Federal Public Policy and Legislative Solutions for Improving Maternal Health

September 2024

Maternal health is a top priority for the AHA and our member hospitals and health systems, and our 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 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, the AHA supports the federal public policy and legislative actions discussed below.

INITIATIVES

At the federal level, several legislative initiatives specific to maternal mortality have been enacted. Several other initiatives have been introduced in Congress the last year.

Further Consolidated Appropriations Act of 2024 (Public Law No: 118-47)

The Further Consolidated Appropriations Act of 2024, passed in March 2024, contained funding for important maternal and child health provisions supported by the AHA. The law requires the Health Resource and Services Administration (HRSA) to develop a plan on how the agency can assist birth center expansion in rural and urban maternity care deserts. The Centers for Disease Control Prevention (CDC) is directed to provide a briefing on the Maternity Practices in Infant Nutrition and Care and Levels of Care Assessment Tool surveys.

The Further Consolidated Appropriations Act of 2024 included additional funding for the CDC, HRSA, the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMSHA) initiatives aimed at improving maternal health and reducing the nation's high maternal mortality rate.

Programmatic funding included:

- **CDC**
  - $110 million for Safe Motherhood and Infant Health to improve the health of pregnant and postpartum women and their babies, including reducing disparities in maternal and infant health outcomes.
- **NIH**
  - $53 million for the Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Initiative.
  - $76 million for the Office of Research on Women's Health.
- **HRSA**
  - $8.8 billion to develop the workforce, improve maternal and child health outcomes and support rural health access.
  - $813 million for the Maternal and Child Health Block Grant.

American Hospital Association™
Advancing Health in America

- $8 million for Maternity Care Target Areas.
- $5 million for grants to educate midwives to address the national shortage of maternity care providers.
- $8 million for certified nurse midwives (CNMs), to grow and diversify the maternal and perinatal health nursing workforce by increasing and diversifying the number of CNMs, with a focus on practitioners working in rural and underserved communities.
- $55 million for State Maternal Health Innovation Grants.
- $12 million for Rural Maternity and Obstetrics Management Strategies (RMOMS).
- $2 million for family medicine/obstetrics training programs in states with high infant morbidity and mortality rates.

- **SAMHSA**
  - $38.9 million for substance abuse treatment for pregnant and post-partum women.

OTHER FEDERAL INITIATIVES

The AHA supports the **Preventing Maternal Deaths Reauthorization Act (H.R.3838/S.2415)**, bipartisan legislation that would reauthorize federal support for state-based maternal mortality review committees, which review pregnancy-related deaths to identify causes and make recommendations to prevent future mortalities. The bill also would require the CDC to work with the HRSA to disseminate best practices to hospitals and other health care providers to prevent maternal mortality. The bill passed the House in March and is awaiting action by the Senate.

The AHA supports the ongoing funding of maternal health programs at the federal level. The Title V Maternal and Child Health Block Grant (MCHBG) is a funding source used to address the most pressing and unique needs of maternal and child health populations in each state, territory and jurisdiction of the United States. The program helps states assure access to quality maternal and child health care services, especially for those with low incomes or who have limited access to care. The AHA supports $1 billion for the Title V MCHBG in FY 2025.

The MCH Block Grant program supports the State MCH Block Grant program, Special Projects of Regional and National Significance and Community Integrated Service Systems grants. According to data gathered by HRSA, the State MCH Block Grant program supports approximately 93% of pregnant women, 99% of infants and 61% of children. Improving maternal and child health is a major priority for the AHA.

The Healthy Start program provides support for high-risk pregnant women, infants and families in communities with exceptionally high rates of infant mortality, including health care services, such as those focused on reducing maternal mortality, as well as the socioeconomic factors of poverty, education and access to care. The AHA supports $185 million in funding for FY 2025.

RECOMMENDATIONS

The AHA suggests implementing the following actions at the federal level, including:

- **Continue efforts to expand Medicaid in non-expansion states and extend postpartum coverage for women enrolled in Medicaid and the Children's Health Insurance Program (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 be reduced over the next several years to the permanent 90% federal match. The American Rescue Plan Act of 2021 (P.L. 117-2) provides an incentive for states that have not already done so to expand Medicaid by temporarily increasing the state's Federal Medical Assistance Percentage for their base program by 5 percentage points for two years. 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[1]. 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[2]. Studies also have found that Medicaid expansion led to a decline in infant mortality, with greater declines seen among African American infants.[3]

The AHA supported the provision in the Consolidated Appropriations Act of 2023 that permanently gave states the option to provide 12 months of postpartum coverage to women rather than previous law which provided a federal match for only 60 days postpartum. To date, 47 states and the District of Columbia have implemented the coverage extension. States choosing this option must provide the full Medicaid benefit for pregnant and postpartum individuals during the 12-month postpartum period. We support making the requirement mandatory for states, rather than an option, which would provide reliable 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 one of the most common complications after pregnancy, affecting one in seven new mothers, or 400,000 births per year, according to the American Psychological Association.[4] 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.

- **Prevent Medicaid and CHIP coverage lapses during the redetermination process.** The unwinding of the COVID-19 public health emergency required states to resume normal eligibility redeterminations operations for the first time in nearly three years. States determined eligibility for more than 90 million individuals over the course of the last year. As a result of this process, some individuals — including postpartum women — are at high risk of losing coverage either because they are no longer eligible for Medicaid and have limited options for other sources of coverage or lose Medicaid coverage for procedural reasons such as failure to complete the critical redetermination process due to lack of awareness.

- **Continue to support 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. The AHA supported provisions in the Inflation Reduction Act (P.L. 117-169) that provided for a three-year extension of enhanced subsidies provided for in the American Rescue Plan Act of 2021; this reduced the cost of Marketplace coverage for all subsidy-eligible individuals and families by increasing the dollar value of the premium tax credit subsidies. These changes are in effect through 2025.

- **Require state Medicaid programs to cover telemedicine for maternal care.** Telehealth became essential during the COVID-19 pandemic for use in all patient care, including maternal care, to provide regular support throughout the perinatal period and keep patients safe during their pregnancy, as well to allow for consultations with specialists and access to care for urban and rural areas that do not have obstetric providers.[5] A study in the CDC's Morbidity and Mortality 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.[6] In addition, the use of remote patient monitoring, such as with blood pressure cuffs and weekly glucose review, both lowered pregnancy-related stress and improved patient satisfaction with their treatment. While the use of telemedicine for obstetric services increased during the pandemic, not all states may be requiring Medicaid to reimburse for these services.[7]

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6090644/
2 https://www.sciencedirect.com/science/article/abs/pii/S1049386720300050
3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5844390/
4 https://www.apa.org/topics/women-girls/postpartum-depression
5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9639859/#bib5
6 https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w&T3_down
7 https://aspe.hhs.gov/sites/default/files/documents/eb9e147935a2663441a9488e36eea6cb/medicaid-telehealth-brief.pdf

- **Improve Medicaid access, provider payment and network adequacy.** The AHA supports CMS regulatory efforts to address the access and care challenges faced by Medicaid and CHIP.[8] Such efforts include regulatory changes that promote greater transparency and accountability in Medicaid fee for service programs with a particular focus on mitigating payment-related barriers that impact providers' participation in the program. CMS issued new policies regarding Medicaid managed care plans that aim to address these payment barriers, as well as to better monitor enrollee access to care. The AHA appreciates efforts to review provider payments for adequacy, as well as proposals to adopt wait time standards and secret shopper surveys to ensure managed care plans maintain adequate networks. The AHA understands that implementing these new requirements will be a challenge for state Medicaid agencies, especially considering the efforts undertaken in support of the Medicaid unwinding process, and stands ready to work with member hospitals, Medicaid officials and other stakeholders to provide additional support as needed. Many of these regulatory improvements focus on services that are vital for the maternal population, including mental health, primary care and obstetrics and gynecology services.[9]

- **Focus on the challenges contributing to rural obstetric (OB) unit closures.** There has been a significant decline in rural hospitals offering obstetric services. Approximately 267 rural hospitals ceased providing obstetric services between 2011 and 2021, representing nearly 25% of America's rural hospital obstetric units.[10] As of 2023, approximately 45% of rural hospitals currently offer labor and delivery services; in 10 states, less than 33% of rural hospitals provide these services.[11] This trend has led to the expansion of "maternity care deserts" in rural America, affecting millions of women of childbearing age and potentially resulting in preterm births and poor maternal and infant outcomes.

  This year, the AHA worked with members to develop strategies to address the rural OB unit closures. These recommendations include:

  - Increasing federal funding for rural OB services in the Medicaid program, including through higher base payment rates, supplemental payments and add-on payments for low-volume providers, along with an increased federal match rate to encourage uptake;
  - Exploring tort reform for maternal care offered in rural areas, which could include caps on non-economic damages, liability safe harbors for evidence-based medicine practices and shortening the statute of limitations;
  - Pursuing legislative antitrust waivers to allow hospitals to discuss ways they can develop innovative solutions to maternity deserts, such as through pooling resources to establish shared maternity units, establishing prenatal hotels or mobile clinics that serve multiple rural communities along with sharing clinical staff; and
  - Addressing workforce challenges by urging CMS to encourage state Medicaid agencies to develop Medicaid GME programs that support rural hospitals offering maternity care.

- **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.[12]

- **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 childhood immunization rates and improving cognitive development, among other findings.[13]

8 https://www.aha.org/lettercomment/2022-04-15-letter-cms-response-rfi-access-coverage-and-care-medicaid-chip
9 https://www.aha.org/lettercomment/2023-06-28-aha-letter-cms-proposed-medicaid-and-chip-access-finance-and-quality-policies
10 https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf
11 https://www.beckershospitalreview.com/finance/rural-hospitals-maternity-care-crisis.html
12 https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w&T3_down
13 https://www.fns.usda.gov/wic/about-wic-how-wic-helps

- **Funding for the Alliance for Innovation on Maternal Health (AIM) program and state-based perinatal quality collaboratives.** We believe that promoting the widespread adoption of the AIM maternal safety bundles at the state level would help improve maternal health by providing standardized approaches for hospitals offering delivery services. Also, perinatal quality collaboratives assist states and territories in improving outcomes for pregnant and postpartum women and their infants. A study in California 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.[14]

- **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.

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 to provide routine care and address other issues, such as expediting subspecialty consults, which can be difficult to achieve in a timely manner. In Medicaid, the use of midwives for low-risk pregnancies can improve outcomes for both maternal and infant health and lower costs for the program.[15] And while the AHA supports 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 Hispanic 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.[16] However, challenges remain with respect to their accreditation, given the absence of federal regulation to determine competencies, as well as funding. As of 2024, 43 states and the District of Colombia have taken steps to provide Medicaid coverage for doula reimbursements.[17] However, for these states that allow Medicaid reimbursement for these services, the reimbursement rates are usually 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.

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 creates barriers for patients' access to important care. 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.[18]

- **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

14 https://www.ajog.org/article/S0002-9378(20)30034-X/fulltext
15 https://www.macpac.gov/publication/access-to-maternity-providers-midwives-and-birth-centers/
16 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/
17 https://ccf.georgetown.edu/2024/04/11/state-momentum-on-medicaid-doula-coverage-rate-increases/
18 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5380444/

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 and underserved areas.

- **Data collection and effective evaluation to improve outcomes and quality.** The issue of data and measure standardization was raised by our members. For example, states, municipalities and hospitals use different terminology for determining maternal morbidities, such as hemorrhage. We encourage CMS to use its existing mechanisms, such as the Core Measure Quality Collaborative, to promote standardized definitions and the development of more meaningful quality measures. 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 across the continuum of care. But, even when they are mandated to screen for maternal health conditions, such as depression, there are not enough mental health providers to whom to make the referral. In addition, patients' lack of social supports, such as those related to childcare, transportation or the inability to take time away from their jobs, may prevent them from attending prenatal and postpartum appointments, thereby disrupting continuity of care during 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 childcare — would be beneficial for their patients.