Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

April 3, 2020

The Honorable Chuck Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

VIA ELECTRONIC SUBMISSION to MaternalHealth@finance.senate.gov

Re: Solutions to Improve Maternal Health through Medicaid

Dear Senators Grassley and Wyden,

Thank you for the opportunity to share ideas on ways to improve maternal health outcomes. The Center for Children and Families is based at Georgetown University's Health Policy Institute with the mission of improving access to health care coverage among the nation's children and families, particularly those with low and moderate incomes. We applaud your interest in finding actionable solutions to address our nation's maternal health crisis.

Medicaid should be a central player in any solution to this crisis. Medicaid, along with the Children's Health Insurance Program (CHIP), is a key support for pregnant and new mothers as well as their children. In 2018, Medicaid paid for nearly half (43 percent) of all births in the United States, including a greater share of births in rural areas, among young women, women of color and women with lower levels of educational attainment.[1] Because Medicaid serves a lower income population with greater underlying health risks, Medicaid beneficiaries have an 82 percent greater chance of severe maternal mortality and morbidity than privately insured women.[2] Within Medicaid beneficiaries, geographic and racial disparities persist. For example, Medicaid beneficiaries who are women of color and indigenous women are at the greatest risk of severe maternal mortality and morbidity.

Our policy recommendations are focused on three key areas: 1) comprehensive health care coverage; 2) services and supports; and 3) infrastructure for a high-quality delivery system.

Specific ways Medicaid and CHIP could better support pregnant and postpartum women are outlined below.

1) Comprehensive Health Care Coverage Before, During and Between Pregnancies

Healthy pregnancies and births rely on access to health care throughout a woman's life: during preconception, postpartum, and between pregnancies. Data from the Centers for Disease Control and Prevention (CDC) show that one in three pregnancy-related deaths occur between one week to one year after delivery and the causes vary by racial group.[3] About one third of women nationally experience some disruption in coverage between the month before they become pregnant and the sixth month after delivery, including losing coverage altogether.[4] In some states, including Texas, Oklahoma and Georgia, more than one-third of women are uninsured between preconception and postpartum. Women of color are also more likely to lose coverage at some point during their pregnancy than are white women, contributing to their greater risk of maternal mortality and morbidity.[5]

State Medicaid policies leave gaps in coverage for women of childbearing age, restricting access to prenatal and interpregnancy care that support healthy birth outcomes. Women in states that have not expanded Medicaid under the Affordable Care Act (ACA) may first experience health insurance as adults through Medicaid pregnancy coverage (available at higher income levels than for other adults).[6] These previously uninsured women bring any unmet health needs to their pregnancies. Chronic conditions such as diabetes, dental disease or hypertension must be addressed as part of a prenatal care.

Medicaid eligibility for pregnant women is also inconsistent across states. As of January 2020, median income eligibility for pregnant women across states was 205% of the federal poverty level (FPL), spanning from a low of 138% FPL in Idaho and South Dakota to a high of 380% FPL in Iowa.[7] Thirty-five states have also chosen to offer Medicaid coverage to lawfully residing pregnant women during their first five years in the U.S. and 17 states use an option in CHIP to finance pregnancy coverage for pregnant women regardless of immigration status.[8] States also have the option to provide presumptive eligibility (PE) to pregnant women and other groups in Medicaid, allowing qualified entities to screen and enroll likely-eligible beneficiaries while the state processes the full application. As of January, 30 states have adopted PE for pregnant women, with only 9 states opting to extend PE to other parents or adults.[9]

*More than any other policy decision**, **Medicaid expansion has been consistently proven to lower maternal and infant mortality and support women's health** before, during and after pregnancy*.[10] Lack of health insurance among women of childbearing age is nearly twice as high in states that have not expanded Medicaid under the ACA.[11] Medicaid

expansion supports increased access to providers for prenatal, birth and postpartum care.[12]

A new study published in the *Women's Health Issues* journal showed Medicaid expansion was significantly associated with lower maternal mortality.[13] The effects were greatest for non-Hispanic black women, the racial group with the highest rates of maternal mortality. Effects were also greater for the period beginning 60 days after birth, when Medicaid pregnancy coverage currently ends. This suggests that, "sustained insurance coverage after childbirth as well as improved preconception coverage could be contributing to decreasing maternal mortality."

The lifesaving benefits of Medicaid expansion also extend to newborns. States that have expanded Medicaid saw a 50 percent greater reduction in infant mortality than non-expansion states, with the greatest decline among African American infants, which drove the overall decline and helped to substantially reduce the racial disparity in infant mortality rates.[14]

Extending post-partum Medicaid coverage to one year after delivery is also being sought by policymakers in at least a dozen states, such as Illinois and Texas, to support consistent coverage during and after pregnancy.[15] The Urban Institute estimates that extending postpartum Medicaid coverage to one year after delivery for new moms has the potential to help at least 200,000 low-income uninsured mothers gain needed coverage.[16] Such coverage brings mothers' enrollment in line with the one year of coverage federal law guarantees for infants whose birth was paid for by Medicaid.[17] Congress could mandate postpartum care for pregnant women to a minimum of 12 months postpartum to ensure minimum coverage is in place nationwide.

2) Services and Supports for Mothers and their Families

Ensuring continuous health care coverage is the first step. Medicaid and CHIP can also pay for interventions and supports that have shown promise in improving both health outcomes and equity. State Medicaid infrastructure and delivery systems, in close partnership with public health agencies, are well-positioned to encourage promising, innovative practices while monitoring quality and specifying the qualifications and requirements necessary for providers. The ideas below are not exhaustive but provide some examples of areas where Medicaid could play a greater role.

Target intensive supports, such as case management, to beneficiaries with known risk based on public health data. Medicaid and other coverage sources ensure women are connected with the right care and resources when they need it. Interconception care can provide needed services after a high-risk delivery or between pregnancies.[18] For example, Georgia and Louisiana have used Section 1115 waivers to provide more intensive coverage and care— including intensive case management alongside prevention, primary care and treatment services— to women with qualifying adverse pregnancy outcomes in select regions.[19] State Medicaid agencies or federal CMS officials can also do more to promote health homes for women with two or more chronic conditions[20] by serving as an

interdisciplinary practice hub that encompasses needed medical, behavioral health and social services. Such health homes could offer comprehensive case management, health promotion, follow-up care, patient and family support, and referrals to community services from a team of professionals highly skilled in supporting women's health.[21]

Invest in two/multi-generation approaches. Maternal and child health are inextricably linked in the prenatal period and early years of a child's life. Medicaid can support this relationship by financing models of care that treat mothers and babies together.

Evidence-based group prenatal care models, such as Centering Pregnancy, can improve birth outcomes and reduce costs to Medicaid by reducing premature births and avoiding neonatal intensive care to babies born at low birthweight.[22] The group care model can also help to buffer stress that comes with new parenthood by deepening social relationships among new mothers. Medicaid programs in several states, including South Carolina, have adopted Centering Pregnancy by paying for these group visits. An evaluation of the model in South Carolina found it reduced the risks of premature birth, low birth weight and neonatal intensive care unit stay for babies, saving about $30,000 for each negative outcome avoided. The authors found that for South Carolina's $1.7 million invested, there was an estimated return on investment of nearly $2.3 million.

After a child is born, Medicaid can also leverage pediatric visits to support new mothers alongside their children. More frequent well-child visits during the first few years of life offer a critical opportunity to reach families and connect them to needed supports. Access to mental health services, for example, is particularly important for pregnant women and new moms. The American Academy of Pediatrics (AAP) recommends maternal depression screening in well child visits as part of its *Bright Futures* guidelines for pediatric primary care.[23] Moms experiencing depression have a harder time bonding with their children[24] and AAP found that children living with mothers with depression may "…show impaired social interactions and delays in development."[25]

A recent analysis from Mathematica estimated the economic and social costs of untreated perinatal mood and anxiety disorders for one-year of births cost $14.2 billion over a five-year period.[26] States have taken action to incorporate mothers' mental health into the well child visit for the baby. A 2016 information bulletin from the Centers for Medicare & Medicaid (CMS) encouraged state Medicaid agencies to support maternal depression screenings during well-child visits.[27] As of March 2020, 42 states and Washington, D.C. allow, recommend or require maternal depression screenings during a child's well visit covered by Medicaid.[28]

Beyond screenings, team-based primary care approaches through pediatric medical homes can help to ensure pediatric practices have the tools needed to connect new parents to needed supports and follow-ups. One such approach is Healthy Steps, an evidence-based model overseen by ZERO TO THREE, which leverages pediatric primary care by incorporating family specialists in the primary care office who conduct screenings, provide referrals and connect families to services. The specialists also support parents with education on infant and toddler nutrition, positive discipline strategies, and direction on

early literacy activities with their children. In dozens of evaluations, families participating in the model have experienced, among other things, lower depressive symptoms in mothers, prolonged breastfeeding and increased attendance at well child visits. DULCE is a similar model which uses a family specialist and adds social determinants of health screening and response.[29] Integrating such pediatric medical home approaches with home visiting and other state systems that support young families can also help ensure more new mothers access they resources they and their families need to thrive.[30]

Medicaid agencies and/or health plans can also develop or champion resources to help connect families with needed services, identifying providers who will treat pregnant women and new mothers' mental health or other needs by insurance type. Utah's Department of Health recently launched a searchable provider database of maternal mental health providers with location and insurance coverage accepted, including listing providers who treat women who are uninsured.[31]

Many states also use a parent mental health diagnosis to trigger eligibility or reimbursement for parent-child treatment or other needed supports that can help the mother and the child. Through its First 1000 Days on Medicaid plan, New York will allow evidence-based dyadic treatment to be paid for under the child's Medicaid ID when a parent/caregiver has a mood, anxiety, or substance use disorder (but the child does not have a diagnosed condition) given the known risk to child development posed by these conditions. Common evidence-based dyadic interventions include: Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) Attachment Biobehavioral Catch-up (ABC), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).[32]

3) Delivery System Infrastructure

The voices and experiences of women in Medicaid must be fully represented as policymakers seek to change the ways medical providers, hospitals, communities, and states provide care. Accountability for improved outcomes also requires a well-supported care delivery infrastructure.

Include other maternity care provider types (e.g. nurse midwifes, doulas) in additional settings (e.g. birth centers, telehealth). Medicaid coverage may be limited by a state's policies on which providers can provide birth care. The recent COVID-19 pandemic is forcing more reliance on telehealth, which could offer a means to learn what may be appropriate in prenatal and postpartum care. Currently, approaches to telehealth are inconsistent across states.

State Medicaid programs are also inconsistent in provider type and payments. Some only reimburse hospital providers and obstetricians for birth, while others cover nurse midwives, doulas and birth care that happens outside of hospitals.[33] While hospitals are necessary, particularly in high-risk or emergency deliveries, standalone birth centers or home births—with proper coordination and communication with a medical home and hospital team—may be viable options for lower-risk pregnancies and free up labor and delivery units when needed. The Strong Start Birth Center evaluation, supported by the

CMS Center for Medicare and Medicaid Innovation (CMMI), found positive maternal health and birth outcomes, for example, as well as cost savings.[34]

Limiting provider types or settings can create access problems for women in rural areas or low-income communities with few obstetricians.[35] A recent National Academies of Sciences report concludes that, "ensuring that levels of payment for maternity and newborn care across birth settings are adequate to support maternity care options across the nation is critical to improving access."[36]

Require or incentivize managed care plans to prioritize interventions with a proven track record as well as promising, innovative new care models. The majority of pregnant women are enrolled in Medicaid managed care plans that should be held accountable for the quality of care received by their members. States can require all Medicaid health plans to expand support for certain interventions like those mentioned here. Plans could also be required to develop performance improvement projects that seek to achieve improved outcomes for pregnant women, reduce the number of babies born at low birth weight, or test new care approaches, such as doulas for prenatal and birth care or increased reimbursements for freestanding birth centers. States could also freeze new enrollment in Medicaid plans that show consistently poor maternal health outcomes, as they do for poor performance on other quality measures. Plans that show better maternal outcomes or cover more services for pregnant women could be rewarded with preferred enrollment of new pregnant women.

Drive system-wide quality improvement efforts**,** as the largest payer for maternal health in most states. Hospital quality improvement efforts, such as the Alliance on Innovation in Maternal Health and the National Network of Perinatal Quality Collaboratives, along with adoption of national standards and guidelines[37] have been shown to improve outcomes for pregnant women and newborns in hospital settings.[38] While these approaches are promising, more sustainable financing from all payers, including Medicaid, is needed. Research on birth settings from the National Academies of Sciences highlighted a continuing need to "pilot and evaluate high-value payment models in maternity care and identify and develop effective strategies for value-based care."[39]

Conclusion

The COVID-19 pandemic we face today has only heightened the need for a robust and flexible health care system that supports pregnant women and other beneficiaries in their homes and communities. Medicaid continues to provide many resources needed to address the pandemic, supported by the increased federal medical assistance percentage (FMAP) rates for states Congress included in the Families First Coronavirus Response Act (P.L. 116-127).

Despite Medicaid's crucial role in our health system, the Trump Administration has taken steps to undermine the program's intent to provide health care coverage by encouraging or approving state actions that make access to coverage more difficult for beneficiaries, such as work requirements, coverage lockouts, and others.[40] One of the most troubling examples is CMS' proposed "Medicaid Fiscal Accountability" rule (MFAR)[41], which would reduce the

types of state funding available for match and, in turn, undercut state ability to draw federal Medicaid funds. Our recent analysis shows that the MFAR rule would cancel out a significant portion of the new funds provided by FMAP increase.[42]

We applaud your interest in this important issue and appreciate the chance to respond. Medicaid is central to any solution that successfully addresses poor maternal health outcomes. Thank you for your consideration of these comments. Feel free to contact Elisabeth Wright Burak (elisabeth.burak@georgetown.edu) with any questions.

Sincerely,

Joan C. Alker

Joan C. Alker
Executive Director

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