providing telemedicine for facilities with no obstetric provider on-site.<sup>6</sup>

**Funding for simulation training.** Providing ongoing education for doctors, nurses and other members of the labor and delivery team regarding how to handle high-risk births will better prepare them to address maternal morbidity and mortality. The CDC's MMWR study suggested health care facilities could improve outcomes by implementing emergency obstetric simulation training for emergency department and obstetric staff members.<sup>7</sup>

**Extend supplemental nutrition services for women.** Giving states the option to offer Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits to women for two years postpartum, an increase from the current standard of up to one year, would provide access to nutritious food during a critical time in a mother's and child's life. Studies have found WIC to be effective in improving birth outcomes and reducing health care costs, improving diet and diet-related outcomes, increasing immunization rates and improving cognitive development, among other findings.<sup>8</sup>

**Funding for the AIM program and state-based perinatal quality collaboratives.** We believe that promoting the widespread adoption of the Alliance for Innovation on Maternal Health (AIM) maternal safety bundles at the state level would help improve maternal health by providing standardized approaches for hospitals offering delivery services. And, the perinatal quality collaboratives assist states and territories to improve outcomes for pregnant and postpartum women and their infants. A recent study examined the impact of a quality-improvement collaborative on racial disparities in severe maternal morbidity due to hemorrhage and found that it was able to reduce rates of this severe maternal morbidity in all races and reduce the gap between African American and white women.<sup>9</sup>

**Funding for implicit bias training.** Entities including teaching hospitals, health systems and medical schools could qualify for grants for ongoing training of health care professionals regarding implicit bias and cultural competence. This training would teach providers how to recognize and interrupt the stereotypes and assumptions that influence their actions and has the potential to improve the quality of care and improve outcomes for mothers and babies in all communities. Specifically, these programs may be used to address systemic and institutionalized racism in the health care system.

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<sup>6</sup> [https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s\\_cid=mm6818e1\\_w#T3\\_down](https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w#T3_down)

<sup>7</sup> Ibid.

<sup>8</sup> <https://www.fns.usda.gov/wic/about-wic-how-wic-helps>

<sup>9</sup> [https://www.ajog.org/article/S0002-9378\(20\)30034-X/fulltext](https://www.ajog.org/article/S0002-9378(20)30034-X/fulltext)

## Additional Suggestions

**Use of non-physician clinicians, and continuity and coordination of care.** Our members would like to see an increased use of midwives and nurse practitioners (NPs) and other clinicians in all aspects of maternal care (prenatal/surgical assist in obstetrics/postpartum). Hospitals identified this as an area of dire need. In particular, NPs' strong medical backgrounds make these clinicians very suitable not only to provide routine care but also address other issues, such as expediting subspecialty consults, which can be difficult to achieve in a timely manner. The use of midwives, especially in underserved areas, can improve access and outcomes.<sup>10</sup> And while we support the increased use of midwifery practices, for those operating at freestanding birthing centers, it is essential for providers that are not otherwise affiliated with their local hospitals to have transfer agreements in place should emergencies arise during deliveries.

Studies have shown that using doulas can improve outcomes for mothers and infants, especially for women at risk of adverse outcomes, including Black and Latinx women. Doulas have demonstrated a reduction in labor time, reduction of mother's anxiety, improvements in mother-baby bonding post-birth and improved breastfeeding success.<sup>11</sup> However, challenges remain with respect to their accreditation, given the absence of federal regulation to determine competencies, as well as funding. For example, only a few states allow Medicaid reimbursement for doula services, and in those states, Medicaid reimbursement rates are set below costs, making the work not financially viable for the practitioners unless it is supported by a health care system or private grant programs.<sup>12</sup>

The use of telehealth with non-physician providers also should be considered.

**Coverage and standards of care to improve maternal health.** Maternal morbidity issues, such as maternal cardiac disease and mental health, are not resolved at delivery or immediately postpartum. Frequently, providers want to offer home care visits to postpartum patients such as those who are discharged with preeclampsia. However, many insurance plans do not cover home visits, which leads to patients declining these valuable services. In addition, changes in Medicaid payment could be used to improve postpartum care and reduce racial and ethnic disparities by bringing together clinicians, social workers and managed care to reduce hospital readmissions and postpartum depression.<sup>13</sup>

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<sup>10</sup> <http://ruralhealthquarterly.com/home/2018/07/09/might-midwives-help-fill-rural-maternity-care-gaps/>

<sup>11</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>

<sup>12</sup> [https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/?utm\\_source=MHTF+Subscribers&utm\\_campaign=fb5b5d09ab-RSS\\_EMAIL\\_CAMPAIGN&utm\\_medium=email&utm\\_term=0\\_8ac9c53ad4-fb5b5d09ab-183820997;https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12213](https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/?utm_source=MHTF+Subscribers&utm_campaign=fb5b5d09ab-RSS_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_8ac9c53ad4-fb5b5d09ab-183820997;https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12213)

<sup>13</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5380444/>

**Addressing disparities and disparate outcomes.** Addressing disparities in outcomes remains an important area of improvement, even for successful quality initiatives, such as the California Maternal Quality Care Collaborative. Work continues at AIM to review access to care and implicit bias as potential causes of disparities, in addition to encouraging the use of its Reduction of Peripartum Racial/Ethnic Disparities Patient Safety Bundle, which provides guidance for organizations and clinicians regarding how to reduce disparities in maternal morbidity and mortality. Our members support investments in accessible technology, such as applications to help monitor blood pressure, glucose levels, depression and other conditions remotely, in order to reach women who are most at risk for negative outcomes. We believe the recommendations made previously will address high rates of adverse outcomes for all women, including those living in rural areas.

**Data collection and effective evaluation to improve outcomes and quality.** The issue of data and measure standardization was raised by our members, as, for example, states, municipalities, and hospitals have different terminology for determining maternal morbidities, such as hemorrhage. We would encourage the Centers for Medicare & Medicaid Services (CMS) to use its existing mechanisms, such as the National Quality Forum and Core Measure Quality Collaborative, to promote standardized definitions. The implementation of MMRCs in all states also should help standardize data collection and the dissemination of strategies to reduce pregnancy-related morbidities and eliminate mortality.

**Social services aimed at supporting mother and child well-being.** Providers want to offer their patients as much support as possible. But, even when they are mandated to screen for postpartum, such as depression, there are not enough mental health providers to whom to make the referral. Patients' lack of social supports may prevent them from returning for postpartum visits, thereby disrupting any continuity of care that was established during their pregnancy. Members have had success with group prenatal care, such as the [CenteringPregnancy](#) model, and suggested federal initiatives that support these efforts – and include transportation to and from the meetings as well as child care – would be beneficial for their patients.