American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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The Honorable Charles Grassley
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide suggestions regarding how to improve maternal health in this country.

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

We appreciate the Senate Finance Committee's work to address the important issue of maternal health, and would ask that any additional legislation introduced at the federal level be mindful of what is already happening at the state and local levels, both under voluntary and mandatory efforts, so that the impact is additive and does not result in fragmented care.

For example, in Texas, the Department of State Health Services partnered with the Alliance for Innovation on Maternal Health (AIM) and the Texas Hospital Association to

create the TexasAIM initiative. Texas hospitals are currently implementing three AIM maternal bundles focused on reducing obstetric hemorrhage, improving obstetric care for women with opioid use disorder and reducing severe hypertension in pregnancy. The state also requires each hospital, by August 31, 2021, have a maternal level of care designation in order to receive Medicaid reimbursement for obstetrical care. The designations are Level I, II, III or IV, with Level IV being the highest level of maternal care and Level I the lowest.

In New York City, the Health and Human Services Department implemented a five-year plan to focus on reducing maternal deaths and life-threatening complications of childbirth among women of color. Funding has been made available to:

- Establish a Maternal Hospital Quality Improvement Network to collect and review severe maternal morbidity data, identify problem areas in care and incorporate best practices to improve patient outcomes;
- Create comprehensive maternity care at the city's public hospitals, NYC Health + Hospitals;
- Enhance the quality and timeliness of data with information provided by the NYC Maternal Mortality and Morbidity Review Committee as well as the NY State Health Department; and
- Launch a public education campaign with community residents and providers regarding pregnancy-related health risks.

In Colorado, Saint Joseph Hospital received funding from the Zoma Foundation to start the Denver-Area Continuum of Maternal Mental Health project, which developed comprehensive mental health screening and treatment for women throughout pregnancy, delivery and one-year postpartum. The program uses the AIM Maternal Mental Health Patient Safety Bundle to organize care. The project began at Saint Joseph and is being extended to SCL Health's three other hospitals – Good Samaritan, Lutheran and Platte Valley Medical Centers.

Also, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Mathematica to compile an inventory of Medicaid initiatives to improve pregnant women's access to services and the quality of care they receive in the states and territories, in which they cataloged almost 400 policies across the following areas: eligibility and enrollment; education and outreach (to providers and beneficiaries); covered benefits; models of care; payment; managed care contracting; performance measurement; and other efforts.

These are but a handful of examples of the substantive work happening in the field that the Committee should consider as it focuses on maternal health.

AHA ACTIVITIES

The AHA has been active in improving maternal health by working to reduce early-elective deliveries, unnecessary caesarian sections, obstetric hemorrhage, preeclampsia and substance use disorders. We also partner with national organizations to safeguard mothers and babies, both before and after delivery. For example, we are a member of AIM, a national, data-driven maternal safety and quality effort.

Regarding policy development for the organization, the AHA's Section for Maternal and Child Health, formed more than 20 years ago, is composed of individuals representing health care leadership from leading women's and children's health provider organizations and systems. The council's discussions focus on public policy issues concerning women's and children's health and the hospitals serving this patient population.

Within the AHA, our Better Health for Mothers and Babies initiative serves as the organizational framework for addressing maternal health. We recognize that expectant and new mothers are at risk from the first days of pregnancy through the postpartum period, and we know that hospitals and their community partners want to do more to improve their care.

The AHA provides a number of resources to our members, including:

- Evidence-based tools that can be implemented by hospitals of all sizes, such as AIM Patient Safety Bundles, California Maternal Quality Care Collaborative toolkits, the Centers for Medicare & Medicaid Services' (CMS) Maternal Opioid Misuse Model, and recommendations from maternal mortality review committees (MMRCs);
- Information for patients and families about the mental health conditions associated with pregnancy, screening recommendations, and initiatives from the March of Dimes and Merck for Mothers, among others; and,
- Links to clinical organizations, including the CMS Strong Start for Mothers and Newborns Initiative and the Council on Patient Safety in Women's Health Care.

We have developed an Action Plan and Checklist to help our members meet the goal of eliminating maternal mortality and reducing severe morbidity. These resources include recommendations for providers and toolkits reflecting best-practices to help hospitals and health systems evaluate and act on their data.

The Action Plan recommends that hospitals:

- Evaluate and act on data.
- Examine disparities.
- Engage mothers and families.
- Partner with clinicians and stakeholders in their community.

This Action Plan is being implemented in partnership with the AHA Physician Alliance, two AHA affiliates - the American Organization for Nursing Leadership and the Institute for Diversity and Health Equity – as well as state, regional and metropolitan hospital associations and AIM.

We also developed a Discussion Guide to help hospital-based clinicians – working with community-based providers and other stakeholders – improve access to care and reduce health inequities for expectant and new mothers. The guide is designed to facilitate discussion and information-sharing within a hospital or health system's practice and among providers across the continuum, covering prenatal care, labor and delivery, discharge protocols and the postpartum period.

We recently shared with the field an interactive Data Visualization and Infographic that highlights racial disparities in maternal health. The Data Visualization allows hospital, health system and state, regional and metropolitan hospital association leaders to examine maternal mortality data, which is stratified by race and time of maternal death (up to 42 days and one year), nationwide and by region and state.

In addition to the resources outlined above, our website features podcasts, webinars and case studies focused on the field's ongoing work to improve maternal health.

FEDERAL LEVEL INITIATIVES AND ACCREDITATION

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

Regarding legislation introduced in the 116th Congress, AHA supports provisions of the Mothers and Offspring Mortality and Morbidity Awareness Act (S. 916/H.R. 1897) that would improve state maternal mortality data, provide funding to promote safety

practices and cultural competency, and extend health coverage and services for low-income postpartum women, including by extending Medicaid and Children's Health Insurance Program (CHIP) coverage for a year postpartum.

The AHA supports the Maternal Health Quality Improvement Act (H.R. 4995), which would help hospitals and health systems improve maternal health by authorizing grants to improve care in rural areas and funding to promote best practices and educate health care professionals on implicit bias, and the Helping Medicaid Offer Maternity Services Act (H.R. 4996), which would give states the option to extend Medicaid and CHIP coverage for pregnant and postpartum women from the current 60 days to one year after birth, with a 5% increase in the Federal Medical Assistance Percentage for the first year a state opts to extend the coverage. It also would require MACPAC to issue a report on access to doula care in Medicaid. Both bills passed the House Energy and Commerce Committee in November.

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

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

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

RECOMMENDATIONS

Regarding our recommendations to the Committee, the AHA suggests the following actions that could be taken at the federal level, including:

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

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

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

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6090644/
[2] https://www.whijournal.com/article/S1049-3867(20)30005-0/fulltext; https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf
[3] https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304218; https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf
[4] https://www.ajmc.com/conferences/acog-2018/obstetricians-are-well-positioned-to-diagnose-treat-postpartum-depression-speakers-say

Require state Medicaid programs to cover telemedicine for maternal care. Telehealth could be used to provide access to care for urban and rural areas that do not have providers, both for regular care throughout the perinatal period as well as consultations with specialists. Only a small number of state Medicaid programs mention obstetrical care in their telemedicine reimbursement law and only 19 state Medicaid programs reimburse for telemedicine services delivered to the patient in their home, which limits reimbursement of services, such as lactation assistance and in-home monitoring during and after pregnancy.[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]

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]

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

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[5] https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/
[6] https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w#T3_down
[7] Ibid.
[8] https://www.fns.usda.gov/wic/about-wic-how-wic-helps
[9] https://www.ajog.org/article/S0002-9378(20)30034-X/fulltext

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

ADDITIONAL INPUT

Use of non-physician clinicians, and continuity and coordination of care. Our members would like to see an increased use of midwives and nurse practitioners (NPs) and other clinicians in all aspects of maternal care (prenatal/surgical assist in obstetrics/ postpartum). Hospitals identified this as an area of dire need. In particular, NPs' strong medical backgrounds make these clinicians very suitable not only to provide routine care but also address other issues, such as expediting subspecialty consults, which can be difficult to achieve in a timely manner. The use of midwives, especially in underserved areas, can improve access and outcomes.[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 African American 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.[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. As discussed earlier, issues around maternal morbidity, such as maternal cardiac disease and mental health,

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[10] http://ruralhealthquarterly.com/home/2018/07/09/might-midwives-help-fill-rural-maternity-care-gaps/
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/
[12] https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/?utm_source=MHTF+Subscribers&utm_campaign=fb5b5d09ab-RSS_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_8ac9c53ad4-fb5b5d09ab-183820997; https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12213

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 in this letter will address high rates of adverse outcomes for all women, including those living in rural areas.

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

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

[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5380444/

Thank you for the opportunity to submit information to the Committee on this important topic. We look forward to continuing to work with you to improve the health of our mothers and babies.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

cc: Members of the U.S. Senate Committee on Finance