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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 addressthis 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

At the federal level, a number of legislative initiatives specific to maternal mortality have been introduced.

The AHA supported provisions included in the American Rescue Plan Act of 2021 (Public Law No: 117-2) that gives states, for five years, the option to extend Medicaid and Children's Health Insurance Program (CHIP) eligibility to pregnant individuals for 12 months postpartum, rather than the current law coverage of 60 days. States choosing this option must provide the full Medicaid benefit for pregnant and postpartum individuals during the 12-month postpartum period.

Regarding legislation introduced in the 117th Congress, AHA supports provisions of the Black Maternal Health Momnibus Act (H.R. 959/S. 346), which seeks to end preventable maternal mortality and severe maternal morbidity in the United States and reduce disparities in maternal health outcomes. Of the twelve bills that are part of the omnibus package, we are supportive of those that address the impact of COVID-19 on pregnant women, as well as behavioral health needs, cultural competency, gaps in the perinatal work force and the social determinants of health that contribute to inequities.

We supported in the last Congress the Maternal Health and 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 provide funding to promote best practices and educate health care professionals on implicit bias. The legislation passed the House and we are hopeful that similar legislation will be introduced and moved through the legislative process this year.

In order to address social needs for mothers, the AHA supported in the last Congress the Social Determinants Accelerator Act (H.R. 4004/S. 2986), which would provide planning grantsand technical assistance to help states and communities address the social determinants of health for high-need Medicaid beneficiaries. Key provisions of the legislation and funding of $3 million was included in the Consolidated Appropriations Act of 2021 (Public Law No: 116-260). The Centers for Disease Control and Prevention (CDC) is expected to issue a Notice of Funding Opportunity this April for "Closing the Gap with Social Determinants of Health Accelerator Plans." We are hopeful that the SDAA sponsors will reintroduce this Congress the full Accelerator Act legislation, which would make substantially more funding available to states and local governments to develop Social Determinant Accelerator Plans.

We also support in the 117th Congress the Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act (S. 509), legislation to assist states in building statewide or regional collaborations to better coordinate health care and social services by leveraging local expertise and technology to help connect people to food, housing, child development, job training, and transportation supports and services.

The AHA supports the funding of maternal health programs at the federal level. The Title V Maternal and Child Health Block Grant (MCHBG) is a cost effective, accountable and flexible funding source used to address the most critical, pressing, and unique needs of maternal and child health populations in each state, territory and jurisdiction of the United States. According to data gathered by the Health Resources and Services Administration (HRSA), 92% of all pregnant women, 98% of infants, and 60% of children nationwide benefitted from a Title V-supported service in FY 2019. The flexibility of the grant program has also allowed Title V programs to address the impact of COVID-19 on pregnant women and children at the local level, including providing hotline resources, funding for remote monitoring equipment and funding for contactless delivery of newborn supplies, such as cribs and diapers. 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. And we were pleased that the Consolidated Appropriations Act of 2021 (Public Law No: 116-260) provided $44 million, an increase of $5 million, for the National Institutes of Health (NIH) Office of Research on Women's Health, $10 million for NIH research on premature births, $63 million, an increase of $5 million, for CDC efforts on safe motherhood, and $975 million, an increase of $32 million, for HRSA programs to improve maternal and child health.

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% federalmatch, which would then

scale down over the next several years to the permanent 90%federal match. The American Rescue Plan Act of 2021 (Public Law No: 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 (FMAP) for their base program by 5 percentage points for two years. We know that 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].

As mentioned previously, we supported the provision in the American Rescue Plan Act of 2021 (Public Law No: 117-2) that gives states, for five years, the option to extend Medicaid and CHIP eligibility to pregnant individuals for 12 months postpartum, rather than current law which provides a federal match for only 60 days postpartum. We support making the requirement mandatory and permanent for states, rather than optional and for the next five years only, 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 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 PPDduring the postpartum period by ensuring coverage is an important tool for improving women's health during this critical time.[4]

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. We supported provisions in the American Rescue Plan Act of 2021 (Public Law No: 117-2) that further reduced the cost of Marketplace coverage for all subsidy-eligible individuals and families by increasing the dollar value of the premium tax credit subsidies. For example, individuals making between 100% and 150% of the federal poverty level (FPL) will not pay anything in Marketplace premiums. In addition, the law expands eligibility for the tax credit subsidies to more individuals. Specifically, more households above 400% FPL, the current maximum eligibility threshold, are newly eligible for subsidies. These changes are temporary and in effect for tax years 2021 and 2022.

Require state Medicaid programs to cover telemedicine for maternal care. Telehealth has become essential during the COVID-19 pandemic for use in all patient care, including maternal care, in order 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 nothave obstetric providers. Only a small number of state Medicaid programs mentionobstetrical 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.[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 facilitieswith no obstetric provider on-site.[6]

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.[7]

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.[8] We are pleased that the American Rescue Plan Act of 2021 (Public Law No: 117-2) includes up to $880 million to help more eligible families access the WIC program and to temporarily increase food benefits. These efforts include: modernizing WIC's enrollment and recertification processes; integrating WIC into health care settings, such as by including WIC in routine prenatal or pediatric appointments; increasing outreach; and a state option to increase monthly benefits.

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 improveoutcomes 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.[9]

Funding for implicit bias training. Entities including teaching hospitals, health systems and medical schools could qualify for grants for ongoing training of health careprofessionals regarding implicit bias and cultural competence. This training would teachproviders 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.

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 canbe difficult to achieve in a timely manner. The use of midwives, especially in underserved areas, can improve access and outcomes.[10] 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.[11] 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.[12]

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.[13]

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 determiningmaternal 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 initiativesthat support these efforts – and include transportation to and from the meetings as well as child care – would be beneficial for their patients.

Sources

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