Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

May 29. 2020

VIA ELECTRONIC SUBMISSION to ruralmaternalrfi@cms.hhs.gov

Nina Brown-Ashford, MD, Acting Director
Office of Minority Health
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Re: CMS Maternal Health RFI (Georgetown University Center for Children and Families)

Dear Dr. Brown-Asford:

The Georgetown University Center for Children and Families (GCCF) is a nonpartisan research and policy center with a mission to improve access to affordable, comprehensive health coverage for children and their families. Thank you for the opportunity to respond to your Request for Information (RFI) on opportunities to improve health care access, quality, and outcomes for women and infants in rural communities before, during, and after pregnancy.

As the nation's first responder, Medicaid is playing a central role in states' ability to respond to the new challenges created by the pandemic. Maternal health access and care were already in crisis before COVID-19, and the pandemic has further laid bare the racial and geographic disparities faced by pregnant women and new mothers across the country. As the virus has spread, it is communities of color, low-income communities and areas with limited access to health care that are increasingly bearing the brunt of the crisis. Disparities in maternal morbidity and mortality follow the same patterns. Women living in rural areas are at higher risk of pregnancy-related death than their peers in urban areas, and the risks are even greater for rural women of color.[1]

These disparities are not inevitable. We applaud the Centers for Medicare and Medicaid Services (CMS) for seeking new solutions. Our comments respond to the RFI's four questions.

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**RFI Question 1: What barriers exist in rural communities in trying to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care?**

Women living in rural areas face a myriad of challenges in accessing care before, during and after pregnancy.[2] Higher uninsured rates, rural hospital closures, maternity care provider shortages and pre-existing unmet health needs all contribute to grater rates of maternal morbidity and mortality among rural women as compared to their urban peers. Between 2007 and 2015, the higher rural maternal mortality and morbidity rate, "represents an excess of approximately 4,378 cases of severe maternal morbidity and mortality among rural residents who would not have experienced morbidity or mortality had they been living in urban areas."[3]

Nationally, more rural women gave birth while uninsured compared with women in urban areas.[4] State Medicaid expansion decisions play a clear role – lack of health insurance among women of childbearing age is nearly twice as high in states that have not expanded Medicaid to adults under the Affordable Care Act (ACA)(16 versus 9 percent in 2017).[5] Non-expansion states also have shockingly high uninsured rates for adults living in small towns and rural areas as of 2016, including South Dakota (47%), Georgia (38%), Oklahoma (38%), Florida (37%), Texas (36%), Alabama (36%), Missouri (35%), and Mississippi (35%).[6]

Medicaid is the most likely source of coverage of childbirth as the largest payer of rural births.[7] In the last decade, 130 rural hospitals have closed their doors, taking with them access to critical services including obstetrics and labor and delivery services.[8] Medicaid expansion could provide the resources to help sustain these hospitals in rural communities.[9] So far in 2020, 12 rural hospitals have closed—half in non-expansion states of Florida (2), Kansas, Missouri, Tennessee and Texas— with more are on the brink this year due to pressures from the COVID-19 pandemic.[10] When communities lose these services, research shows that pre-term births increase in the following year, harming mothers and babies and adding billions in costs to the health, education and social services systems for years to come.[11]

Even before women in rural areas give birth, they struggle to find health providers, as CMS detailed in its 2019 issue brief.[12] Overall provider shortages contribute to the higher levels of unmet health needs faced by pregnant women in rural areas. While the prevalence of chronic illnesses has increased over the past decade for all pregnant women, those in rural areas experience higher rates of illness including chronic hypertension, preexisting disease states, and substance use disorders.[13] In Texas, for example, the state's Maternal Mortality and Morbidity Task Force reported unmet substance use disorder treatment needs for women before, during and after pregnancy. [14] The Task Force report pointed to drug overdose as the leading cause of the state's pregnancy-related deaths for Texas women after 60 days postpartum, reporting opioids as the most frequently used drug. The risk for overdose-related maternal deaths in the

state was higher among white women, women over age 40, women in urban counties and for women enrolled in Medicaid at the time of delivery.

Mental health care access has also been documented as a key need for pregnant and postpartum women. Though postpartum depression screening is recommended universally, a new analysis by the Centers for Disease Control (CDC) found that one in five women reported that their health care provider did not ask about depression during prenatal visits. One in eight women reported they were not asked about depression during postpartum visits.[15] On average, about 13 percent of women with a recent live birth reported depressive symptoms, with a low of 9.7 percent in Illinois to a high of 23.5 percent of women surveyed in Mississippi. American Indian/Alaska Native women, Asian women and Black non-Hispanic women reported the highest rates of depressive symptoms of any racial groups, and women under age 24 reported higher rates of symptoms than older women.[16]

"The prevalence of depressive symptoms exceeded 20% among women who were aged ≤19 years, were American Indian/Alaska Native, smoked during or after pregnancy, experienced intimate partner violence before or during pregnancy, self-reported depression before or during pregnancy, or whose infant had died since birth," the CDC report found.

As data like these suggest, barriers to accessing care—and maternal mortality and morbidity—do not affect all women equally. Nationally, "non-Hispanic black, American Indian/Alaska Native, Hispanic, and Asian residents of both rural and urban areas had at least 33 percent increased odds of severe maternal morbidity and mortality compared to non-Hispanic white residents," research published in *Health Affairs* finds.[17] Black women in rural areas are at an especially high risk for poor outcomes. For instance, in Illinois, non-Hispanic black women were six times more likely to die of a pregnancy-related condition as non-Hispanic white women between 2014 and 2016.[18] The state's pregnancy-associated mortality ratio, which represents the number of deaths that occurred for every 100,000 live births in a specific group of women, was highest for women living in rural counties. Women who lived in the suburban counties surrounding Cook County had the lowest pregnancy-associated mortality ratio. In Texas, the state's Maternal Mortality and Morbidity Task Force found the rural panhandle region had the highest rate of maternal deaths between 2012 and 2015.[19] For black women, the highest maternal death rate region was central Texas, which, while slightly more urban than the panhandle region, is still predominantly rural as defined by the U.S. Census Bureau.[20]

While geography is clearly a key factor, focused attention is needed to address the endemic racism harming black women and their families, as well as other women of color. For example, black Americans are systematically undertreated for pain relative to white Americans, which research suggests can be traced in part to false beliefs about biological differences between

black and white patients that can contribute to judgements about pain assessment and treatment.[21] In a recent survey of African American adults, 32 percent said they had personally experienced racial discrimination while going to a doctor or health clinic.[22] Without systemically acknowledging and addressing the documented racial discrimination faced by women of color, and Black women specifically, any interventions to end maternal mortality will be limited in their ability to successfully improve health equity.

**RFI Question 2: What opportunities are there to improve the above areas (i.e., access, quality and outcomes)?**

Comprehensive coverage through Medicaid must be at the center of any policy solutions to the rural maternal health crisis. In 2018, Medicaid paid for half of all births in rural areas, and for most births among young women, women of color and women with lower levels of educational attainment.[23] 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.[24] Among 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.[25]

*Medicaid expansion through the Affordable Care Act (ACA) has nearly closed the rural/urban gap in the uninsured rate for adult Americans.*[26] On average, small towns and rural areas in Medicaid expansion states showed a 16 percent uninsured rate versus 32 percent in the non-expansion states in 2015/16. In the states that have expanded Medicaid, the uninsured rate in small towns and rural areas fell to a level that comes closer to rates in metro areas (16 percent versus 12 percent).

*States that expanded Medicaid through the ACA have made more progress lowering maternal and infant mortality rates.* As recommended by the American College of Obstetricians and Gynecologists (ACOG) for optimal maternal and fetal outcomes, women must have access to health services before they become pregnant.[27] Medicaid expansion can fill gaps in coverage for women of childbearing age, helping to increase access to prenatal and interpregnancy care that support healthy birth outcomes during a consequential period. Among the key findings in GCCF's research brief[28]:

> *The uninsured rate for women of childbearing age is nearly twice as high in states that have not expanded Medicaid compared to those that have expanded Medicaid (16 percent v. 9 percent). States with the highest uninsured rates for women of childbearing age are: Alabama, Alaska, Florida,*

*Georgia, Idaho, Mississippi, Nevada, North Carolina, Oklahoma, South Carolina, Texas and Wyoming.*

Uninsured women in non-expansion states may first gain health insurance through Medicaid pregnancy-related coverage, which is generally available at higher income levels than for other adults (see below). These previously uninsured women bring any unmet health needs to their pregnancies. Preventable, chronic conditions, such as diabetes, dental disease or hypertension that may have been addressed earlier with health coverage must instead be addressed as part of prenatal care.

Medicaid expansion helps to ensure women have access to preventive health care throughout their reproductive life, before, during, between, and after pregnancies. 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.[29] 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.[30]

A peer-reviewed study published in *Women's Health Issues* showed Medicaid expansion was significantly associated with lower maternal mortality.[31] The effects were greatest for non-Hispanic Black women, the racial group with the highest rates of maternal mortality and for the period beginning 60 days after birth, when Medicaid pregnancy coverage 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 racial disparities in infant mortality rates.[32]

*Additional state eligibility and enrollment options for pregnant women can facilitate more immediate access to needed prenatal care***.** State Medicaid eligibility and enrollment policies specific to pregnant women, a federally-required coverage group, vary widely. In addition to income, state options to enhance coverage and speed enrollment among pregnant women include using Medicaid to cover lawfully residing immigrant women, using CHIP to cover immigrant women regardless of status, and expanded use of presumptive eligibility (PE).[33] As of January 2020, median income eligibility across states for pregnant women was 205 percent of the federal poverty level (FPL), spanning from a low of 138 percent FPL in Idaho and South

Dakota to a high of 380 percent FPL in Iowa.[34] Thirty-five states have additionally opted to offer Medicaid coverage to lawfully residing pregnant women during their first five years in the U.S. Seventeen states use a CHIP option to finance pregnancy coverage for women regardless of immigration status. To ease barriers to care impacted by enrollment delays, states may provide PE to pregnant women and other groups in Medicaid, which allows state-determined 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.[35] At least three of these states (Kansas, Illinois, New Mexico) have expended existing PE availability for pregnant women during the COVID-19 emergency period.[36]

*Extending postpartum coverage to 12 months for pregnant women in Medicaid can ensure consistent health care for new parents and newborns during a consequential period of maternal health and early child development.* Policymakers in at least 20 states have taken steps to support consistent coverage during and after pregnancy by extending postpartum coverage.[37] The Urban Institute estimates that extending postpartum Medicaid coverage to one year after delivery has the potential to help at least 200,000 low-income uninsured mothers gain needed coverage.[38] Twelve months of continuous postpartum eligibility would also bring mothers' enrollment in line with the one year of coverage federal law guarantees for infants whose birth was paid for by Medicaid. This option is currently only available through a state 1115 waiver, but Congress has proposed measures to require or allow states to more easily adopt extended postpartum coverage.[39] We urge you to include this measure in the President's budget proposal.

**RFI Questions 3: What initiatives, including community-based efforts, have shown a positive impact on addressing barriers or maximizing opportunities?**

Ensuring continuous health care coverage is an essential first step but efforts cannot stop there. Medicaid and CHIP can also support interventions and services that have shown promise in improving both health outcomes and equity.[40] State Medicaid 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.

*Targeting intensive supports, such as case management, to beneficiaries with known risks based on public health data.* Medicaid and other coverage sources should 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.[41] 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.[42] States could go further by designating health homes for women with two or more chronic conditions, to serve as an interdisciplinary practice hub to address the range of social and medical needs women have before, during and after pregnancy. 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. States with strong comprehensive home visiting models, such as those funded by HHS's Health Resources and Services' Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), can explore ways to improve linkages between home visits and primary care practices as well.

*Supporting two/multi-generation approaches to care.* Maternal and child health are inextricably linked in the prenatal period and early years of a child's life. Particularly in rural areas where provider shortages may make it difficult for women and children to see specialists, recognizing each interaction with the health system as a place where mother and child can be served together can maximize the reach of the health system for families in rural areas. 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 for babies born at low birthweight.[43] The group care model can also help to buffer stress that comes with parenting 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 South Carolina's model found it reduced the risks of premature birth, low birthweight and neonatal intensive care stays for babies, saving about $30,000 for each negative outcome avoided.[44] For South Carolina's $1.7 million invested, there was an estimated return on investment of nearly $2.3 million.

*Exploring new telehealth strategies to serve mothers and babies together.* Telehealth can help augment the level of care available to rural mothers and children. For instance, Georgia's Centering Pregnancy program connected the Georgia Department of Public Health, Southwest Georgia Public Health District and an Atlanta-based maternal-fetal medicine specialist to provide telemedicine consultations for African-American and Hispanic women with high-risk pregnancies participating in the program.[45] During the COVID-19 pandemic, home visiting services, early intervention therapies, mental health services and well-child visits are increasingly available to families via telehealth[46] and in many states, Medicaid agencies are reimbursing providers for these services.[47] These practices are promising, and could support rural residents' access to care even after the immediate COVID crisis subsides.

*Using pediatric well-child visits to identify parent needs that can impact early child development, such as postpartum depression.* Well-child visits during the first few years of life offer a critical opportunity to reach families and connect them to needed supports, including mental health. 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.[48] Moms experiencing depression have a harder time bonding with their children[49] and AAP found that children living with mothers with depression may "…show impaired social interactions and delays in development."[50] 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.[51]

States have taken action to incorporate mothers' mental health into infant well-child visits. A 2016 information bulletin from CMS encouraged state Medicaid agencies to support maternal depression screenings during well-child visits.[52] 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.[53] These options should be widely publicized to providers and families in rural areas.

Comprehensive, team-based pediatric primary care approaches can further help to ensure practices have the tools needed to connect new parents to needed supports and follow-ups. Co-locating services in the medical home can also reduce transportation barriers, a major challenge in rural areas. 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. These 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 rates of maternal depressive symptoms, prolonged breastfeeding and increased attendance at well child visits. DULCE is a similar model which uses a family specialist and screens for social determinants of health.[54] 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.[55]

*Using parental risk factors to ease access to needed parent-child services or treatments.* Many states use a parent mental health or substance abuse disorder to trigger eligibility or reimbursement for parent-child treatment, specific parenting programs, or other needed supports that can help the mother and the child together. 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.[56] 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).[57] Supporting children whose parents have a diagnosed substance use disorder is especially important in rural areas, where opioid disorder rates, in particular, have increased among women giving birth.[58]

*Monitoring compliance with mental health parity and network adequacy for managed care organizations (MCOs) and service providers.* Medicaid and CHIP must include behavioral health and substance use disorder treatment, particularly for pregnant women and new mothers at the highest risk, at the same levels as more traditional physical health care.[59] As mentioned above, a leading cause of death for new mothers in the postpartum year is drug overdose, and rural areas are the hardest hit in the opioid use disorder crisis. Evidence-based SUD treatment has also proven more effective in treating pregnant women and keeping families together, rather than punitive state approaches including jail time, which jeopardize a family's stability and interrupt the critical bonding between parent and child in the earliest years.[60]

States can also help to develop or champion resources that identify providers who will treat pregnant women and new mothers' mental health or other needs by insurance type. For example, Utah's Department of Health recently launched a searchable provider database of maternal mental health providers with location and types of insurance coverage accepted, including listing providers who treat women who are uninsured.[61]

*Creating or expanding the reach of state Maternal Mortality Review Committees (MMRCs) with strong representation by Medicaid beneficiaries and agency staff.* Many states have developed Maternal Mortality Review Committees (MMRCs) to deeply review the cause of each maternal death and develop recommendations of action that could help prevent similar deaths.[62] 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. It is through this process that many states are understanding rural and ethnic disparities affecting pregnant women. Including voices of the communities most affected—rural, communities of color, low-income communities, tribal communities—which are critical to identifying the root causes of maternal morbidity and mortality.

*Including other maternity care provider types (e.g. nurse midwifes, doulas) and additional settings (e.g. birth centers, telehealth).* States employ a range of payment and delivery system approaches for maternity care in Medicaid. Some only reimburse hospital providers and obstetricians for birth, while others cover nurse midwives, doulas and birth care that happens

outside of hospitals.[63] Given the range of approaches states employ, CMS should continue to monitor, share, and elevate best practices and payment approaches involving a broader range of providers and settings. For example, the CMS Center for Medicare and Medicaid Innovation (CMMI)'s Strong Start Birth Center evaluation found positive maternal health and birth outcomes for low risk pregnant women who gave birth in freestanding birth centers, as well as cost savings.[64] While hospitals are necessary, particularly for 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. 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."[65]

Social distancing guidelines and stretched hospital capacity from the COVID-19 pandemic have driven many states to expand telehealth options and consider new settings and financing for needed care. State experiences during this period will provide lessons to learn from on the most effective ways to extend access to prenatal and postpartum care beyond traditional settings and providers.

*Requiring or encouraging 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 and their infants, 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.

*Adopting comprehensive quality improvement efforts.* As the largest payer for maternal health, Medicaid should help to drive system-wide quality improvement efforts. 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[66] have been shown to improve outcomes for pregnant women and newborns in hospital settings.[67] 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."[68]

### RFI Questions 4: What can CMS do?

Based on the range of opportunities outlined above, we recommend CMS consider the following steps to assist states in their efforts to improve rural maternal health.

**Promote Medicaid expansion without added red tape.** The link between state expansion and improved outcomes for pregnant women and newborns is striking. New conditions on Medicaid coverage such as work reporting, coverage lockouts, and others depress enrollment, even if a potential beneficiary is exempt.[69] Coverage should be accessible to all women without extraneous conditions. Our state analyses of pending Section 1115 Medicaid demonstration proposals to impose work requirements on parents, most recently in South Carolina, highlight the disproportionate impact of coverage losses that would ensue on Black women and families in rural areas.[70] Given the alarming racial and geographic disparities that already exist, now is not the time to add barriers that would undermine efforts to improve their access to care.

**Approve proposed state Medicaid demonstrations testing the postpartum coverage extensions beyond 60 days and propose 12 months of postpartum coverage for *all* pregnant women in Medicaid as part of the Administration's budget and legislative proposals.** We applaud CMS's recognition of the importance of extending postpartum coverage beyond the current 60 days postpartum, to mitigate, "the ongoing pregnancy-related risks and chronic conditions that women experience up to a year after giving birth."[71] Yet the President's most recent budget proposal fell short by limiting the 12-month postpartum coverage extension *only* to women with substance use disorders. The breadth of barriers to care during a consequential and stressful time after a child's birth, combined with growing state interest, illustrate the importance of ensuring a full year of postpartum coverage to *all* women who give birth while covered by Medicaid.

**Encourage state adoption of eligibility and enrollment options for pregnant women in Medicaid and CHIP.** CMS could offer state plan amendment (SPA) or waiver templates for eligibility and enrollment options that serve to enhance access among women before, during and after pregnancy, such as presumptive eligibility or a full 12 months of postpartum coverage. The recent emergency SPA template provided in the current COVID-19 emergency offers one example. CMS could also issue an informational bulletin highlighting the benefits of these streamlined eligibility and enrollment options.

**Reinstate rules that monitor payment and access to care.** CMS has proposed rescinding two important means for states to monitor access to care: the so-called Access Rule, requiring 1) states to monitor payment rates and access to care in fee-for-service settings; and 2) minimum network adequacy standards required for Medicaid managed care.[72] Taken together, these rules would provide better information and review of access to needed care.

**Issue additional guidance or tools on evidence-based or promising new ways to reach rural pregnant women and their families, including shared guidance with partner agencies where possible.** CMS has issued informational bulletins on timely issues related to pregnant women and their children in recent years, including home visiting (with HRSA) and mental health and substance abuse. Such bulletins or related guidance could help states identify promising approaches that may work in their states. Many of the state examples and models outlined in CMS's 2019 issue brief,[73] as well as new innovative options that have been identified during the pandemic (e.g. telehealth), could be packaged to promote state adoption. CMS's recent toolkit on telehealth is one such example. As states continue to learn about the best ways to reach rural pregnant women, CMS can further lift up and promote those lessons in real time. Possible topics could include:

- Serving new mothers and infants together, lifting up, but not endorsing, specific dyadic interventions or models. CMS raised the importance of mother-newborn interactions as part of treatment in 2018 neonatal abstinence syndrome guidance, for example.[74]
- Successful approaches to access and quality by a broader range providers or settings (e.g. doulas, stand-alone birth centers) and how they may work in rural areas.
- Interventions or models expressly linked to improving outcomes for Black, American Indian/Alaska Native, Latina, and Asian women, especially in rural areas.
- Monitoring and reporting on referrals and access to mental health and substance abuse treatment for, as required by federal parity and access laws.
- Opportunities to designate health homes for women with two or more chronic conditions, to serve as an interdisciplinary practice hub to address medical, behavioral, and social service needs before, during and after pregnancy.[75]
- Targeting intensive services, such as case management, to certain high-risk beneficiaries based on public health data.
- Team-based primary care approaches that support new parents.

Given the wide range of knowledge across the Department of Health and Human Services (Administration for Children and Families, CDC, HRSA, Substance Abuse and Mental Health Services Administration, and more) about what works, joint guidance would also be a powerful signal to states about the importance of serving rural pregnant women and showcasing the expertise of agency partners. Highlighting linkages between proven or promising interventions to Medicaid payment could help states to consider new approaches. Joint guidance would also

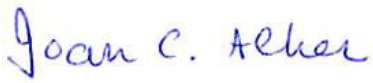
be one specific way to inform and model the strong, ongoing cross-agency partnerships between Medicaid, public health, social services, early childhood, child welfare, and other agencies that are central to effective investments and service delivery at the federal, state, and community levels.

**Strengthen Medicaid data reporting and monitoring at the state and MCO plan levels, especially by race and ethnicity where possible.** We are pleased to see the work on the CMS Maternity Core Set, including measures from the Child and Adult Core sets, many of which states will soon be required to report.[76] In addition to reporting statewide measures, it will be difficult to fully understand Medicaid's role without the ability to understand process and outcome measures disaggregated by managed care plan, region or community, and provider types. Moreover, any ability to understand Medicaid payments by beneficiary race and ethnicity are essential to pinpoint specific gaps in care for certain communities of women. CMS can further lift up ways state Medicaid agencies can prioritize women's health care in their state quality strategies. Examples include requiring more robust and real-time data reporting by plans, prioritizing or requiring plans to adopt performance improvement projects or corrective actions, requiring MCO coverage for promising interventions, or linking payments to quality improvements.

**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 – especially those in rural areas. Women of color and their families face additional barriers in rural areas and these racial disparities must be addressed in any strategy to combat the unacceptable rates of maternal and infant mortality in the United States. As the largest payer of pregnancy related care, a strong and well financed Medicaid program is essential to any national response to the burdens on rural communities. We appreciate your interest in this critical issue and value the chance to respond. If you have any questions, please contact Elisabeth Wright Burak (ewb27@georgetown.edu, 202-687-0883).

Sincerely,



Joan C. Alker
Executive Director and Research Professor

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