



Virtual Roundtable Discussion on Improving Maternal Health

Monday, October 26, 2020, 2-3 p.m. ET

This roundtable is sponsored by the Blue Cross Blue Shield Association, with content development at the sole discretion of NASHP

Speakers

- **Maureen Hensley-Quinn**, NASHP Senior Program Director (Moderator)
- **Anita Stewart**, MD, Medical Director, Blue Cross Blue Shield of Illinois
- **Lynnette Rhodes**, Medicaid Director, Georgia Department of Community Health

Medicaid Initiatives to Improve Maternal Health

- The Medicaid and CHIP Payment and Access Commission (MACPAC) worked with Mathematica to catalog maternal health improvement initiatives in Medicaid
- Nearly 350 efforts identified in areas such as:
 - Covered benefits (e.g. screening for postpartum depression and home visiting)
 - Payment models or policies
 - Beneficiary or provider education and outreach
 - Managed care contracting strategies
 - Performance measurement and performance improvement projects
 - Eligibility and enrollment
 - Models of care delivery

Source: Slides from MACPAC panel on State Medicaid Initiatives to Improve Maternal Health held on 2/27/20:
<https://www.macpac.gov/wp-content/uploads/2020/02/Panel-State-Medicaid-Initiatives-to-Improve-Maternal-Health.pdf>





MATERNAL/CHILD HEALTH PREVENTATIVE CARE PILOT

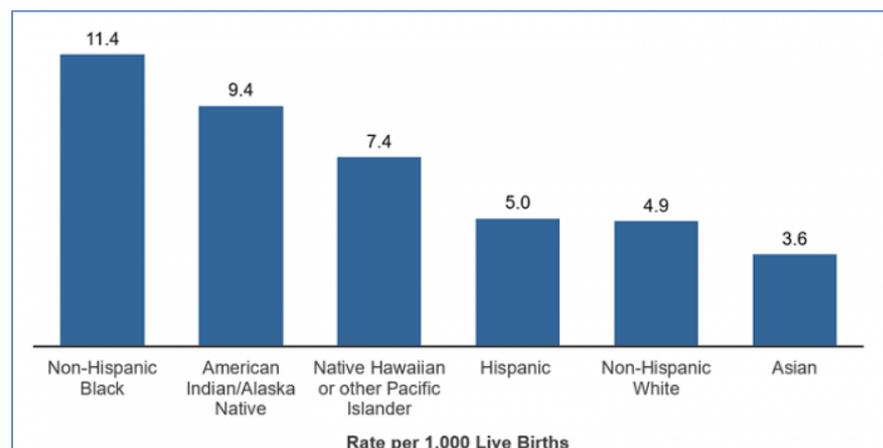
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CURRENT STATE: MATERNAL AND CHILD HEALTH

- In comparison to other developed nations, the United States ranks poorly in preventing maternal deaths, despite outspending all other nations in hospital provided maternity care.
- The maternal mortality rate increased from 17 deaths per 100,000 live births in 1990 to 26 deaths per 100,000 in 2015.
 - **Meanwhile, worldwide the maternal mortality rate decreased by 44%.**
- The infant mortality rate in the United States is 5.9 deaths per 1,000 live births.
 - **However minority, in particular Black African American, infants are at the greatest risk.**

Infant Mortality Rates by Race and Ethnicity, 2016



CDC: Infant Mortality <https://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm>



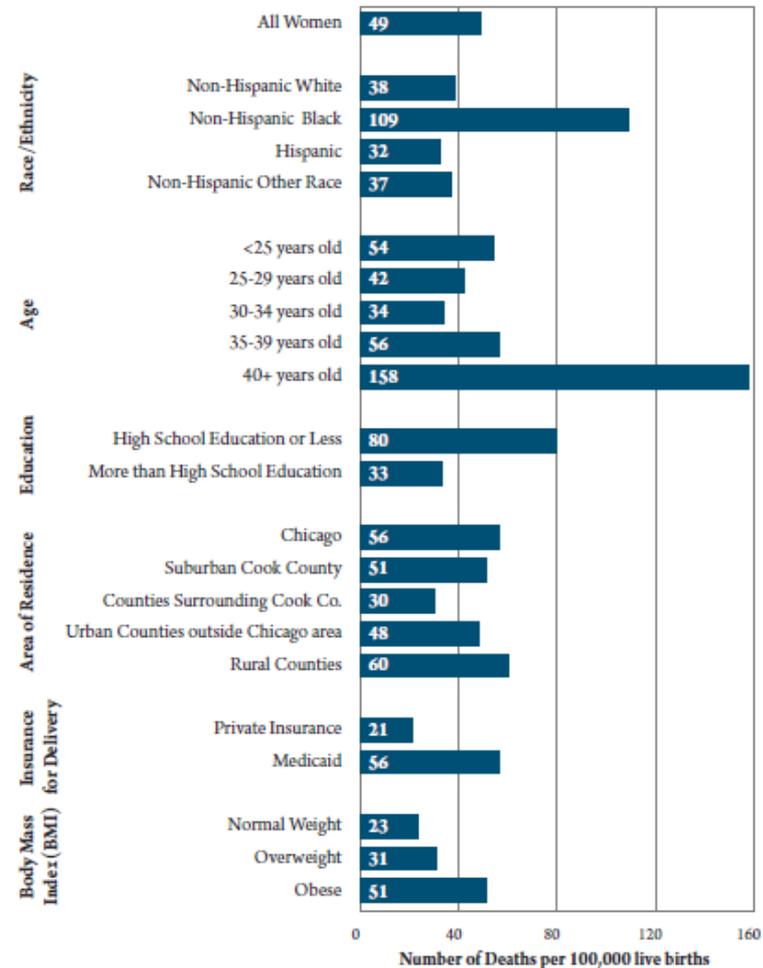
CURRENT STATE: MATERNAL AND CHILD HEALTH

- In general, minority women are more likely to have decreased access to high quality information on reproductive health, and health related services than White women.
- Minority women are also more likely to fall victim to discrimination within the healthcare system, experiencing greater incidents of disrespect and indignity.
- The population at greatest risk for death is Black/African American women.
- Native populations within the continental United States and Alaska also have poor outcomes in comparison to White women.

MATERNAL AND CHILD HEALTH IN ILLINOIS

- Nationally: 26 deaths per 100,000 in 2015
 - Black women are 3 to 4 times more likely to die of pregnancy-related complications as White women.
- In Illinois, an average of 73 women died each year within one year of pregnancy (2008-2016).
 - Black women are 6 times more likely to die of pregnancy-related complications than White women.

Figure 7: Pregnancy-Associated Mortality Ratio (PAMR), By Demographics, Illinois 2014-2016



PILOT OVERVIEW

PROJECT SUMMARY



BCBSIL seeks to ensure the Medicaid line of business is able to provide equitable access to preventive health care and reduce health disparities prevalent in the maternal and child population.



BCBSIL proposes a 12-month pilot, which would address several of the social determinants of health that negatively impact health outcomes in the maternal and child population. Pilot program would be member and community centered.



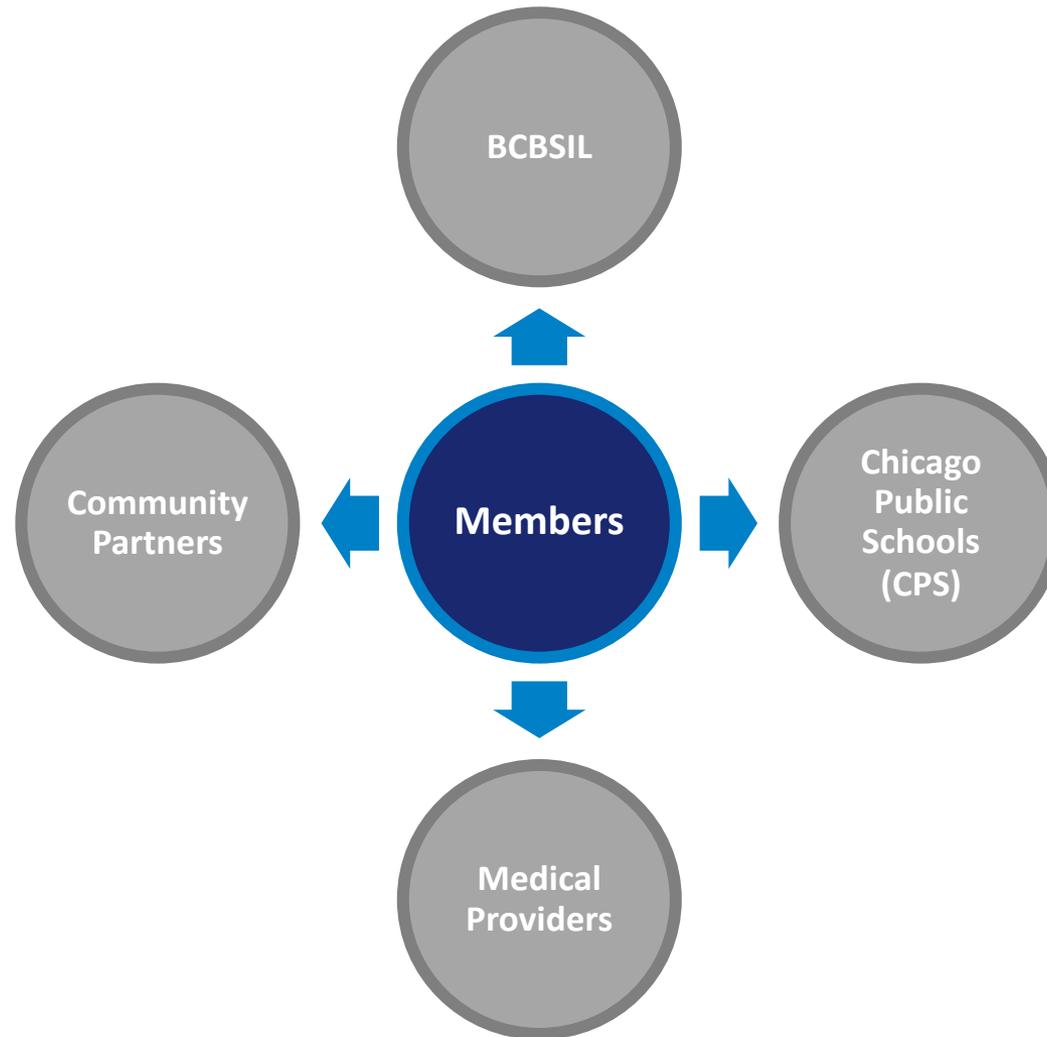
In partnership with community organizations and medical providers, BCBSIL will develop approaches that will improve maternal and child health outcomes. These approaches include the development of referral systems with identified partners, as well as the creation and dissemination of preventative healthcare information.



Pilot program is expected to reduce the number of elective, non-medically necessary Caesarian sections and NICU admissions, as well as improve HEDIS rates in prenatal visits and immunizations. Improved HEDIS rates would lead to potentially greater recoupment of withholds from the State.



BCBSIL & COMMUNITY PROVIDERS: HUB AND SPOKE MODEL



EXPECTATIONS & TIMELINE



GOAL 1: REDUCTION OF C-SECTIONS

Strategy 1

OB providers will provide the indication for C-section and gestational age of infant on all claims

Strategy 2

Identify community organizations for partnership

Strategy 3

Medicaid staff will identify and reach out to community organization that will serve as resource hubs

Strategy 4

Develop linkage agreements with the identified community organizations and providers



GOAL 2: IMPROVE RATES OF PRENATAL AND POSTPARTUM CARE

Strategy 1

- Identify zip codes with high rates of maternal and child health disparities to serve as target areas
- Identify at least 3 OB practice groups within each target area willing to partner with BCBSIL

Strategy 2

- Develop a reward system for members and community partners
 - Reward offered upon completion of milestone (i.e. completion of prenatal care visits; reward offered day of completion)

Strategy 3

- OB provider offices identified will be offered on-site or telephonic BCBS Care Coordinators to work with BCBS members
- Care Coordinator will aid the provider in obtaining needed resources that are covered in the benefit plan or via community resources



GOAL 3: IMPROVED PEDIATRIC IMMUNIZATION AND DENTAL CARE RATES

Strategy 1

- Leverage relationship with Chicago Public Schools and develop a referral system for children in need of:
 - Immunizations
 - Preventive dental care
 - Preventive health care

Strategy 2

- Involve community organizations in the distribution of information regarding importance of immunizations and dental care
- Continue meetings with Chicago Public School to further define working relationship

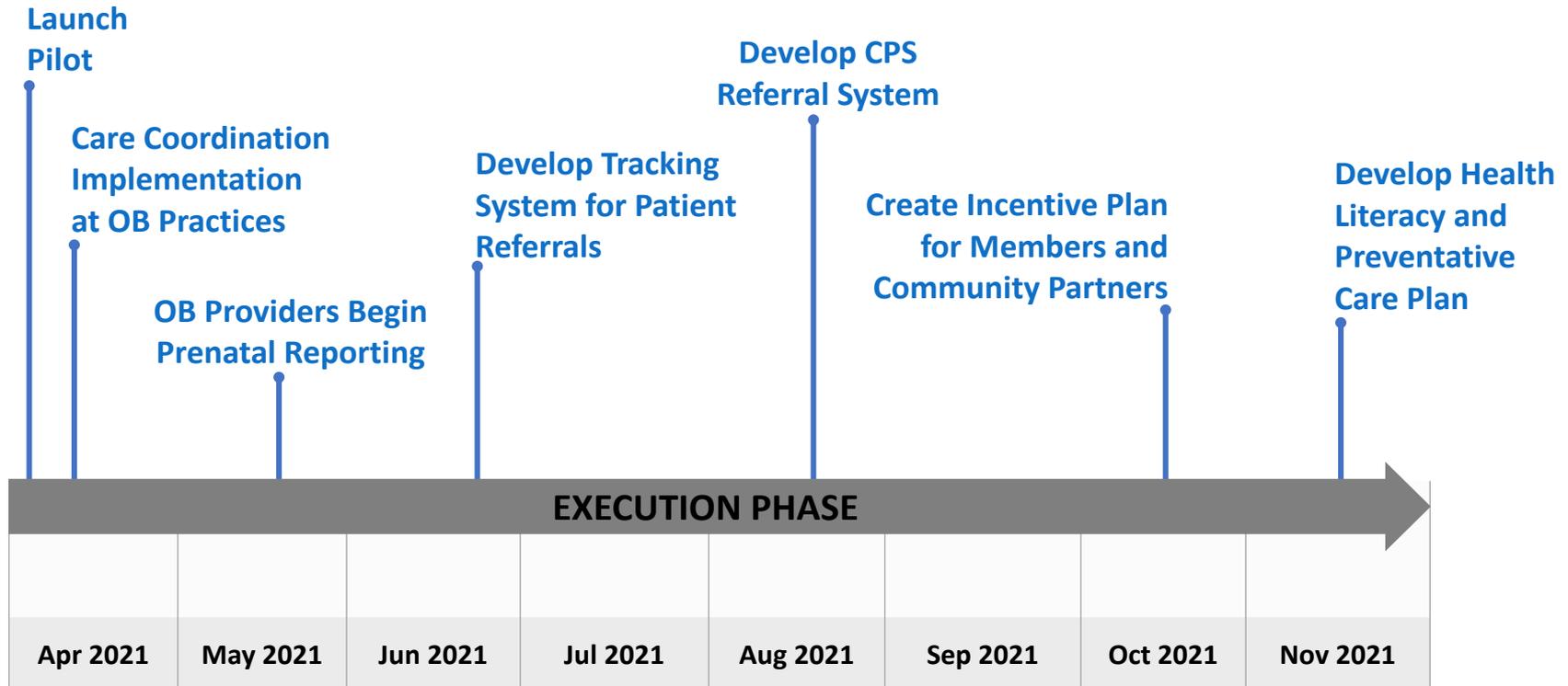


PROPOSED PILOT TIMELINE: PLANNING





PROPOSED PILOT TIMELINE: EXECUTION



KEY DELIVERABLES

MEASURABLE OUTCOMES

Process/Sustainability Measures	Health Outcomes Measures
<ul style="list-style-type: none"> • Number of community resources able to provide health and other resources • Number of community referrals sent by BCBSIL care coordinators to each community resource • Number of referrals received by BCBSIL care coordinators from community entities for resources • Number of patient referrals/information given to community residents by community entities • Number of members obtaining 7 or more prenatal visits and at least one postpartum visit in offices utilizing care coordination <ul style="list-style-type: none"> ○ Comparison to similar practice without care coordination 	<ul style="list-style-type: none"> • Rate of C-sections performed • Rate of preterm C-sections performed without documentation of medical necessity • Rate of NICU admissions • Number of pregnant women identified as high risk status post pregnancy • Number of pediatric visits resulting in immunization • Number of visits resulting in pediatric dental care

NEXT STEPS

NEXT STEPS



Engage appropriate leaders to support pilot



Establish Workgroup meeting cadence



Perform target area analysis

APPENDIX



MATERNAL & CHILD HEALTH RESOURCES

- [Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes](#)
- [Reducing Early Elective Deliveries in Medicaid and CHIP](#)
- [Racial/Ethnic Disparities in Pregnancy-Related Deaths](#)
- [Early Elective Deliveries in Medicaid](#)
- [Variation in NICU Admission Rates Without Identifiable Cause](#)
- [Association Between NICU Admission Rates and Illness Acuity](#)
- [Decision Making About Method of Delivery on the U.S.-Mexico Border](#)



PROPOSED PILOT GANTT CHART

Activity	2020				2021												2022												
	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q4	Q4	Q4		
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19	M20	M21	M22	M23	M24	M25	M26	M27	M28	M29
Initiation and Planning Phase																													
Identify and Engage Medicaid team	x	x	x																										
Identify target areas (zip codes) with high MIH rates			x	x	x																								
Identify OB providers to partner with BCBSIL				x	x	x																							
Identify community organizations and resources				x	x	x	x	x																					
Engage CPS for partnership				x	x	x	x	x																					
Medicaid team to secure linkage agreements						x	x	x	x	x	x																		
Establish prenatal care requirement incentives for providers						x	x	x	x	x	x																		
Collect baseline data (prenatal and pediatric)							x	x	x	x																			
Implementation Phase																													
Launch pilot program								x	x	x	x																		
Care coordination implementation at OB practices								x	x	x	x	x																	
OB providers report prenatal data									x	x	x	x	x	x	x	x	x	x	x	x	x								
Develop a tracking system for patient referrals											x	x	x	x	x														
Develop CPS referral system												x	x	x	x	x	x												
Create incentive plan for members and community partners														x	x	x	x												
Develop health literacy and preventative care plan															x	x	x	x	x										
Post-pilot data analysis (prenatal and pediatric)																					x	x	x	x	x				
Review of claims data for elective non-medically necessary Caesarian sections and NICU admissions																					x	x	x	x	x	x	x	x	

NASHP Maternal Health Resources

- Maternal Health and Mortality resources page:
<https://nashp.org/policy/maternal-child-and-adolescent-health/maternal-health-and-mortality/>
- Map of State Efforts to Extend Medicaid Postpartum Coverage:
<https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/>
- Resources to Help States Improve Integrated Care for Pregnant and Parenting Women: <https://nashp.org/resources-to-help-states-improve-integrated-care-for-pregnant-and-parenting-women/>
- State Medicaid Policies for Maternal Depression Screening:
<https://healthychild.nashp.org/screening/maternal-depression-screening>



Georgia Section 1115 Demonstration Waiver Application

October 8, 2020

Department of Community Health

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Section 1: Program Description

The Georgia Department of Community Health (DCH) is seeking a five-year Medicaid Section 1115 Research and Demonstration Waiver to improve postpartum maternal morbidity and mortality in the State by extending access to quality care and by ensuring continuity of care and care coordination during the postpartum period. The waiver will allow the State to extend postpartum Medicaid coverage from 60 days to one hundred and eighty (180) days or six months to decrease postpartum maternal morbidity and mortality.

Section 1.1: Background

Created in 1999 by the General Assembly, DCH is one of four primary health agencies in Georgia. It is the State's primary agency for the deployment of Medicaid services. The Department's mission is to provide Georgians with access to accessible, affordable, and high-quality healthcare.

Currently, Georgia's Right from the Start Medical Assistance Group (RSM) enables children and adults under age 19, pregnant women, low income families, and women with breast or cervical cancer to receive comprehensive health services through Medicaid and related programs. The State currently administers RSM throughout a woman's pregnancy and through a 60-day postpartum period. In 2010, the State and DCH instituted the Planning for Healthy Babies (P4HB) program to supplement coverage for women through a Section 1115 Waiver. P4HB provides no-cost services to eligible women that include Family Planning Services, Interpregnancy Care (IPC), and Resource Mother Outreach for mothers who delivered very low birth weight (VLBW) babies.

The comparatively high rate of maternal mortality continues to be a pressing challenge for the State to ameliorate. This led the Georgia General Assembly (GGA) to pass H.R. 589 during the 2019 legislative session to create the House Study Committee on Maternal Mortality. The Committee set out to identify causes and potential solutions to the State's comparatively high maternal mortality rates. The Committee subsequently developed a final report based on a review of maternal death data from 2012-2015. Their findings showed that 60% of maternal deaths within the sample period were deemed preventable.

The State recognizes that maternal deaths are a serious public health concern with considerable short- and long-term individual, family, and societal impacts. Moreover, the State recognizes that in order to ultimately decrease maternal mortality in Georgia, intra-state coordination and collaboration is critical from the beginning. Accordingly, the GGA worked in consultation with DCH and Georgia's Department of Public Health (DPH) to craft and advocate for the passage of H.B. 1114 during the 2020 legislative session. Governor Brian P. Kemp subsequently signed the bill into law. There are two primary provisions of the legislation:

- The first provision authorizes the extension of Medicaid coverage for lactation services to pregnant and lactating women and their children. This provision will be implemented through the submission of a State Plan Amendment.
- The second provision, which is the focus of this Demonstration Waiver, authorizes the extension of postpartum Medicaid coverage from a period of 60 days to one hundred and eighty (180) days or six months. Through the extended duration of benefits during the postpartum period, the goal of the legislation is to provide continuity of care that will ultimately reduce maternal morbidity and mortality.

Section 1.2: Hypotheses & Evaluation

The following table presents an overview of the goals sought by the waiver, along with their respective hypotheses and metrics to evaluate

Table 1.1: Goals, Hypotheses, and Metrics

Goal	Hypothesis	Metrics
Reduce maternal morbidity and mortality for Medicaid members in Georgia	Extending eligibility for pregnant women from 60 days to one hundred and eighty (180) days or six months postpartum will reduce maternal morbidity and mortality for Medicaid members in Georgia by providing continued Care Management Organization (CMO) care coordination and continuity in provider networks at a medically vulnerable time.	Rates of maternal morbidity and mortality year-over-year. Number of women who access services during pre (5-year baseline with postpartum at 60 days) vs post (intervention of one hundred and eighty (180) days or six months postpartum) Postpartum visit rates pre vs. post
Support the long-term fiscal sustainability of the Medicaid program in Georgia	Targeting specific populations to extend Medicaid benefits rather than expanding will support the financial sustainability of the Medicaid program.	Total cost of health services per population capita pre- and post-intervention v. the national average

Section 1.3: Impact to Medicaid and CHIP

The legislation does not affect or modify any components of the State’s current Medicaid or CHIP programs.

Section 2: Demonstration Eligibility

Section 2.1: Populations Eligible

The proposal to extend postpartum care from 60 days to one hundred and eighty (180) days or six months will only be implemented for the eligibility groups included in the following table. The eligible populations will have incomes up to, but not exceeding, 220% of FPL with up to 5% income disregard in limited circumstances.

Table 2.1: Eligible Populations

Eligibility Group Name	CFR and Social Security Act Citations
Qualified Pregnant Women and Children	42 CFR § 435.116 SSA § 1902(a)(10)(A)(i)(III) SSA § 1905(n)
Mandatory Poverty Level Pregnant Women	SSA § 1902(a)(10)(A)(i)(IV) SSA § 1902(l)(1)(A)

Optional Poverty Level Related Pregnancy – Women & Infants	SSA § 1902(a)(10)(A)(ii)(IX) SSA § 1902(I)(2)
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Section 2.2: Determination, Maintenance, and Termination

Eligibility Determination

Eligibility for the extended postpartum period is determined by the date the birth takes place. The proposal extends existing postpartum coverage from 60 days to one hundred and eighty (180) days or six months (i.e., by an additional one hundred and twenty (120) days or four months). This extension has no material impact on eligibility determinations.

Individuals on other forms of Medicaid that are not listed in the table above are not eligible for this proposed extension; they will not transition into RSM coverage, and they will maintain their current coverage.

Maintaining Eligibility

To promote the continuity of postpartum care, a participant who is deemed eligible, according to the eligibility groups listed in Table 2.1, will maintain coverage for the duration of the one hundred and eighty (180) days or six month postpartum period, regardless of what point in the postpartum period they entered the program. After the conclusion of the 6-month postpartum period, an eligibility redetermination will be made pursuant to *42 CFR 435.916(a)* as to whether an individual will maintain their status as qualified for full Medicaid benefits as part of a separate eligibility group; the transition will take place automatically.

Section 2.3: Geography and Timeframe

DCH seeks a five-year Demonstration approval period and intends to implement the Demonstration statewide effective July 1, 2021.

In the interest of equity, DCH will extend a “transition period” to mothers whose 60-day postpartum benefits prior to this Demonstration would have expired between June 1, 2021 and June 30, 2021. For example, in the case of an April 15, 2021 delivery, mothers will be permitted to seamlessly benefit from the extended postpartum coverage proffered in this Demonstration.

Section 2.4: Enrollment Transitions

Individuals will seamlessly transition into this waiver exactly as they did previously under the 60-day postpartum benefit period; the substantive change is simply an extended postpartum benefit period. All mothers covered by this proposed extension will transition after the extended one hundred and eighty (180) days or six-month postpartum benefit period to the appropriate Medicaid program, if eligible, based on their current eligibility; this transition will take place automatically.

For those over Medicaid eligibility limits, transition into other P4HB offerings is an exception and will depend upon prior enrollment; specifically, if the individual was not formerly enrolled in the P4HB program, an application will have to be completed for the transition to take place.

Section 2.5: Eligibility Policies – Retroactive Coverage

There is no change to the State’s current retroactive coverage policy. New entrants to the program will have retroactive coverage back to the beginning of the month in which their application was submitted, and a one quarter look-back period will be reviewed for eligibility.

Section 3: Demonstration Benefits and Cost Sharing Requirements

This Demonstration does not change the current Medicaid benefit package design, except for the additional Resource Mother Services that will be provided to mothers who have given birth to a VLBW baby. There is no cost-sharing, copayments, or coinsurance for any existing Medicaid benefit provided under the waiver. Current benefits will continue to be applied in accordance with the State Plan Amendment and all eligible members will continue to receive all eligible benefits in the 6-month postpartum period covered by this waiver.

Section 4: Delivery System and Payment Rates for Services

Section 4.1: Managed Care Delivery System

Consistent with the current structure of the RSM program, the State will utilize a managed care delivery system to provide services to all members eligible for this proposed extension, other than those in SSI. The State currently contracts with multiple CMOs, which were selected through a competitive procurement process. The State does not intend to amend its existing contracts with its CMOs to implement the provisions of this 1115 Demonstration waiver. The State believes the existing CMO infrastructure has adequate capacity to handle the proposed extension of the postpartum period. If capacity issues arise, the State will reassess their contracting strategy in a timely fashion.

Section 4.2: Health Plan Selection

CMO assignment/selection will follow the same process used outside this waiver. Members who do not already belong to a CMO upon entry into the program will be automatically enrolled into a CMO. Members will then have a 90-day window to switch to a different plan if they choose to before being locked into their assigned plan until their annual anniversary date the following year.

Section 4.3: Payment Rates for Service

The capitation rate-setting methodology for this Demonstration will be the same methodology used to set rates for the current Medicaid populations and will comply with all federal rate-setting requirements and guidance. Rate cell determinations will be aligned with the respective age cohort in the RSM/LIM rate cell.

Section 5: Implementation of Demonstration

The State intends to implement this waiver statewide. The State anticipates an effective date of July 1, 2021. This aligns with the start of the CMO contract year.

Section 5.1: Notification

The State will develop and deploy an appropriate communications strategy to inform not only all current RSM enrollees, but also members in the “Transition Period” cohort. Pending approval of this Demonstration, DCH intends to provide notice by April 1, 2021.

Adequate notifications will be provided for those members who are in the “Transition Period” cohort.

Communications will also target CMOs, pertinent associations, hospitals, lactation service professionals, through provider-specific messages. Additional communications to all pertinent organizations will be conducted via email.

Because members will transition seamlessly into this augmented postpartum period at the conclusion of 60-day coverage, no additional enrollments will be required.

Section 6: Demonstration Financing and Budget Neutrality

Refer to Attachment 2 for the Budget Neutrality Historical, With Waiver, and Without Waiver exhibit. As discussed further below, the State is requesting the Postpartum Care population be considered “hypothetical”; therefore, a simplified single exhibit is provided.

Overview

The Georgia Postpartum Care 1115 Waiver provides 4 months of extended postpartum coverage for individuals up to 225% of the FPL. The individuals continuing their healthcare coverage will remain enrolled in the State’s capitated managed care program. The State currently contracts with multiple statewide CMOs to support the program and its enrollees. The State is requesting the waiver start as of July 1, 2021 to align with the projected implementation date and the current managed care program rate period.

Given that this population currently has coverage for 60 days of postpartum care and that the benefits remain unchanged, the State used exiting cost and utilization data to develop the baseline per member per month amount.

For purposes of this Budget Neutrality Section and for the population anticipated to enroll, the State is requesting the expenditures under this waiver to be considered “hypothetical” per the August 22, 2018 State Medicaid Director’s Letter (SMD #18-009):

“In cases where expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority, such as a waiver under Part 1915 of the Act, CMS considers these expenditures to be “hypothetical;” that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS currently makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were approved Medicaid state plan services.”

Enrollment

Table 6.2 summarizes enrollment estimates for the Postpartum Care population. The population figures reflected are the average assumed enrollment for each demonstration year (DY). Enrollment reflects the State’s estimates for those enrolling in CMOs.

The enrollment estimates were based on the number of monthly deliveries from State Fiscal Year (SFY) 2016 to 2020, with 2 months (approximately 60 days) following delivery month of current postpartum care coverage, and then 4 months of extended postpartum coverage.

While the Postpartum Care waiver coverage is forecasted to begin on July 1, 2021, the enrollment estimates reflect some enrollment of individuals that have lost coverage prior to July 1, 2021, should they re-enroll for coverage under the extended postpartum time period.

The enrollment ramp-up for DY01 assumes the following:

- 10% of January 2021 deliveries re-enroll July 2021
- 25% of February 2021 deliveries re-enroll July 2021
- 50% of March 2021 deliveries re-enroll July 2021
- 100% of April 2021 deliveries are extended coverage after the current 60-day coverage

Georgia DCH identified deliveries for the RSM group from July 2015 through June 2019 (SFY 2016 – 2019) and July 2019 through March 2020 (SFY 2020 year to date) with enrollment and claims paid

through June 2020. Using this RSM delivery data by month, region, and age cohort, the number of individuals that would have received the extended 4 months of postpartum care were determined. This historical enrollment estimate was determined assuming that 2 months post-delivery month (approximately 60 days) individuals would receive the current postpartum care coverage, followed by 4 months of extended postpartum coverage. Table 6.1 demonstrates how this was applied to the deliveries for each month of the historical data period. Table 6.2 summarizes the hypothetical historical enrollment with this logic applied to the data from July 2015 through March 2020.

Table 6.1: Sample Enrollment Assumption Applied to Historical Data

Delivery Month	Age Cohort	Region	Monthly Deliveries	Waiver Enrollment								
				Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Jul-18	21 – 44 Female	01- CMO Atlanta Region	838	Delivery	60 Day		Waiver Covered					
Aug-18	21 – 44 Female	01- CMO Atlanta Region	821		Delivery	60 Day		Waiver Covered				
Sep-18	21 – 44 Female	01- CMO Atlanta Region	836			Delivery	60 Day		Waiver Covered			

Table 6.2: Historical Hypothetical Enrollment based on SFY16-20 data

SFY / Month	7	8	9	10	11	12	1	2	3	4	5	6	Total MMs
2016	-	-	-	3,275	6,578	9,567	12,611	12,257	12,008	12,139	12,136	12,115	92,686
2017	11,688	11,343	11,069	11,108	11,467	12,957	14,044	15,285	16,532	16,532	16,394	15,790	164,209
2018	14,865	13,826	13,320	12,699	12,934	12,856	12,519	12,502	11,869	11,854	11,634	11,055	151,933
2019	10,109	9,185	8,619	8,528	8,991	9,091	9,825	10,517	11,244	12,329	12,459	12,597	123,494
2020	12,476	12,275	12,187	12,383	12,816	12,877	13,482	13,421	13,477	13,769	13,335	13,288	155,786
2021	9,766	6,220	3,186	-	-	-	-	-	-	-	-	-	19,172

Since deliveries in the first few months of the historical data would not be hypothetically covered under the extended postpartum period until October or later, completion and seasonality was applied to SFY 2016 hypothetical enrollment to have 5 full years of hypothetical historical enrollment (SF16-SFY20). Table 6.3 shows the completed enrollment for the historical period of SFY16-20.

Table 6.3: Completed Historical Hypothetical Enrollment for SFY16-20

SFY / Month	7	8	9	10	11	12	1	2	3	4	5	6	Total MMs
2016	11,402	10,820	10,487	10,376	10,722	11,087	12,611	12,257	12,008	12,139	12,136	12,115	138,159
2017	11,688	11,343	11,069	11,108	11,467	12,957	14,044	15,285	16,532	16,532	16,394	15,790	164,209
2018	14,865	13,826	13,320	12,699	12,934	12,856	12,519	12,502	11,869	11,854	11,634	11,055	151,933
2019	10,109	9,185	8,619	8,528	8,991	9,091	9,825	10,517	11,244	12,329	12,459	12,597	123,494
2020	12,476	12,275	12,187	12,383	12,816	12,877	13,482	13,421	13,477	13,769	13,335	13,288	155,786

Table 6.4: Historical Average Monthly Enrollment by SFY

2016	2017	2018	2019	2020
11,513	13,684	12,661	10,291	12,982
Trend	18.9%	-7.5%	-18.7%	26.1%
5-year average trend				3.0%

Table 6.5 summarizes estimated enrollment and eligible member months for each of the demonstration years applying the average enrollment trend for the hypothetical historical population of 3.0%.

Table 6.5: Estimated Enrollment by Demonstration Year

Demonstration Year (DY)	Eligible Member Months	Average Monthly Enrollment
DY1	151,555	12,630
DY2	170,231	14,186
DY3	175,338	14,612
DY4	180,598	15,050
DY5	186,016	15,501

Expenditures Per Member Per Month (PMPM)

5-Year Georgia Families historic average certified capitation rates for SFY 2016 to 2020 by rate cohort and region were provided by the State’s rate setting actuary to develop the PMPM estimates. There are 18 unique managed care rate codes varying by cohort and region that currently include pregnant women and the 60-day postpartum coverage. Individuals in the extended one hundred and twenty (12) days or four month postpartum coverage will remain in these rate cohorts during coverage.

The historical PMPM for the hypothetical population was determined using the enrollment methodology described in the prior section and applying the actuarially certified capitation rate for the related SFY to the hypothetical extended postpartum coverage period. Table 6.6 summarizes the weighted average capitation rate for the 5-year historical period using the historical enrollment estimates described in the enrollment section.

Table 6.6: Historical Average Capitation Rate by SFY

FY	Effective Date	End Date	Rate Cohort	Region	Ave. Cap Rate
2016	Jul-15	Jun- 16	All	All	322.03
2017	Jul-16	Jun- 17	All	All	319.44
2018	Jul-17	Jun- 18	All	All	319.39
2019	Jul-18	Jun- 19	All	All	332.01
2020	Jul-19	Jun- 20	All	All	337.61

This weighted average was trended forward to determine the base period PMPM for the demonstration years. Based on the recently submitted 1115 Georgia Pathways demonstration waiver which leveraged projected trends in the approved Calendar Year (CY) 2018 Georgia Families Rate Certification, experience observed in other states, and review of the President’s trend, the State is applying a 4.5% annual trend rate applied to the SFY 2020 average capitation rate to develop the projected demonstration year PMPMs. Table 6.7 shows the demonstration year PMPMs.

Table 6.7: Estimated PMPM for Waiver by Demonstration Year

DY1	DY2	DY3	DY4	DY5
\$368.68	\$385.27	\$402.61	\$420.73	\$439.66

Non-Benefit Expenses

The actuarially sound capitation rates effective during the demonstration years for the expanded Postpartum Care waiver coverage population will need to include considerations for administrative expenses, risk margin, and premium based taxes, etc. These costs have been included in the weighted average capitation rate used for the historical PMPMs and therefore included in the projected demonstration year PMPMs.

Retroactive Coverage

Given that the vast majority of individuals receiving the Postpartum Care extended coverage also delivered their baby while enrolled in Medicaid, the estimates do not include any prior quarter costs. Prior period costs are already reflected in the capitation rate development.

Premiums and copays

There are no premiums or copays for this population so there are no adjustments reflected in the PMPM.

Please see **Attachment 2** for the State’s historical and projected expenditures for the requested period of the Demonstration.

Section 7: List of Proposed Waivers and Expenditure Authorities

Section 7.1: Title XIX Waivers

Below is a list of proposed waivers necessary to implement Georgia's 1115 Demonstration:

- **Definition of Pregnant Woman: SSA § 1905(n)/42 CFR § 435.4**
 - Necessary to redefine “qualified pregnant woman or child” (SSA) and “pregnant women” (CFR) to augment the baseline postpartum period from 60 days to 6 months.
- **Extended Eligibility & Continuous Eligibility: SSA § 1902(e)(5) and (6)/42 CFR § 435.170(b) and (c)**
 - Necessary to extend both eligibility and continuous eligibility for newly defined “qualified pregnant woman or child” and “pregnant woman” from 60 days to 6 months.
- **Suspended Renewals Until End of Postpartum Period: 42 CFR § 435.916(a)**
 - Necessary to ensure continuity of coverage for newly defined “pregnant woman” until after the augmented postpartum period ends, i.e., six months plus one day post-delivery.

Section 7.2: Expenditure Authorities

Under this Demonstration, the State also requests expenditure authority for women up to 220% of the FPL (i.e., 225% with 5% disregard) for the extended 4-month postpartum period of coverage, which are not otherwise included as expenditures under § 1903 of the SSA. These expenditures shall, for the Demonstration, be regarded as matchable expenditures under the State's Medicaid Title XIX State Plan.

Section 8: Public Notice and Comment Period

Section 8.1: Public Notice

The Public Notice & Comment Period will begin on October 8, 2020 and will close on November 9, 2020, lasting 30 days.

Section 8.2: Public Hearings

The State will hold two public hearing on the dates listed below:

Public Hearing 1: Thursday, October 15, 2020 at 11:00 a.m. EST via WebEx Audio. Log in information is as follows:

Event number: 127 018 2352

Event password: Public

1. Copy the following link to a browser:
<https://dchevents.webex.com/dchevents/onstage/g.php?MTID=eb1f15c274a1077f7db5bf0f92172dcd0>
2. Click "Join Now".
3. To Join the audio conference only:
Call-in toll number (US/Canada): 1-650-479-3207 Access code: 127 018 2352

Public Hearing 2: Monday, October 19, 2020 at 10:00a.m. EST, at the following location (in-person):

Mercer School of Medicine-Savannah Campus
Hoskins Center for Biomedical Research

1250 East 66th Street, Savannah, GA 31404

Individuals attending in-person will be required to comply with the requirements of the Mercer School of Medicine pertaining to the wearing of masks and other restrictions due to COVID-19

Each of the two public hearings will follow the same format, beginning with an overview of the waiver proposal, followed by the collection of oral public comment. A court reporter will transcribe and enter into the public record all verbal comments presented during each of the public hearings. The transcripts from each of the public hearings will be available on the Department of Community Health's website, <https://medicaid.georgia.gov/>. A sign language interpreter will be available at all the hearings for the individuals present, and individuals requiring special accommodations, including auxiliary communicative aids and services during these meetings can request such accommodations in advance of the meeting.

Section 8.3: Public Comments

In addition to making public comments at the public hearings, individuals may submit written comment by email at postpartum.comments@dch.ga.gov or by mail at the following address:

Attn: Lynnette Rhodes
Georgia Department of Community Health
2 Peachtree Street, NW, 36th Floor
Atlanta, GA 30303

The State will provide a comprehensive list of the comments received during the 30-day period to CMS, as well as a summary of the State's responses that note how/if the State incorporated the feedback into their final application.

Section 8.4: Tribal Consultation

The State of Georgia does not have any Federally recognized Indian tribes within its borders and thus has not established a separate process for consultation with any tribes with respect to this Section 1115 Demonstration waiver application.

Section 9: Demonstration Administration

Name and Title: Lynnette Rhodes, Executive Director, Medical Assistance Plans, Georgia Department of Community Health

Telephone Number: 404-656-7513

Email Address: lrhodes@dch.ga.gov

Attachment 1: Evaluation Plan

Evaluation Outcome Measures	Target or Comparison Subgroups	Data Sources	Analytic Methods
Goal 1: Reduce the rate of postpartum morbidity and mortality			
<ul style="list-style-type: none"> • Morbidity and mortality in postpartum women compared to years prior controlling for population (e.g., per # births) • Number of women who access services during pre (baseline) vs post (intervention) • Postpartum visit rates 	<ul style="list-style-type: none"> • No control group – Demonstration applies to all • Data will be collected to include demographic comparisons, i.e., age, race • No inclusion or exclusion criteria except for date of birth compared to implementation date 	<ul style="list-style-type: none"> • DCH Data <ul style="list-style-type: none"> ○ Claims ○ Enrollment • DPH Data <ul style="list-style-type: none"> ○ Death records 	<ul style="list-style-type: none"> • Pre (5 year aggregate baseline) vs. post (after intervention implementation) comparison <ul style="list-style-type: none"> ○ Chi² to determine statistically significant difference pre vs. post ○ Difference-in-difference approach to assess the magnitude of lead measures ○ Track and trend HEDIS / Adult Core Set measure <i>Prenatal and Postpartum Care: Postpartum Care</i>
Goal 2: Support the long-term sustainability of the state's Medicaid program by maintaining fiscal balance			
<ul style="list-style-type: none"> • Total cost of health services per population capita compared pre and post intervention. 	<ul style="list-style-type: none"> • No control group – Demonstration applies to all • Data will be collected to include breakdown of spending categories 	<ul style="list-style-type: none"> • DCH Data <ul style="list-style-type: none"> ○ Claims ○ Enrollment 	<ul style="list-style-type: none"> • Annually compare 5-year fixed pre cost to post costs • Determine changes in utilization by spending category • Test association between additional months of coverage and acute care utilization

Attachment 2: Budget Neutrality With and Without Waiver Exhibits

RSM Historic Summary	2016	2017	2018	2019	2020	5-Years
Total Expenditures	\$ 44,491,408	\$ 52,454,916	\$ 48,525,755	\$ 41,000,950	\$ 52,595,041	\$ 239,088,069
Eligible Member Months	138,159	164,209	151,933	123,494	155,786	733,581
PMPM Cost	\$ 322.03	\$ 319.44	\$ 319.39	\$ 332.01	\$ 337.61	\$ 325.89
Trend Rates	2016	2017	2018	2019	2020	Average
Total Expenditures		17.9%	-7.5%	-15.5%	28.3%	4.3%
Eligible Member Months		18.9%	-7.5%	-18.7%	26.1%	3.0%
PMPM Cost		-0.8%	0.0%	4.0%	1.7%	1.2%

Trend	Base Year - 2020	Months of Aging	Trend	DY 01	DY 01 Ramp Up	Waiver Trend
Eligible Member Months	155,786	24	3.0%	165,273	0.917	3.0%
PMPM Cost	\$ 337.61	24	4.5%	\$ 368.68		4.5%

Extended Postpartum Without Waiver	DEMONSTRATION YEARS (DY)					TOTAL
Pop Type: Hypothetical	DY 01	DY 02	DY 03	DY 04	DY 05	WOW
Eligible Member Months	151,555	170,231	175,338	180,598	186,016	
PMPM Cost	\$ 368.68	\$ 385.27	\$ 402.61	\$ 420.73	\$ 439.66	
Total Expenditure	\$ 55,875,423	\$ 65,584,897	\$ 70,592,832	\$ 75,982,997	\$ 81,783,795	\$ 349,819,943

Extended Postpartum With Waiver	DEMONSTRATION YEARS (DY)					TOTAL
Pop Type: Hypothetical	DY 01	DY 02	DY 03	DY 04	DY 05	WW
Eligible Member Months	151,555	170,231	175,338	180,598	186,016	
PMPM Cost	\$ 368.68	\$ 385.27	\$ 402.61	\$ 420.73	\$ 439.66	
Total Expenditure	\$ 55,875,423	\$ 65,584,897	\$ 70,592,832	\$ 75,982,997	\$ 81,783,795	\$ 349,819,943

HYPOTHETICALS VARIANCE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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IMPROVING BLACK MATERNAL CARE AND HEALTH THROUGH PREGNANCY AND CHILDBIRTH

Despite tremendous health advances, the United States continues to have the highest maternal death rate of any developed country. While most of the world has drastically reduced rates of maternal mortality over the past several decades, the U.S. is one of a handful of countries where the problem has not only worsened, but has worsened significantly.

Across the country, maternity care deserts, continued disparities in the rates of health insurance coverage and affordability concerns are threatening women's access to necessary care before, during and after childbirth. These barriers, among other challenges, help contribute to substantial racial disparities facing African American women.

60% OF PREGNANCY-RELATED DEATHS are preventable.¹

Black women are **3X MORE LIKELY** than white women to die from pregnancy-related complications.²

Preeclampsia and eclampsia are **60% MORE COMMON** among African American women.³

As an important step in improving Black maternal healthcare, the Blue Cross Blue Shield Association (BCBSA) strongly supports the "Momnibus" bill authored by Black Maternal Health Caucus Co-Chairs, Reps. Underwood and Adams. BCBSA is working to build support for this important legislation, which focuses on addressing gaps in the existing maternal health system that contribute to these disparities and result in Black women experiencing higher rates of pregnancy-related complications and more maternal health complications.

¹ CDC. 2019. "Pregnancy-Related Deaths | VitalSigns." Centers for Disease Control and Prevention. May 14, 2019. <https://www.cdc.gov/vitalsigns/maternal-deaths/>.

² Pregnancy Mortality Surveillance System." 2019. 2019. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>.

³ Finger, Kathryn, Iris Mabry-Hernandez, Quyen Ngo-Metzger, Tracy Wolff, Claudia Steiner, and Anne Elixhauser. 2017. "STATISTICAL BRIEF #222 Highlights Delivery Hospitalizations Involving Preeclampsia and Eclampsia, 2005-2014." <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb222-Preeclampsia-Eclampsia-Delivery-Trends.pdf>.

At the community level, Blue Cross and Blue Shield companies are working with physician, hospital and community partners to lead initiatives that break down barriers, address disparities and close critical access gaps for a safer and healthier pregnancy, delivery and postpartum.

HERE ARE SOME EXAMPLES:



In Maryland, Virginia and Washington, D.C., **CareFirst BlueCross BlueShield** is awarding \$2 million over the next two years to programs seeking to improve birth outcomes, maternal health and lower infant mortality rates. CareFirst already has contributed more than \$18 million to address these issues since 2007, and the investments are paying off. From 2009 to 2018, through the B'More for Health Babies Initiative, Baltimore City, whose residents often have significant unmet maternal and child health needs, saw a 36 percent decrease in infant mortality, a 38 percent decrease in the Black-white disparity in infant mortality and a 55 percent decrease in teen births.



Blue Cross & Blue Shield of Mississippi (BCBSMS) supports hospitals in improving health outcomes through the BCBSMS Maternity Quality Model. There are three focuses: the 39 Weeks Initiative, a partnership with network clinicians to reduce the number of medically unnecessary early term deliveries; Baby Friendly, which enhances the mother/baby experience through training and education; and Maternal Safety Bundles, a partnership with Mississippi Perinatal Quality Collaborative focusing on education and training for improving maternal care.

As part of Maternal Safety Bundles, BCBSMS is training healthcare professionals in hospitals throughout the state to better identify and respond to complications – including severe bleeding and high blood pressure – which are two of the most preventable causes of pregnancy-related deaths that are often undetected, misdiagnosed or ignored. They are also working towards safely reducing the number of medically unnecessary C-sections.

Finally, the Blue Primary Care Women's Wellness Home initiative is expanding the relationship between patient and OB-GYN by addressing a mother's unresolved chronic illnesses – high blood pressure, diabetes and obesity – a common source of maternal and infant complications at birth. This is helping to close a critical access gap in rural Mississippi, where the maternal mortality rate is highest.



BlueCross BlueShield of Tennessee has helped establish an extensive network of telemedicine sites in rural communities – called the Solutions to Obstetrics in Rural Communities (STORC) – to improve access to specialty care for women with high-risk pregnancies. Rather than traveling to one of the state's major cities for care, STORC sites are staffed with an ultrasound technician and an advanced practice nurse who can video conference with a specialist. Currently, there are STORC sites in 13 rural Tennessee communities, many with no obstetrical specialists or women's healthcare professionals at all. The program, which began in 2009 with 134 visits, grew to 3,953 visits in 2018. More than 90 percent of women in the program have delivered healthy babies.



Blue Cross and Blue Shield of Louisiana offers Healthy Blue Beginnings for mothers with high-risk pregnancies. The program identifies at-risk women and offers expectant mothers confidential nursing support specific to their individual needs. Expectant mothers are also encouraged to sign up for text4baby, which sends free health and safety tips via text message. Each message is tailored to the mother's due date.

Additionally, Healthy Blue, a Louisiana Medicaid health plan, takes a proactive approach to maternal and infant health offering expectant mothers the comprehensive program, New Baby, New Life. Pregnant women undergo risk assessments to determine the level of support they'll need throughout pregnancy. The program provides the women with enhanced case management, care coordination and education.



Blue Cross and Blue Shield of South Carolina is part of a statewide collaboration helping babies reach their first birthday. The South Carolina Birth Outcomes Initiative educates women about the benefits of regular prenatal care and the importance of waiting until 39 weeks before giving birth. Now, fewer babies are born with low birth weights; fewer spend their first weeks in the NICU; there has been a 30 percent decrease in babies born before 37 weeks; and infant mortality has dropped to its lowest rate in 20 years.

As part of our efforts to better understand the scope of the issue, BCBSA's Health of America (HoA) initiative⁴ harnessed data to examine the most significant complications that occurred in 1.8 million pregnancies and deliveries between 2014 and 2018. As the insurer to one in three Americans, we have unique insights into the health of the population in virtually every ZIP code in the United States.

Here are some findings from the HoA analysis:

When controlling for income and geography (urban/suburban/rural), Black women experience higher rates of preeclampsia and multiple delivery complications than Hispanic and white women. However, Black women experience lower rates of gestational diabetes and embolism compared to the other groups.

PREGNANCY AND CHILDBIRTH COMPLICATIONS

Select Complications	Prevalence Rate of Complications in 2018 (per 1,000)			
	Overall	Black	Hispanic	White
Pregnancy				
Gestational Diabetes	147.5	138.5	160.4	145.1
Preeclampsia	64.5	85.8	63.1	63.8
Childbirth				
Eclampsia	1.7	2.2	1.9	1.2
Cardiomyopathy	2.1	2.7	0.8	2.5
Embolism	2.7	2.0	2.7	3.1
Sepsis	2.5	3.5	4.9	1.8

CHRONIC CONDITIONS

Independent of pregnancy and when controlling for income and geography, Black women have higher underlying prevalence rates for the physical conditions examined as well as substance use disorders compared to Hispanic and white women. In comparison to Black and Hispanic women, white women have lower rates of diagnosed chronic conditions, but higher rates of diagnosed anxiety and major depression.

Select Conditions	Prevalence Rate of Chronic Conditions in 2018 (per 1,000)			
	Overall	Black	Hispanic	White
Physical Conditions				
Hypertension	8.2	12.7	7.5	8.1
Type II Diabetes	4.4	5.1	4.6	4.4
Diagnosed Obesity	18.2	26.1	17.6	17.6
Diagnosed Behavioral Health Conditions				
Substance Use Disorder	1.7	2.0	0.9	1.7
Anxiety	18.7	13.7	12.2	19.5
Major Depression	5.5	4.2	3.3	6.1

⁴ The analysis was based on the data of over 1.8 million pregnancy episodes between the ages of 18 and 44 with BCBS coverage between 2014 and 2018. There were approximately 350,000 pregnancies annually for this population during this time. Pregnancy rate was calculated as a distinct number of pregnant women divided by a distinct number of all women within a given age range. Pregnancy complications were identified at any point during the pregnancy while childbirth complications were identified at any point during the delivery episode. Postpartum depression diagnosis was captured up to one year post-delivery. The more comprehensive health of these women before, during and after pregnancy was captured using BCBS Health Index data. The analysis incorporates the 2010 census data to examine the variation in maternal health by race. Additionally, the analysis only looks at the health of commercially insured women; however, if women covered by Medicaid were included, results would likely be different.

Because we do not have specific demographic data on BCBS enrollees, the cohort of women were defined based on their residency in ZIP codes with majority African American populations. Our cohort represented approximately 34 percent of all African Americans as per the 2010 U.S. Census. These included over 1,200 of the 40,000+ ZIP codes in the U.S. and captured approximately 12,600 pregnancies in 2018. Note, not all African American pregnancies were captured by these ZIP codes nor were all the pregnancies in these ZIP codes necessarily among African American women. Non-African American categories include all races/ethnicities except for African American. In order to control for income and geography (urban/rural/suburban), ZIP codes with majority African American populations were matched with ZIP codes that were majority white non-Hispanic, had similar per-capita income and identical geographic category.

POSTPARTUM DEPRESSION

Overall diagnosis of postpartum depression is on the rise across all races and ethnicities. However, diagnosis rates are growing fastest among Black women.

Population	Postpartum Depression Diagnosis Rate (per 1,000 women)					
	2014	2015	2016	2017	2018	Change from 2014-2018
Overall	73.6	72.2	65.1	80.9	94.6	28.5%
Black	59.5	55.4	47.7	62.3	78.8	32.4%
Hispanic	44.6	43.7	35.8	46.5	55.5	24.3%
White	76.5	75.2	68.4	84.7	99.2	29.7%

For the full HoA report on trends in pregnancy and childbirth complications in the U.S. visit: <https://www.bcbs.com/the-health-of-america/reports/trends-in-pregnancy-and-childbirth-complications-in-the-us>.

Published June 17, 2020

TRENDS IN PREGNANCY AND CHILDBIRTH COMPLICATIONS IN THE U.S.

HARNESSING DATA,
FOR THE HEALTH OF AMERICA.SM



CONTENTS

1. [Introduction and Key Findings](#)
2. [Increases in Pre-existing Conditions](#)
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INTRODUCTION

Millions of women give birth in the U.S. every year. A majority of these women have healthy pregnancies and deliveries. However, an analysis of Blue Cross Blue Shield data reveals an increasing number of women are experiencing pregnancy complications and childbirth complications.

This report examines 1.8 million pregnancies between 2014 and 2018 among commercially insured women ages 18-44.¹ While the overall pregnancy rate has declined by 2% in this population since 2014, it varies considerably by age. The rate for women ages 18-24 declined by 12% while the rate for women ages 35-44 increased by 9%. While the average age of pregnancy increased over the study period from 30.6 to 31, childbirth complications did not increase with age.

Using our market-leading claims database, this report digs deeper into this population of women to gain a better understanding of their health before, during and after pregnancy. It also showcases how Blue Cross and Blue Shield companies are taking actions to improve women's health across the country.

KEY FINDINGS

1. A **GREATER NUMBER OF WOMEN** ARE ENTERING PREGNANCY WITH PRE-EXISTING CONDITIONS.

2. THE NUMBER OF WOMEN EXPERIENCING BOTH PREGNANCY COMPLICATIONS AND CHILDBIRTH COMPLICATIONS **INCREASED 31.5%**.

↑ **16.4%** PREGNANCY COMPLICATIONS ↑ **14.2%** CHILDBIRTH COMPLICATIONS

3. WOMEN WITH PREGNANCY COMPLICATIONS ARE **TWICE AS LIKELY** TO HAVE CHILDBIRTH COMPLICATIONS.

4. THE NUMBER OF WOMEN DIAGNOSED WITH POSTPARTUM DEPRESSION **INCREASED BY NEARLY 30%**.



The [Health of Millennials report](#) found double digit increases in millennials for 8 of the 10 top health conditions like major depression, hypertension and type II diabetes. Additionally, prevalence rates for these conditions are higher in millennials than in their Gen X counterparts at the same age.

1. This dataset includes only Blue Cross Blue Shield commercially-insured women, over 99% of whom were pregnant between the ages of 18-44.

2. In April 2020, BCBSA surveyed >1,000 of commercially insured women 18-44 who were pregnant or delivered in March/April to understand the impact COVID has had on their mental health, prenatal care, postnatal care and delivery plans.

CHRONIC CONDITIONS ARE MORE PREVALENT BEFORE PREGNANCY

There was a significant increase in the prevalence of chronic physical and behavioral health conditions before becoming pregnant from 2015 to 2018,³ with the largest increases seen in diagnosed obesity and major depression (see Exhibit 1). Pre-existing conditions increase the risk of pregnancy complications and childbirth complications.

EXHIBIT 1: PREVALENCE OF PRE-EXISTING CONDITIONS PRIOR TO PREGNANCY, 2015-2018

CONDITIONS	PREVALENCE RATE PER 100		
	2015	2018	CHANGE 2015-2018
PHYSICAL CONDITIONS			
Hypertension	6.3	8.2	31%
Type II Diabetes	3.4	4.4	28%
Diagnosed Obesity	9.1	18.2	100%
BEHAVIORAL HEALTH CONDITIONS			
Substance Use Disorder	1.4	1.7	24%
Anxiety	15.3	18.7	23%
Major Depression	4.1	5.5	35%



Listen

Blue Cross & Blue Shield of Mississippi has embedded health coaches and nutritionists in OBGYN offices to help women manage chronic diseases and lead healthier lives.

» LISTEN TO PODCAST

SURVEY: PRENATAL CARE

Experts recommend early and routine prenatal and postnatal care to ensure a safe pregnancy, childbirth and healthy postpartum period. However, a BCBSA survey found that some commercially insured women are not receiving this recommended care. Our survey⁴ found:

14% DID NOT RECEIVE PRENATAL CARE WITHIN THE FIRST TRIMESTER OF THEIR PREGNANCY.

➔ **46% of these women** did not receive this care due to social barriers such as availability of appointments, lack of transportation or nearby providers.

1/3 REPORTED RECEIVING FEWER THAN THE RECOMMENDED 10 PRENATAL VISITS.

➔ **Nearly a quarter** of these women reported having complications during childbirth.



Read

BlueCross BlueShield of Tennessee helped launch a major telemedicine network to serve rural women with high risk pregnancies. » READ MORE

THE IMPACT OF COVID-19²

Accessing prenatal care has changed for a majority of women since the start of the COVID-19 pandemic. **61% of the women** surveyed saw limited office hours from their doctors and **48% had their prenatal appointments shifted to virtual visits.**

More concerning is that **over 1 in 4 women surveyed missed prenatal appointments** since the start of the pandemic or when social distancing restrictions were put into place.



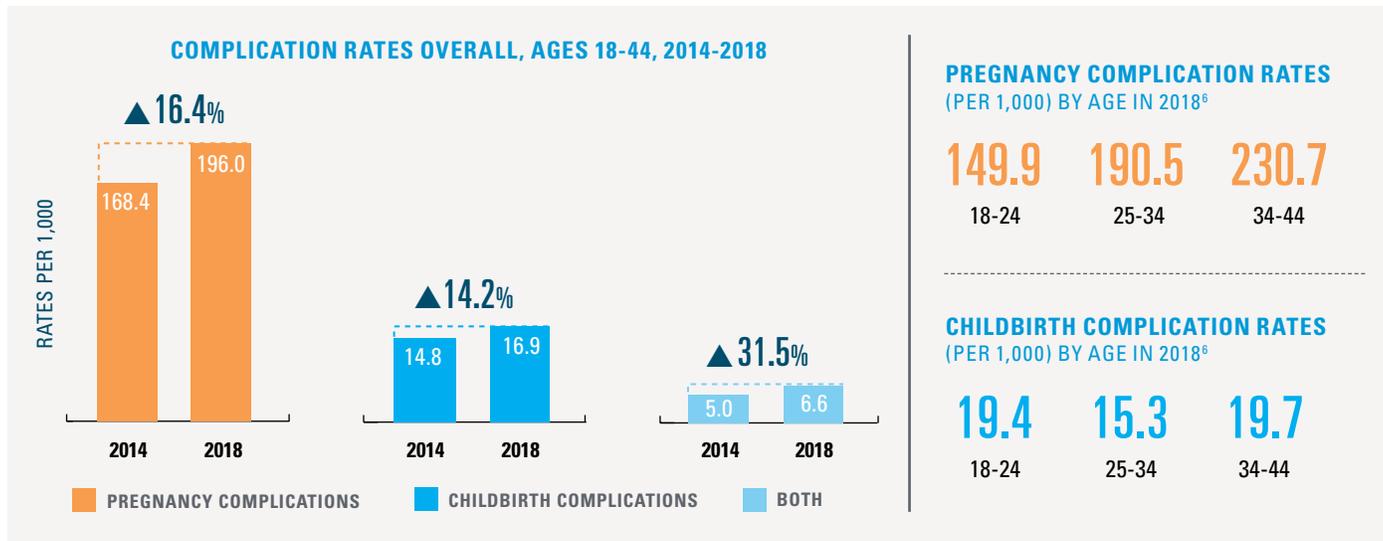
3. BCBS Health Index data only goes back to 2014, thus we're only able to examine prior health for women who were pregnant between 2015 and 2018.

4. In January 2020, BCBSA surveyed >1900 commercially insured women, ages 18-44, who delivered a baby in the last 12 months and asked them about their utilization of prenatal and postnatal care.

GESTATIONAL DIABETES AND PREECLAMPSIA DRIVING INCREASE IN PREGNANCY COMPLICATION RATES

While 80% of women have healthy pregnancies and deliveries, rates of complications are rising. Between 2014-2018, the rates of pregnancy complications rose more than 16%, while rates for childbirth complications rose more than 14%. About seven out of every 1,000 pregnant women experienced both kinds of complications, a nearly 31% increase since 2014. Pregnancy complication rates were much higher for older women⁵ (see Exhibit 2).

EXHIBIT 2: OVERALL RATES OF PREGNANCY COMPLICATIONS AND CHILDBIRTH COMPLICATIONS BY AGE, 2014-2018



Among pregnancy complications, rates of both gestational diabetes and preeclampsia increased by double digits. For childbirth, rates of almost all complications but transfusion increased by double digits, as well. While rates of childbirth complications were low, the rates of these complications are increasing rapidly (see Exhibit 3).

EXHIBIT 3: PREGNANCY AND CHILDBIRTH COMPLICATIONS AMONG WOMEN 18-44, 2014-2018

CONDITIONS	PREVALENCE RATE PER 1,000		
	2014	2018	CHANGE 2014-2018
PREGNANCY COMPLICATIONS			
Gestational Diabetes	126.6	147.5	16.6%
Preeclampsia	54.2	64.5	19.0%
CHILDBIRTH COMPLICATIONS			
Eclampsia	1.1	1.7	57.9%
Cardiomyopathy	1.5	2.1	39.0%
Embolism	2.0	2.7	32.0%
Sepsis	1.7	2.5	45.1%
Transfusion	8.5	7.8	-7.8%
Respiratory Distress	0.7	1.0	46.4%

5. Pregnancy complications include gestational diabetes and preeclampsia. Childbirth complications include eclampsia, cardiomyopathy, sepsis, embolism, transfusions, heart attack, respiratory distress, shock, and anesthesia complications occurred within a certain window surrounding delivery.

6. 2018 age distribution of pregnant women in the study: 18-24: 12.6%; 25-34: 61.0%; 35-44: 26.4%.

In addition, women who have complications during pregnancy, like gestational diabetes or preeclampsia, are twice as likely to have childbirth complications than women who did not have pregnancy complications.

EXHIBIT 4: RATES OF CHILDBIRTH COMPLICATIONS AMONG WOMEN WITH/WITHOUT PREGNANCY COMPLICATIONS IN 2018

CONDITIONS	CHILDBIRTH COMPLICATION RATE PER 1,000	
	NO PREGNANCY COMPLICATIONS	HAD PREGNANCY COMPLICATIONS
CHILDBIRTH COMPLICATIONS	13.3	29.1 (2.2X)
Eclampsia	0.4	6.3 (16.0X)
Cardiomyopathy	1.5	4.3 (2.9X)
Embolism	2.4	3.6 (1.5X)
Sepsis	2.3	3.0 (1.3X)
Transfusion	6.5	12.4 (1.9X)
Respiratory Distress	0.8	1.7 (2.2X)

 **Read**

Working with OBGYNs, Blue Cross and Blue Shield of Alabama helps make regular prenatal care safe during COVID-19.

» [READ MORE](#)

Rates of pregnancy complications and childbirth complications vary by state. These variations can be driven by a variety of factors like the overall health of women in those regions, provider practices, access to care and/or other social determinants of health.



THE IMPACT OF COVID-19²

The COVID-19 pandemic impacted delivery plans for the majority of women surveyed:



53% were not able to have a loved one in the delivery room with them.

15% used a different doctor.

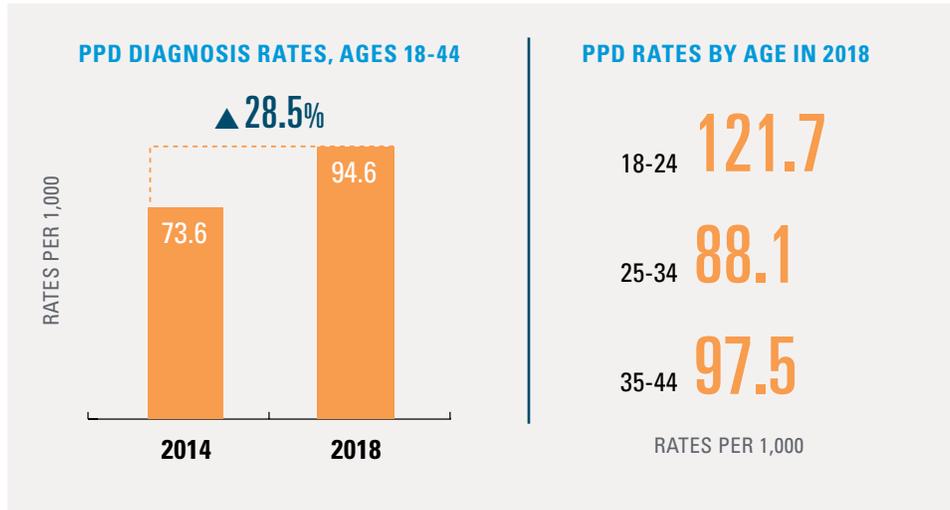
28% delivered at a different hospital than they originally planned.

15% shifted to a home birth.

INCREASES IN POSTPARTUM DEPRESSION

In 2018, nearly one in 10 women who delivered a baby was diagnosed with postpartum depression (PPD). That number is up almost 30% from 2014. Postpartum depression diagnoses were most prevalent in women aged 18-24. Some of this increase could be attributed to a greater awareness of the condition and more screening (see Exhibit 5).

EXHIBIT 5: RATE OF POSTPARTUM DEPRESSION (PPD) BY AGE, 2014-2018⁷



 **Read**

BlueCross & BlueShield of Rhode Island is providing resources for pediatricians to screen new mothers for postpartum depression and hire staff to connect them with treatment right away.

» [READ MORE](#)



AT RISK FOR POSTPARTUM DEPRESSION

Pre-existing behavioral health conditions are linked with a greater risk for postpartum depression. More than two thirds of women diagnosed with postpartum depression had at least one other behavioral health diagnosis before becoming pregnant, and more than 1 in 4 women had two or more pre-existing behavioral health conditions.

TOP PRE-EXISTING BEHAVIORAL HEALTH CONDITIONS AMONG WOMEN DIAGNOSED WITH POSTPARTUM DEPRESSION:



SURVEY: POSTNATAL CARE⁴

» **MOST WOMEN REPORTED RECEIVING THE RECOMMENDED POSTPARTUM CARE AT SIX WEEKS.**

However, **4% of women received no postpartum care at all.**

» **A MAJORITY OF WOMEN REPORTED BEING SCREENED FOR POSTPARTUM DEPRESSION.**

However, **26% said they were not screened** or did not know if they were screened.

IMPACT OF COVID-19²



Postnatal care plans changed for a majority of women due to COVID-19. **Over half said their doctor's office hours are limited** and **half have shifted to virtual visits.**

Additionally, a fifth of women missed their postnatal visits.

7. Our data shows a dip in diagnoses of postpartum depression in 2016 followed by a rise. This trend is likely driven by two events: 1) the transition from ICD-9 to ICD-10 medical coding in 2015 and 2) in 2016, the U.S. Preventive Services Task Force recommended screening for depression in the general adult population, including pregnancy and postpartum women.

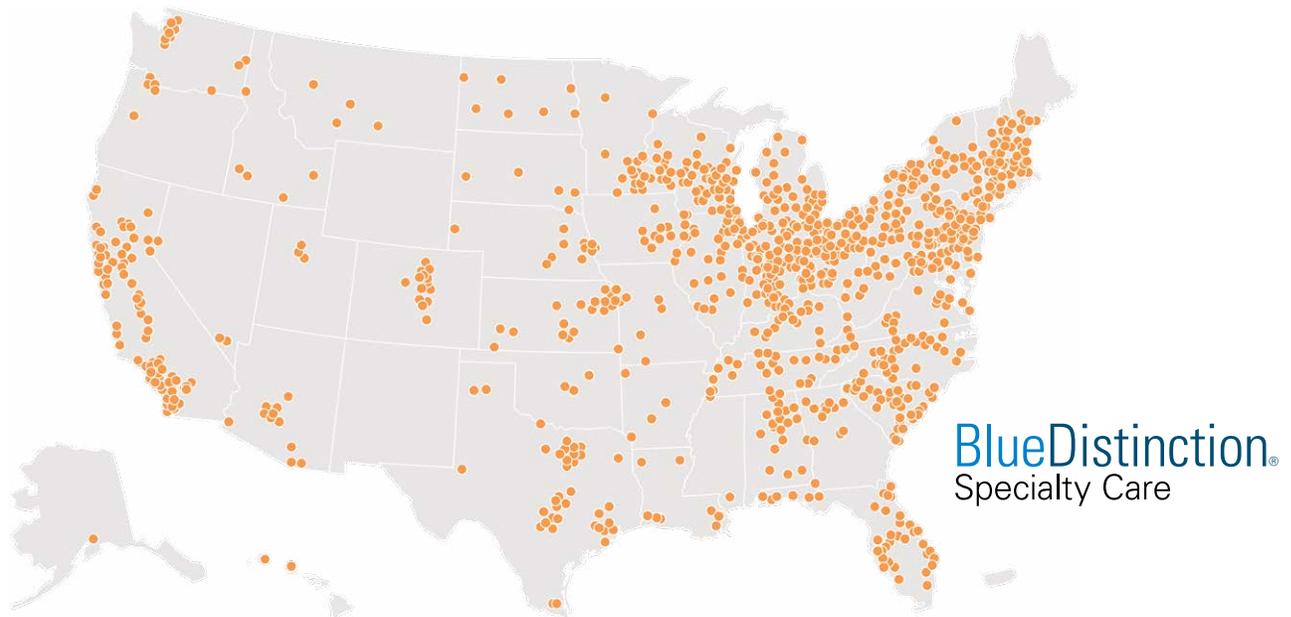
THE FINANCIAL IMPACT OF PREGNANCY COMPLICATIONS AND CHILDBIRTH COMPLICATIONS

In addition to having adverse health consequences, pregnancy complications and childbirth complications drive increased healthcare costs. Pregnancy complications increase the average cost of a vaginal delivery by 16% and a c-section delivery by 18%, while childbirth complications increase the average cost of these deliveries by 63% and 52% respectively.⁸

THE QUALITY OF MATERNAL HEALTHCARE CAN MITIGATE RISK AND COST

Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+) for Maternity Care are healthcare facilities and providers recognized for their demonstrated expertise delivering high quality, cost-effective care. In 2018, BDC/BDC+ facilities across the country cared for more than 40% of Blue Cross and Blue Shield commercially insured women giving birth. On average, BDC/BDC+ facilities cared for higher risk women while still maintaining comparable delivery outcomes to the national average and BDC+ facilities had significantly lower costs.^{9,10}

EXHIBIT 6: >1,000 BLUE DISTINCTION CENTERS AND BLUE DISTINCTION CENTERS+ FOR MATERNITY CARE¹¹



CONCLUSION

This report underscores the importance of focusing on the health of pregnant women in America, especially as health conditions increase in this population—increasing the likelihood of complications during pregnancy and childbirth as well as diagnoses of postpartum depression. Access to quality care is critical to helping women lead healthier lives, have healthier pregnancies and uncomplicated births. Blue Cross and Blue Shield companies across the country are making maternal health a priority in their communities—for the Health of America.

8. A regression model was run on 2018 childbirth episodes to assess how each major factor drives cost, while controlling for other factors. Cost, the dependent variable, was regressed on the occurrence of pre-delivery complications (binary variable), the occurrence of delivery complications (binary variable), and whether the delivery was via C-section as opposed to vaginal (binary variable). Interaction terms between delivery method and occurrence of complications were included.

9. Significance testing was applied and indicated statistical significance for the difference between Blue Distinction Centers and the national average for overall health of women, pregnancy complications and cost. There was no statistical significance for the difference in childbirth complications.

10. BDC/BDC+ facilities care for women with a Health Index of 94.3, which is lower than the national average of 94.5. One point lower on the Health Index translates to an 8% increase in the impact of health conditions that could lower overall health.

11. <https://www.bcbs.com/blue-distinction-center/facility>

METHODOLOGY

This is the 31st study of the Blue Cross Blue Shield, The Health of America Report® series, a collaboration between Blue Cross Blue Shield Association and Blue Health Intelligence (BHI), which uses a market-leading claims database to uncover key trends and insights in healthcare affordability and access to care. This report analyzes the data of over 1.8 million pregnancy episodes between 2014 and 2018. Pregnancy episodes were identified by TEG grouper, including both those ending with a delivery and those without a delivery.

This report studies pregnancy and childbirth complications as well as chronic conditions affecting the health of pregnant women, using an integrated dataset combining the pregnancy episodes data curated from BCBS Axis Data and the BCBS Health Index.

The complications studied were selected based on CDC information and input from clinical experts. Complications are divided into two groups based on when they occur during a childbirth episode. The analysis of pregnancy complications include gestational diabetes and preeclampsia. Childbirth complications include eclampsia, cardiomyopathy, sepsis, embolism, transfusions, heart attack, respiratory distress, shock, and anesthesia complications occurred within a certain window surrounding delivery (see Figure A below).

FIGURE A: TIME WINDOW USED FOR EACH CHILDBIRTH COMPLICATION

CHILDBIRTH COMPLICATION	DAYS BEFORE DELIVERY	DAYS AFTER DELIVERY
Eclampsia	7	7
Cardiomyopathy	30	150
Embolism	3	3
Heart Attack	3	3
Respiratory Distress	3	3
Sepsis	3	42
Transfusions	7	7
Shock	7	7
Anesthesia Complications	3	3

The chronic conditions studied include both behavioral health and physical health conditions. Behavioral health conditions focus on substance use disorders, anxiety and major depression that are highly associated with postpartum depression. Similarly, select physical health conditions focus on those that substantially increase the risk of pregnancy and childbirth complications such as hypertension and diagnosed obesity.



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APPENDIX

FIGURE B: PREGNANCY RATE OVERALL AND BY AGE GROUP, 2014 – 2018

PREGNANCY RATE (PER 100 WOMEN)						
AGE	2014	2015	2016	2017	2018	CHANGE 2014-2018
All (18-44)	5.2	5.2	5.2	5.1	5.1	-2%
18-24	2.8	2.8	2.7	2.6	2.5	-12%
25-34	8.8	8.6	8.6	8.3	8.5	-4%
35-44	3.3	3.4	3.5	3.5	3.6	9%

FIGURE C: PREGNANCY AND CHILDBIRTH COMPLICATIONS PER 1,000, 2014 – 2018

PREGNANCY RATE (PER 100 WOMEN)				
MEASURES	AGE BREAKOUT	2014	2018	CHANGE 2014-2018
PREGNANCY COMPLICATION (PER 1000)	All	168.4	196.0	16.4%
	18-24	125.0	149.9	19.9%
	25-34	166.0	190.5	14.8%
	35-44	200.4	230.7	15.1%
CHILDBIRTH COMPLICATION (PER 1000)	All	14.8	16.9	14.2%
	18-24	17.2	19.4	12.4%
	25-34	13.2	15.3	15.4%
	35-44	17.8	19.7	10.2%

Why 12 months postpartum – not shorter, not longer

- A pregnancy-related death is defined by the Centers for Disease Control and Prevention (CDC) as the death of a woman while pregnant or within 1 year of the end of a pregnancy –regardless of the outcome, duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
- State maternal mortality review committees use pregnancy through one year as their standard, as does the Preventing Maternal Deaths Act of 2018. This bill authorizes the CDC to support state and tribal maternal mortality review committees.
- Federal statute already covers a baby whose birth was financed by Medicaid for one year. The 12-month provision would match the mother’s coverage with the baby’s coverage.
- The American Medical Association (AMA), and America’s frontline physicians Group of Six - American College of Obstetricians and Gynecologists (ACOG), the American College of Physicians (ACP), the American Academy of Family Physicians, the American Academy of Pediatrics, the American Psychiatric Association, and the American Osteopathic Association (AOA) strongly support extending Medicaid coverage for women through 12 months postpartum.
- Multiple state maternal mortality review committees have recommended extending Medicaid coverage to 12 months postpartum as a way to improve maternal health outcomes following findings that many maternal deaths, including those linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, occur in the postpartum period.

Why this is different than the ACA Medicaid expansion

- This legislation would align Medicaid’s coverage period with the time period used by the CDC and maternal mortality review committees in defining the postpartum period. It brings Medicaid’s currently arbitrary time period of 60 days to one that is established.
- This is a state option – no state must adopt this measure. It is completely voluntary.
- The enhanced match proposed in HR4966 is very modest. A former CBO economist states that his cost estimate of HR4996 does not change significantly with or without the one-year five percent increase in Federal match.
- The Trump Administration has supported the 12-month Medicaid postpartum policy.

Data - CDC

- The U.S. government measures maternal health using a one-year marker.
 - Among deaths that occurred within 42 days of the end of pregnancy, infection was the leading cause of death, followed by hemorrhage, and cardiovascular and coronary conditions. Together, these three cause of death groupings represented 46% of deaths that occurred during this time period.
 - Among deaths that occurred 43 days to one year after the end of pregnancy, there were two leading causes of pregnancy-related death - cardiomyopathy, followed by mental health conditions.
- The U.S. CDC has found that one in three pregnancy-related deaths occurred between one week and one full year after birth.



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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April 3, 2020

The Honorable Chuck Grassley
Chairman of the Finance Committee
United States Senate
Washington D.C. 20510

The Honorable Ron Wyden
Ranking Member of the Finance Committee
United States Senate
Washington D.C. 20510

Submitted to the Senate Finance Committee via email, MaternalHealth@finance.senate.gov

RE: Request for Information on Solutions to Improve Maternal Health

Dear Sens. Grassley and Wyden:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Request for Information (RFI) regarding data and findings contributing to poor maternal health outcomes in the United States (March. 3, 2020; RFI).

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (BCBS Plans) that collectively provide healthcare coverage for one in three Americans. For 90 years, BCBS companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid. BCBS Plans provide coverage for over 8 million Medicaid and Children’s Health Insurance Program (CHIP) enrollees in 24 states and Puerto Rico, including expansion adults, pregnant women, children, individuals with disabilities and the elderly.

Across various insurance markets, BCBS Plans have developed comprehensive programs that support women before, throughout and after pregnancy, providing quality healthcare to improve maternal and infant health outcomes. In spite of tremendous medical advances, maternal mortality and morbidity remain high in the U.S., with the Centers for Disease Control and Prevention (CDC) estimating 700 maternal deaths and 50,000 cases of severe maternal morbidity annually.^{1,2} Further exacerbating these maternal health trends are the disparities impacting women of color and women who reside in rural communities who experience

¹ Centers for Disease Control and Prevention. Pregnancy-related deaths [Internet]. Atlanta (GA): CDC. Retrieved 22 March 2020, from: https://www.cdc.gov/reproductive_health/maternalinfanthealth/pregnancy-relatedmortality.htm

Note: A pregnancy-related death is defined by the CDC as the death of a woman while pregnant or within one year of the end of a pregnancy from any cause related to or aggravated by the pregnancy or its management.

² Centers for Disease Control and Prevention. Severe maternal morbidity in the United States. Atlanta (GA): CDC; Retrieved 22 March 2020, from: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severe_maternalmorbidity.html

disproportionately higher rates of mortality and life-threatening complications during and after childbirth.^{3,4,5}

In order to improve maternal health trends, we strongly urge the Committee to support the Helping Medicaid Offer Maternity Services (MOMS) Act (H.R. 4996) introduced by bipartisan congressional leaders in the 116th Congress. This legislation would provide comprehensive maternity and postpartum coverage for Medicaid-covered pregnant women by creating a state plan option to extend eligibility from 60 days to 365 days postpartum and align with the time period used by the CDC and maternal mortality review committees in defining the postpartum period.¹

In our comments below, we also outline factors and barriers that prevent innovation and improvements to address poor maternal health outcomes, while highlighting the programs and initiatives the BCBS Plans currently implement to reduce these factors. Given the unprecedented rise in maternal mortality rates,⁶ we provide recommendations that we hope the Senate Finance Committee will also consider as it develops a maternal health package to improve these outcomes.

Issue # 1: Strengthen Coverage and Standards of Care to Improve Maternal Health

Medicaid serves as the backbone of the nation's healthcare safety net, providing coverage for almost 71 million individuals and families, and is the largest payer of pregnancy care and births in the U.S., covering almost 43 percent of births in 2018.^{7,8,9} Medicaid also provides coverage for a higher proportion of women with high-risk pregnancies than other insurance programs. Among Medicaid-covered women, 27 percent are black women, who are three to four times more likely to die of pregnancy-related causes than white non-Hispanic women.¹⁰ Under the pregnancy-related eligibility pathway, at a minimum, Medicaid beneficiaries must be covered through the month in which the sixtieth day postpartum occurs. Termination of Medicaid maternity coverage after 60 days postpartum results in some women becoming uninsured or losing access to comprehensive care during a time when more than half of pregnancy-related

³ Garcia MC, Faul M, Massetti G, Thomas CC, Hong Y, Bauer UE, et al. Reducing potentially excess deaths from the five leading causes of death in the rural United States. *MMWR Surveill Summ*. 2017;66(2):1–7.

⁴ Cosby AG, McDoom-Echebiri MM, James W, Khandekar H, Brown W, Hanna HL. Growth and persistence of place-based mortality in the United States: the rural mortality penalty. *Am J Public Health*. 2019; 109(1):155–62.

⁵ Kozhimannil, K. B., Henning-Smith, C. E., Shipman, S. A., Johnston, K. J., Gong, G., & Probst, J. (2019, December 1). Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15. *Health Affairs*, 38(12). <https://doi.org/10.1377/hlthaff.2019.00805>

⁶ Pregnancy Related-Deaths Happen Before, During, and Up to a Year After Delivery. (2019, May 7). 3 in 5 pregnancy-related deaths could be prevented, no matter when they occur. CDC. Retrieved from <https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html>

⁷ Centers for Medicare and Medicaid Services. December 2019 Medicaid and CHIP Enrollment Data Highlights. Retried 29 March 2020, from <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

⁸ Centers for Disease Control and Prevention. National Vital Statistics Reports – Births: Final Data for 2018. Atlanta (GA): CDC; Retrieved 29 March 2020, from: https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf

⁹ Medicaid and CHIP Payment and Access Commission. (2020, January). Medicaid's Role in Financing Maternity Care. Retrieved 1 April 2020, from: <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>

¹⁰ Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities. (2018 April). National Partnership for Women & Families. Retrieved on 22 March 2020, from <https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html>

maternal deaths occur.¹¹ Although states currently have the opportunity to extend pregnancy-related eligibility beyond 60 days postpartum, they must do so through a Section 1115 waiver vehicle, which is administratively burdensome to develop and maintain as it must be renewed every three to five years.

Recommendations:

Recent studies by maternal mortality review committees and the CDC have estimated that over 60 percent of maternal deaths are preventable,^{12,13} and over 50 percent of maternal deaths occur postpartum.¹⁴ Continuous, high-quality care received throughout pregnancy, during delivery and in the postpartum period significantly contributes to positive health outcomes.¹⁵ Evidence also demonstrates that extended coverage for new and underserved mothers beyond the postpartum period to 365 days has resulted in reducing preterm birth rates and the number of low birth weight births for black infants in rural and urban communities, key metrics for the long-term health outcomes for children.¹⁶ These findings support the need for Congress and the Centers for Medicare & Medicaid Services (CMS) to implement innovative value-based payment models that promote efforts to reduce maternal mortality rates, improve health outcomes and accountability in maternity care.

To strengthen coverage and standards of care to improve maternal health, we recommend the Committee consider the following:

- **Address access and coverage gaps:**
 - Establish a state plan option to extend Medicaid postpartum eligibility from 60 days to 365 days (*H.R. 4996, Helping MOMs Act*)
 - Require comprehensive coverage for women eligible for Medicaid through pregnancy-related and parents-of-dependents pathways, including services like oral care
- **Fund expansion and coverage of telehealth services:**
 - Enhance funding for the Lifeline Program, administered by the Federal Communications Commission (FCC) that partners with wireless providers to provide phones to Medicaid beneficiaries, giving healthcare providers and plans a pathway to connect with patients and beneficiaries, especially those in medically underserved areas
 - Provide funding to expand telehealth and remote monitoring in Medicaid to help improve healthcare access for mothers and infants in underserved communities,

¹¹ Gifford, K., Walls, J., Ranji, U., Salganicoff, A., & Gomez, I. (2019, June 19). Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey - Introduction. *Kaiser Family Foundation*. Retrieved from <https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-and-perinatal-benefits-introduction/>

¹² Review to Action, Building U.S. capacity to review and prevent maternal deaths. (2018). Report from nine maternal mortality review committees. Retrieved from Review to Action website: http://reviewtoaction.org/Report_from_Nine_MMRCs

¹³ Pregnancy Related-Deaths Happen Before, During, and Up to a Year After Delivery. (2019, May 7). 3 in 5 pregnancy-related deaths could be prevented, no matter when they occur. CDC. Retrieved from <https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html>

¹⁴ Petersen, E. E., Davis, N. L., Goodman, D., Mayes, N., Johnston, E., Syverson, C., ... Barfield, W. (2019). Vital signs: Pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 States, 2013–2017. *Morbidity and Mortality Weekly Report* 68(18), 423–429. doi: 10.15585/mmwr.mm6818e1

¹⁵ Johnson, K., Rosenbaum, S., & Handley, M. (2020, January 9). The Next Steps to Advance Maternal and Child Health In Medicaid: Filling Gaps in Postpartum Coverage and Newborn Enrollment. *Health Affairs*. doi: [10.1377/hblog20191230.967912](https://doi.org/10.1377/hblog20191230.967912)

¹⁶ Brown, C.C., Moore, J.E., Felix, H.C., et al. (2019, April 23). Association of State Medicaid Expansion Status with Low Birth Weight and Preterm Birth. *JAMA*. 321(16): 1598-1609. doi: 10.1001/jama.2019.3678.

- especially in rural areas with provider access issues (*H.R. 6138, Tech to Save Moms Act*)
- Provide grant funding for providers to build and expand the use of telehealth and remote patient-monitoring capabilities for pregnant women, postpartum mothers and their newborns
- **Support development of innovative and value-based payment models:**
 - Direct the Center for Medicare and Medicaid Innovation (CMMI) to develop innovative maternity and postpartum care payment models and demonstrations targeted to underserved and rural populations that provide access to clinical and non-clinical services in order to improve maternal health outcomes and reduce morbidity and mortality rates

Rationale:

Address access and coverage gaps. Given the disparities influencing maternal health outcomes for low-income women and the trend of 52 percent of pregnancy-related deaths occurring after delivery, it is critically important that Medicaid-covered pregnant women have access to comprehensive healthcare coverage and support during the postpartum period.¹⁷ The Helping MOMS Act (H.R. 4996) would create a state plan option to extend pregnancy-related Medicaid eligibility to 365 days postpartum, aligning with the definition established by the CDC and maternal mortality review committees. Based on our analysis of the bill, the federal cost of this state plan option to extend postpartum eligibility would be roughly \$1.8 billion over 10 years and save roughly \$798 million in uncompensated care costs.

In addition to bipartisan congressional support, the American Medical Association (AMA) and America's frontline physicians' Group of Six – the American College of Obstetricians and Gynecologists (ACOG), the American College of Physicians (ACP), the American Academy of Family Physicians, the American Academy of Pediatrics, the American Psychiatric Association, and the American Osteopathic Association (AOA) – have also expressed support of this measure.¹⁸ Multiple state maternal mortality review committees have conducted independent extensive research that concluded extending Medicaid coverage to 12 months postpartum is necessary to improve maternal health outcomes by addressing conditions like cardiovascular disease, cardiomyopathy, overdose and suicide that cause maternal mortality.¹⁷

Lastly, benefits for women eligible for Medicaid through the pregnancy pathway are not comprehensive across all states. Under the pregnancy pathway, Medicaid covers services that are “necessary for the health of a pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant.”¹⁹ Federal statute requires that states provide coverage for prenatal care, delivery, postpartum care, and family planning, as well as medically necessary services for conditions that may complicate pregnancy and delivery.²⁰

¹⁷ Stuebe, A., Moore, J. E., Mittal, P., Reddy, L., Low, L. K., & Brown, H. (2019, May 6). Extending Medicaid Coverage for Postpartum Moms. Health Affairs. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190501.254675/full/>

¹⁸ American Medical Association. (2019). AMA Support for 12 Months Postpartum Medicaid Coverage. Retrieved 25 March 2020, from <https://www.acog.org/About-ACOG/News-Room/Statements/2019/AMA-Support-for-12-Months-Postpartum-Medicaid-Coverage>

¹⁹ 42 C.F.R. § 440.210(a)(2)(i)

²⁰ 42 C.F.R. § 440.210(a)(2)(i)-(ii)

Fund expansion and coverage of telehealth services. Traditional prenatal care models recommend upwards of 14 in-person visits throughout a pregnancy,²¹ requiring significant travel time, especially in rural geographies, and time away from work or family responsibilities. For mothers in rural geographies or those without a reliable mode of transportation in suburban and urban communities, attending frequent and necessary prenatal visits can be particularly challenging. This is especially true in situations where patients need to travel outside of their communities to seek care due to provider shortages.

With the expansion and availability of telehealth, expectant mothers and postpartum women now have the option to access care immediately without traveling long distances or worrying about transportation.²² Women may access prenatal services through videoconferences to replace in-person visits, implementing at-home monitoring, and enabling consultation with remote specialists, including maternal-fetal medicine providers. During the postpartum period, telemedicine can enable earlier postpartum follow-up visits, screenings for postpartum depression and access to lactation consultants. Through telemedicine, expectant mothers with high-risk pregnancies in rural geographies can also access a wider network of provider options through local hospitals or clinics to receive needed specialty care.

To close gaps in access to maternity and postpartum care services for women, BCBS Plans have leveraged telemedicine to reduce healthcare barriers and increase the availability of specialty care providers to meet members where they are. Here are two examples:

- Through their [Due Date Plus](#) app, developed by Wildflower, beneficiaries enrolled in Blue Shield of California Promise Health Plan can enter their member ID number to gain access to a variety of member-specific resources and support.²³ Due Date Plus provides daily support throughout pregnancy by offering advice, tips, reminders and education on what to expect. The app also incorporates local resources and is available in Spanish and English.
- BlueCross BlueShield of Tennessee helped establish an extensive network of telemedicine sites in rural communities – called the Solutions to Obstetrics in Rural Communities (STORC) – to improve access to specialty care for women with high-risk pregnancies.²⁴ To avoid having a woman travel to one of the state’s major cities for care, STORC sites are staffed with an ultrasound technician and an advanced practice nurse who can video conference with a specialist. Currently, there are STORC sites in 13 rural Tennessee communities, many with no obstetric specialists or women’s healthcare

²¹ Optimizing Postpartum Care (n.d.). American College of Obstetrics and Gynecologists. Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false>

²² Weigel, G., Frederiksen, B., & Ranji, U. (2020, February 25). Telemedicine and Pregnancy Care. Retrieved from <https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/>

²³ PRNewswire. (2018, November 15). California Moms and Babies to Benefit From New, Enhanced Mobile Health Apps | Markets Insider. Retrieved 25 March 2020, from <https://markets.businessinsider.com/news/stocks/california-moms-and-babies-to-benefit-from-new-enhanced-mobile-health-apps-1027731212>

²⁴ Blue Cross Blue Shield Association. (2018, May 22). Using Telemedicine To Improve Rural Women's Health And Save Babies' Lives. Retrieved 23 March 2020, from <https://www.bcbs.com/the-health-of-america/podcast/using-telemedicine-improve-rural-womens-health-and-save-babies-lives>

professionals at all. The program began in 2009 with 134 visits and has grown to 3,953 in 2018, with more than 90 percent of women delivering healthy babies.

Unfortunately, access to telemedicine varies state by state and across provider practices. In order to broaden access to telemedicine technologies, Congress should invest funding to expand telehealth and remote monitoring in Medicaid to help improve healthcare access for mothers and infants in underserved communities, especially in rural areas with provider access issues (H.R. 6138). These efforts include expanding the geographic areas and services eligible for telehealth reimbursement across all payers and removing other regulatory barriers to using telehealth. Furthermore, programs like the Federal Communication Commission's Lifeline Program partner with wireless providers to provide phones to Medicaid beneficiaries, giving healthcare providers and plans a pathway to connect with patients and beneficiaries, especially those in medically underserved areas. Providing additional funding to the Lifeline Program would maximize access to this critically important program. Lastly, additional grant funding is needed to help providers build and expand the use of telehealth and remote patient-monitoring capabilities for pregnant women, postpartum mothers and their newborns.

Support development of innovative and value-based payment models. As Congress and the Administration work with stakeholders to improve care coordination and patient-centered maternity care models, it is also necessary to implement payment models that support high-quality delivery of these services to ensure greater adoption across the health system. Research from the Health Care Transformation Task Force determined three prominent payment strategies that transition away from fee-for-service (FFS) toward outcomes-driven maternity payment levels with increasing provider accountability for cost and quality: (1) perinatal fee schedule changes; (2) value-based maternity payment; and (3) comprehensive payment for women and their newborns.²⁵ CMMI could leverage each of these strategies to develop a demonstration targeted to improving health outcomes and reductions in maternal mortality and morbidity.

As the Committee considers payment models, we want to highlight use of bundled payments for maternity episodes of care. Under this payment model, a set target price is established for the entire maternity episode, including all professional and facility fees, and adjusted provider payments are based on whether overall cost targets and quality metrics are met. Through a bundled payment approach, non-clinical activities directed towards enhanced care coordination and referrals for social supports could be included in the bundle to promote activities that address social determinants of health (SDOH).

BCBS Plans have also identified a significant barrier to greater adoption of these payment arrangements in situations where the provider that delivers the baby is also the provider attributed to the payment and any shared savings. This savings mechanism does not necessarily reimburse other care team members who may have contributed to lower episode costs and higher quality outcomes through comprehensive perinatal care. Not attributing

²⁵ Health Care Transformation Task Force. (2019, July). Expanding Access to Outcomes-Driven Maternity Care through Value-Based Payment. Retrieve 29 March 2020, from: <https://hcttf.org/wp-content/uploads/2019/07/Expanding-Access-to-Outcomes-Driven-Maternity-Care-through-Value-Based-Payment.pdf>

savings to the upstream care providers that avoid hospital expenditures not only fails to acknowledge the work of those providers, it misses a critical opportunity to reinvest in prevention efforts.

Under bundled payment models, coverage of long-acting reversible contraception (LARC) devices may not be adequate to incentivize providers to offer such services during the maternity episode. We also observe that unbundling LARC payments from the larger episode and increasing payment rates for LARC when separate can increase access to contraception that promotes pregnancy spacing.

Issue # 2: Address Disparities, Disparate Outcomes and Bolster Social Services to Support Mother and Child Well-Being

Among developed countries, the U.S. has the highest rate of maternal mortality, and, within the U.S., low-income women and women of color experience the highest mortality rates.^{26,27,28} These trends stem, in large part, from disparities in socioeconomic factors and SDOH, including limited living-wage jobs, stable jobs, educational access, affordable healthcare and affordable housing. Studies have also demonstrated that postpartum depression occurs two to four times as often for women living in poverty, as compared to middle or upper income women.²⁹ Further compounding these concerns are issues accessing health and social support services and the inability for communities to address unmet needs.

Among women of color, poor healthcare quality, discrimination and implicit biases in the medical field drive disparities, contributing to poor health outcomes for women and infants. Recent evidence found that 82 percent of women enrolled in Medicaid – a population that is largely Hispanic, African American, American Indian and Alaskan Native⁹ – experienced severe maternal morbidity compared to those with private insurance.³⁰ Studies have also demonstrated that a positive diagnosis for postpartum depression occurs two to four times as often for women living in poverty, as compared to middle or upper income women.³¹

Recommendations:

To address disparities and their impact on outcomes and to bolster social services to support the well-being of women and children, we recommend the Committee consider the following:

²⁶ Butkus R, Rapp K, Cooney TG, et al, for the Health and Public Policy Committee of the American College of Physicians. Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health. *Ann Intern Med.* 2020;172:S50–S59. doi: <https://doi.org/10.7326/M19-2410>

²⁷ Vilda D, Wallace M, Dyer L, Harville E, & Theall K. (2019). Income inequality and racial disparities in pregnancy-related mortality in the US. *SSM Popul Health.* 2019; 9. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6734101/pdf/main.pdf>

²⁸ Petersen, E.E., Davis, N.L., Goodman, D., et al. Vital signs: pregnancy related deaths, United States, 2011-2015, and strategies for prevention, 13 states, 2013-2017. (2019 May 10); 68(18): 423-429. doi. 10.15585/mmwr.mm6818e1.

²⁹ The Centers for Disease Control and Prevention. (n.d). Retrieved from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>.

³⁰ Kozhimannil, K. (2020, January) Maternal Morbidity Among Women in Medicaid. Retrieved from: <https://www.macpac.gov/wp-content/uploads/2020/01/Maternal-Morbidity-among-Women-in-Medicaid.pdf>

³¹ The Centers for Disease Control and Prevention. (n.d). Retrieved from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>.

- **Identify disparities and address access concerns:**
 - Direct the Medicaid and CHIP Payment Access Commission (MACPAC) to evaluate the impact of extending postpartum eligibility, including opportunities to address SDOH during the postpartum period (*H.R. 4996, Helping MOMs Act*)
 - Establish a task force to coordinate efforts to address SDOH for women in the prenatal and postpartum periods, with a special focus on racial and ethnic disparities (*H.R. 6132, Social Determinants for Moms Act*)
 - Establish the Maternal Mental and Behavioral Health Task Force dedicated to improving maternal mental and behavioral health outcomes with a particular focus on outcomes for minority women (*H.R. 6143, Moms MATTER Act of 2020*)
 - Preserve the mandatory Medicaid non-emergency medical transportation (NEMT) benefit and build off of recent Medicare Advantage (MA) flexibilities to include NEMT in supplemental benefits
- **Bolster data and evidence around SDOH:**
 - Direct CMS to provide states flexibilities in the Medicaid and Medicare programs for incorporating reimbursable risk assessments that identify SDOH impacting the health of individuals and their family
 - Direct CMS to provide reimbursement for risk assessments that identify SDOH and administrative activities geared towards referring beneficiaries to local resources and social supports
 - Direct CMS to allow the cost of value-added benefits and activities that target specific SDOH to be included in the numerator of Medicaid MCO medical loss ratio (MLR) calculations
- **Inject funding into programs and local organizations to address maternal mortality:**
 - Expand funding for Health Resources and Services Administration (HRSA) Maternal, Infant and Early Childhood Home Visiting (MIECHV) program in order to target high-needs communities and SDOH affecting families, such as social support, parental stress, access to healthcare and income and poverty status as well as environmental conditions (*H.R. 4768, Home Visiting to Reduce Maternal Mortality and Morbidity Act*)
 - Establish HHS grants to eligible entities to establish or expand community-based programs to prevent maternal mortality and severe maternal morbidity among black women (*H.R. 6144, Kira Johnson Act*)
- **Establish provider training opportunities to build cultural competency and address implicit biases:**
 - Direct HHS to issue guidance to states to educate providers and plans about the value and process of delivering respectful maternal healthcare through diverse care provider models and diversity in the perinatal workforce (*H.R. 6164, Perinatal Workforce Act*)
 - Establish a grant program to schools of allopathic, osteopathic, nursing and other health professional fields to implement implicit bias training with priority given to training with respect to obstetrics and gynecology (*H.R. 4995, Maternal Health Quality Improvement Act*)

Rationale:

Identify disparities and address access concerns. As we mentioned previously, for pregnant women enrolled in Medicaid, the lack of coverage after 60 days postpartum can greatly impact their health. To address comprehensive coverage of healthcare services for women, the Committee and Congress should prioritize and enact the Helping Mom's Act (H.R. 4996) to extend postpartum eligibility to 365 days, prioritizing coverage for low-income pregnant women, women of color and those residing in rural geographies. H.R. 4996 also directs the Medicaid and CHIP Payment Access Commission (MACPAC) to evaluate the impact of extending postpartum eligibility, including opportunities to address SDOH postpartum.

As exploration of the impact of SDOH continues to build, it is important for Congress and HHS to leverage the expertise of stakeholders who actively engage with or provide coverage for pregnant women to inform policies that will address maternal mortality and morbidity. To this end, Congress should establish a task force to coordinate efforts to address SDOH for women in the prenatal and postpartum periods, with a special focus on racial and ethnic disparities (H.R. 6132). Given the impact of mental health and substance use disorders that complicate maternal health, Congress should also establish a Maternal Mental and Behavioral Health Task Force dedicated to improving maternal mental and behavioral health outcomes with a particular focus on outcomes for minority women (H.R. 6143).

One SDOH with a direct link to access to care is transportation. Lack of reliable modes of transportation can be a significant barrier for women in rural or urban geographic areas when accessing prenatal and postpartum care and follow-up as well as routine medical visits for newborns. To ensure transportation is not a barrier to access care, Medicaid regulations require states to provide transportation to and from providers, a benefit known as NEMT. Additionally, the President's most recent budget for fiscal year (FY) 2020 included a proposal to make the Medicaid NEMT benefit an optional one. CMS also released guidance for the Health American Opportunity Demonstration (HAO), which emphasized the option for states to waive the NEMT for the new adult group as part of their Section 1115 waivers.

NEMT services are an important benefit to address transportation challenges for pregnant and postpartum women and their newborns to access routine and specialty healthcare services. To address the effects of inadequate transportation, BCBS Plans have partnered with transportation providers like Lyft to ensure members are not missing vital healthcare appointments simply because they lack reliable transportation. In order to continue providing these services to all Medicaid beneficiaries, including pregnant women, it is critically important that NEMT remain a mandatory benefit. Congress should require NEMT as a core Medicaid benefit in statute to clarify that it must be covered as a mandatory benefit and may not be waived.

Bolster data and evidence around SDOH. Data from risk assessments and high-risk screenings that build off the Pregnancy Risk Assessment Monitoring System (PRAMS), a joint research project between the state department of health and the CDC's Division of Reproductive Health, is available to develop individual care plans that meet the whole-person care of women. However, not every hospital and clinic has implemented risk assessments into

their care plan. As states continue to develop innovative programs for the Medicaid population, we encourage the Committee to direct CMS to provide reimbursement to health plans, providers and clinics for risk assessments that identify SDOH as well as administrative activities geared towards referring beneficiaries to local resources and social supports. Furthermore, we ask that Congress direct CMS to count the cost of value-added benefits and activities that are targeted to addressing SDOH within the numerator of MLR calculations for Medicaid MCOs in order to encourage greater investments in this area.

For example, Healthy Blue, a Louisiana Medicaid health plan, takes a proactive approach to maternal and infant health by offering expectant mothers a comprehensive program, New Baby, New LifeSM.³² Through this program, pregnant women undergo risk assessments and are provided with enhanced case management, care coordination and education throughout the pregnancy to meet their needs. Case managers also collaborate with community agencies to ensure mothers have access to social services, including transportation, the Special Supplemental Nutrition Program for women, infants and children (WIC), breastfeeding support and counseling.

Inject funding into programs and local organizations to address maternal mortality. Home visiting programs, such as HRSA's MIECHV program have generated cost savings, reduced health services utilization and improved maternal newborn health, allowing states to reinvest these savings to expand services.³³ In FY 2018, the MIECHV Program funded services in 22 percent of all rural counties, and 50 percent of all counties served by the program were rural. A recent review of evidence-based programs found the average cost of home visits to a family for 45 weeks was \$6,554, and for every dollar invested in the programs, up to \$5.70 in savings was achieved in the long-run.

Further, a national study of the Mother and Infant Home Visiting Program Evaluation (MIHOPE), funded by MIECHV, found improvements in women health, increases in health insurance coverage and reduction in depressive symptoms.³⁴ In Wisconsin, Medicaid offers a prenatal care coordination (PNCC) benefit that delivers services based on a mutually created care plan and makes referrals to community resources, such as WIC, supports job-training or continued education, and helps in reducing the barriers to prenatal care attendance. Research showed that women who received the PNCC services had better birth outcomes than women without access to PNCC benefits. These improved outcomes included reductions in the rates of low-birth-weight infants, very-low-birth-weight infants, infants transferred to the neonatal intensive care units and preterm infants.³⁵

³² Community Care Health Plan of Louisiana, Inc. (n.d.). Maternal Child Program. Retrieved 23 March 2020, from <https://providers.healthyblue.com/la/pages/maternal-services.aspx>

³³ Health Resources and Services Administration (HRSA). (2019). Maternal, Infant, and Early Childhood Home Visiting Program. Retrieved 25 March, 2020, from: <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/home-visiting-infographic.pdf>

³⁴ Michalopoulos, C., Crowne, S.S., Portilla, X.A. et al. (2019, January) A Summary of Results from the MIHOP and MIHOPE-Strong Start Studies of Evidence-Based Home Visiting. Retrieved from: https://www.acf.hhs.gov/sites/default/files/opre/mihope_summary_brief_01_16_19_508.pdf

³⁵ Normile, B., VanLandeghem, K., & King, A. (2017, August). National Academy for State Health Policy. Retrieved 27 March 2020, from: <https://nashp.org/wp-content/uploads/2017/09/Home-Visiting-Brief.pdf>

Blue Shield of California Promise Health Plan identified that between Los Angeles (LA) Medi-Cal plans and home visiting programs in LA County, few enrollees in home visiting programs were referred prenatally, and even fewer were referred in their first trimester. Therefore, First 5 LA and Promise Health Plan partnered in an effort to leverage provider, plan and county resources for maternal care integration, making referral to home visiting part of the standard care for plan members. The ultimate goal of this partnership is to continue bolstering early prenatal participation in evidence-based home visiting services in the Antelope Valley and to place home visiting within the model of care for the most vulnerable women.

Establish provider-training opportunities to build cultural competency and address implicit biases. Implicit bias trainings that provide systemwide staff education on how to ask demographic questions and train providers to be aware of unconscious stereotypes should be implemented in obstetrics and gynecology practices. In 2016, The Council on Patient Safety in Women's Health Care and the Alliance for Innovation in Maternal Health (AIM Program) published the "Reduction of Peripartum Racial/Ethnic Disparities Patient Safety Bundle." This bundle, endorsed by ACOG, also recommends implicit bias training as one of many action steps that institutions and clinicians can implement to reduce disparities in maternal morbidity and mortality.³⁶

To build provider-training programs that address implicit bias, Congress should direct HHS to issue guidance to states to educate providers and plans about the value and process of delivering respectful maternal healthcare through diverse care provider models and diversity in the perinatal workforce (H.R. 6164). Additionally, Congress should establish a grant program to schools of allopathic, osteopathic, nursing and other health professional fields to implement implicit bias training with priority given to training with respect to obstetrics and gynecology (H.R. 4995).

Issue # 3: Expand Use of Non-physician Clinicians and Continuity, Coordination of Care

As the shortage of health professionals continues to grow, women particularly face unprecedented barriers to maternity care.³⁷ Additionally, the current novel coronavirus (COVID-19) pandemic has put greater financial and workforce strain on providers and hospitals, exacerbating delayed care and hospital closures and fueling disparities among rural individuals and families.³⁸ Furthermore, holistic maternal and postpartum care requires access to services beyond those offered in a clinical setting and address SDOH, especially to correct disparities among low-income women and women of color. According to ACOG, postpartum care should include a comprehensive care team including the maternity provider, infant healthcare provider, community supports, and the woman's family and friends.

³⁶ Council on Patient Safety in Women's Health Care. Safe Health Care for Every Woman. *Alliance for Innovation on Maternal Health (AIM)*. Retrieved from <http://www.safehealthcareforeverywoman.org/aim.php>

³⁷ Doximity. (2019, September). 2019 OB-GYN Workforce Study: Physician Shortages Contribute to Women's Health Crisis. Retrieved 29 March, 2020 from https://s3.amazonaws.com/s3.doximity.com/press/2019_ob_gyn_workforce_study.pdf

³⁸ Weber, L. (2020, March 21). Coronavirus Threatens The Lives Of Rural Hospitals Already Stretched To Breaking Point. Retrieved 23 March 2020, from <https://khn.org/news/coronavirus-threatens-the-lives-of-rural-hospitals-already-stretched-to-breaking-point/view>

Recommendations:

To expand use of non-physician clinicians and improve coordination of care, we recommend the Committee consider the following:

- **Ensure Medicaid covers services by midwives and doulas:**
 - Provide coverage under the Medicaid program for services provided by doulas and midwives (*H.R. 2751, Mamas First Act*)
 - Direct CMS to clarify the appropriate current procedural terminology (CPT) code for obtaining reimbursement for doula services
 - Require the MACPAC to provide a report and guidance on increasing access to certified nurse-midwives, certified midwives and doula care for Medicaid beneficiaries
- **Support programs and local organizations to address maternal mortality:**
 - Appropriate funding for a Pregnancy Medical Home Demonstration Project to assist 10 states in implementing and sustaining a pregnancy medical home (PMH) program, incentivizing non-physician clinicians to deliver integrated healthcare services to pregnant and postpartum women in Medicaid (*S. 1600, Maternal CARE Act*)
 - Establish a Medicaid demonstration program for innovative payment models for freestanding birth center services and provide coverage of freestanding birth centers under CHIP (*H.R. 5189, Birth Access Benefiting Improved Facility Services (BABIES) Act*)

Rationale:

Ensure Medicaid covers services by midwives and doulas. When building a maternity care team, expectant mothers that had a nurse midwife to support them throughout the term of pregnancy had notably improved maternity care outcomes.³⁹ In fact, a study found that greater integration of certified nurse midwives and improved access to midwives in all settings are associated with substantially higher rates of vaginal delivery, breastfeeding at birth and at six months, vaginal birth after cesarean (VBAC) delivery, as well as significantly lower rates of preterm births, low-weight birth infants, and cesarean deliveries.⁴⁰ Important to the development of a comprehensive care model, midwives have the flexibility to attend births in various settings making them well-positioned to support women as they consider their labor preferences and appropriate method of delivery.⁴¹

Evidence has also demonstrated that doula support can improve maternal health outcomes. Doulas are trained maternal support professionals who provide care in the psycho-social,

³⁹ American College of Nurse-Midwives (2012). Midwifery: Evidence-based practice. Retrieved 29 March 2020, from <http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000004184/Midwifery-Evidence-Based-Practice-March-2013.pdf>

⁴⁰ Vedam, S., Stoll, K., Declercq, E., Cramer, R., Cheyney, M., Fisher, T., ... Butt, E. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PLoS one*, 13(2), e0192523. doi: 10.1371/journal.pone.0192523

⁴¹ Health Care Transformation Task Force. (2019, July). Expanding Access to Outcomes-Driven Maternity Care through Value-Based Payment. Retrieved 29 March 2020, from: <https://hcttf.org/wp-content/uploads/2019/07/Expanding-Access-to-Outcomes-Driven-Maternity-Care-through-Value-Based-Payment.pdf>

emotional and educational aspects of pregnancy, childbirth and the postpartum period.⁴¹ Doula support has been shown to have particularly strong effects for women who are low-income, socially disadvantaged or experience language or cultural barriers to care.⁴² As evident, recent data shows that women with trained doula support were 39 percent less likely to have a cesarean delivery and 35 percent less likely to report their childbirth experience negatively.⁴³

Given the growing evidence that doula care does improve maternal health, especially for underserved women, four states (Minnesota,⁴⁴ Oregon,⁴⁵ Indiana,⁴⁶ and New Jersey⁴⁷) as of May 2019 have passed legislation that allows for Medicaid reimbursement of doula care. Last year, New York state announced the launch of a pilot expansion allowing the state Medicaid program to reimburse for doula care for both Medicaid fee-for-service and Medicaid Managed Care enrollees.⁴⁸

In order to encourage the uptake of Medicaid reimbursement for doula care, Congress should provide coverage under the Medicaid program for services provided by doulas and midwives (H.R. 2751). This legislation defines a doula as certified by an organization (established for a minimum of five years), completing continuing education, who provides non-medical advice, information, emotional support and physical comfort during such individual's pregnancy, childbirth and postpartum period. Furthermore, to facilitate reimbursement for doula care, Congress should direct CMS to clarify which CPT codes may be used to obtain Medicaid reimbursement for doula services. Lastly, Congress should require the MACPAC to provide a report and guidance on increasing access to certified nurse-midwives, certified midwives and doula care for Medicaid beneficiaries.

Support programs and local organizations to address maternal mortality. Another model that leads high-value maternity care is pregnancy medical homes (PMHs), which offer coordinated care through an expanded care team. A study of the PMH models in Texas for women enrolled in Medicaid and CHIP Perinate (a program providing prenatal care for low-income expectant mothers who do not qualify for Medicaid) demonstrated the positive impact of evidence-based, coordinated prenatal care. In Texas, a care team under this model includes physicians and midwives who are integrated with other healthcare services such as pediatrics, behavioral health, optometry, dental, laboratory and pharmacy. These PMHs also provide walk-in care at a clinic and 24-hour nurse availability for triage. A 2017 study found that women prospectively assigned to a PMH had lower utilization rates for hospital admissions and

⁴² Kang, H.K. (2014). Influence of Cultural and Community Perceptions on Birth and Perinatal Care of Immigrant Women: Doulas' Perspective. *The Journal of Perinatal Education*, (23) 1: 25-32. doi: [10.1891/1058-1243.23.1.25](https://doi.org/10.1891/1058-1243.23.1.25)

⁴³ Simkin, P. (2018). What do doulas really do? *Midwifery Today*. Retrieved 29 March 2020, from <https://midwiferytoday.com/mt-articles/what-dodoulas-really-do/>

⁴⁴ Office of the Revisor of Statutes. (n.d.). Retrieved from <https://www.revisor.mn.gov/statutes/cite/148.995>

⁴⁵ Oregon Secretary of State. (n.d.). Retrieved from <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=244195>

⁴⁶ Indiana SB416. (n.d.). Retrieved from <https://trackbill.com/bill/indiana-senate-bill-416-medicaid-coverage-for-doula-services/1622229/>

⁴⁷ LegiNation. (n.d.). NJ - S1784. Retrieved from <https://www.billtrack50.com/BillDetail/946535>

⁴⁸ Department of Health. (n.d.). Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm

emergency care, generating \$330,161 in annual emergency department savings and \$494,313 in annual savings related to inpatient days relative to the control group.⁴⁹

PMHs have also demonstrated increased utilization of evidence-based postpartum care visits. Further evidence to the positive outcomes of PMHs, research from Medicaid external quality reviews found that Wisconsin's Obstetric Medical Home led to an increase in postpartum care visits from 61.4 percent in 2013 to 85.5 percent in 2015, with an increase in timely postpartum care and behavioral healthcare compared to women not enrolled in the model.⁵⁰ Congress should appropriate funding for a Pregnancy Medical Home Demonstration Project to assist 10 states in implementing and sustaining PMH program, incentivizing non-physician clinicians to deliver integrated healthcare services to pregnant and postpartum women in Medicaid (S. 1600).

The freestanding birth center, an enhanced model of culturally competent and low-risk maternity care, has demonstrated reduced rates of labor and delivery interventions.⁵¹ A recent 2018 study of the Strong Start for Mothers and Newborn initiative, funded by CMMI with the goal of improving outcomes for women and children enrolled in Medicaid and CHIP, found that women served by birth centers had even lower risk levels and significantly lower levels of preterm births (4.5 percent) compared to women receiving care in maternity care homes (12.9 percent) or group prenatal care (12 percent).⁵² The Minnesota Birth Center (MBC) located in Minneapolis and St. Paul has been successful in delivering high-value maternity care since 2012. Between 2012 to 2016, MBC delivered 1,096 babies with a 92 percent vaginal birth rate, and a 70 percent VBAC rate, far higher than the national average.^{53,54} MBC has also achieved substantial healthcare cost reductions relative to local hospitals, with an average combined savings of \$11,954 for a vaginal delivery without complications and normal newborn charges.⁵⁵ To further research evaluating freestanding birth centers, Congress should establish a Medicaid demonstration program for innovative payment models for freestanding birth center services and provide coverage of freestanding birth centers under CHIP (H.R. 5189).

⁴⁹ Suhag, A., Dutta, R., Schwarzwald, H. L., Taylor, T., & Hollier, L. (2017). Pregnancy medical home: Outcomes and cost savings. *American Journal of Obstetrics & Gynecology*, 216(1), S39-S40. doi: 10.1016/j.ajog.2016.11.940

⁵⁰ Agrawal, A. (2017). Case study: Wisconsin's obstetric medical home program promotes improved birth outcomes. National Association of State Health Policy and National Institute for Children's Health Quality. Retrieved from <https://www.nichq.org/sites/default/files/inline-files/Wisconsin-Case-Study.pdf>

⁵¹ Stapleton, S. R., Osborne, C., & Illuzzi, J. (2013). Outcomes of care in birth centers: Demonstration of a durable model. *Journal of Midwifery & Women's Health*, 58, 3-14. doi: 10.1111/jmwh.12003

⁵² Hill, I., Dubay, L., Courtot, B., Benatar, S., Bowen, G., Blavin, F., & Morgan, J. (2018). Strong start for mothers and newborns evaluation: Year 5 project synthesis (Urban Institute Report No. 5.1). Retrieved from <https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf>

⁵³ 5 Years: Minnesota Birth Center [Digital Image]. (2016). Retrieved from <https://theminnesotabirthcenter.com/wpcontent/uploads/2017/11/infographic2016finished.png>

⁵⁴ Centers for Disease Control and Prevention, National Center for Health Statistics. (n.d.). Births - method of delivery. Retrieved 26 March 2020 from <https://www.cdc.gov/nchs/fastats/delivery.htm>

⁵⁵ Minnesota Birth Center. (n.d.). Insured clients. Retrieved 26 March 26, 2020, from <https://theminnesotabirthcenter.com/insuredclients/>

Issue # 4: Enhance Data Collection and Effective Evaluation to Improve Outcomes and Quality

Heart disease, stroke, cancer, unintentional injury and chronic lower respiratory disease are frequent causes that lead to higher maternal mortality trends, disproportionately in rural communities.⁵⁶ To create care plans and services that lower these trends, performance measurements and perinatal quality measures have and can continue to provide crucial data that help maternity care teams, women, purchasers and payers of maternity care services, administrators, policymakers, public health leaders and advocates make informed decisions. As mentioned previously, pregnancy risk assessments are particularly important in capturing health behaviors and access to care as well as identifying SDOH that may impact a women's health. In many situations, new mothers receiving postpartum care may visit providers located in different areas and in different health systems from their newborns. This is especially true for women with both commercial and Medicaid coverage for care.⁵⁷

Recommendations:

To address the need for equity-focused measurements and data collection aimed at improving maternal health outcomes, we recommend the Committee consider the following:

- Direct CMS to develop quality measures for maternal and infant health and standardized data collection across states as well as collection and publication of survey data from providers, facilities and health plans (*H.R. 1551/S. 1960, Quality Care for Moms and Babies Act; H.R. 6165/S. 3424, Data to Save Moms Act*)
 - Encourage the Measure Applications Partnership (MAP) and CMS to add to the Medicaid Core Sets existing (e.g., Cesarean Birth (NQF 0471), Exclusive Breast Milk Feeding (NQF 0480) or new measures that promote access to healthy perinatal physiologic processes

Rationale:

Through the Quality Care for Moms and Babies (QCMBA) Act (H.R. 1551), a standard set of maternal and infant health quality measures could be used to ensure maternity care providers use standardized, stakeholder-endorsed tools to evaluate maternal and infant health outcomes. With the understanding that comprehensive measure strengthen data collection, BCBSA established in 2016 the *Blue Distinction Center for Maternity Care Program* to help prospective parents find hospitals that deliver quality, affordable maternity care. The program evaluates hospitals on several quality measures, including the percentage of newborns delivered through an early elective delivery (i.e., induced labor, elective caesarian section), an ongoing concern in the medical community.

⁵⁶ Moy E, Garcia MC, Bastian B, Rossen LM, Ingram DD, Faul M, et al. Leading causes of death in nonmetropolitan and metropolitan areas— United States, 1999–2014. *MMWR Surveill Summ.* 2017;66(1):1–8.

⁵⁷ Henderson, V., Stumbras, K., Caskey, R., Haider, S., Rankin, K., & Handler, A. (2016, June 24). Understanding Factors Associated with Postpartum Visit Attendance and Contraception Choices: Listening to Low-Income Postpartum Women and Health Care Providers. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5290059/>

Hospitals that receive a Blue Distinction Center for Maternity Care designation agree to meet requirements that align with principles that support evidence-based practices of care. These centers must also implement programs to promote successful breastfeeding, as described in the Baby-Friendly Hospital Initiative by Baby-Friendly USA or the Mother-Friendly Hospital program by the Coalition for Improving Maternity Services (CIMS) through its “Ten Steps of Mother-Friendly Care.” Lastly, the program also evaluates hospitals on overall patient satisfaction, including a willingness to recommend the hospital to others.⁵⁸

Providers receiving a Blue Distinction Center+ designation go beyond Blue Distinction Centers because they also are measured on how efficiently they deliver high-quality patient care.⁵⁹ To qualify as a Blue Distinction Center+ for Maternity Care, a hospital must achieve a C-section rate of 27 percent or lower, among other patient health outcomes and quality measures. Additionally, these Centers have an average C-section rate of 23.7 percent, which surpasses the Healthy People 2020 federal goal to reduce C-section rates for first-time, low-risk mothers to 23.9 percent by 2020. Compared to other hospitals, Blue Distinction Centers+ also have 70 percent fewer early (37 – 39 weeks) elective deliveries and 53 percent fewer episiotomies.

To continue promoting innovation, CareFirst BlueCross BlueShield (CareFirst) also is awarding \$2 million over the next two years to programs seeking to improve birth outcomes, maternal health and lower infant mortality rates in Maryland, Virginia and Washington, D.C. Since 2007, CareFirst has already contributed more than \$18 million to address disparities, and these investments have resulted in improved health outcomes. From 2009 to 2018, Baltimore City, whose residents often have significant unmet maternal and child health needs, saw a 38 percent decrease in the black-white disparity in infant mortality.⁶⁰

Another resource that BCBS Plans utilize is the Maternal Data Center (MDC), an online web tool created by the California Maternal Quality Care Collaborative that generates near real-time data and performance metrics on maternity care services for hospital participants.⁶¹ Currently, it is available in hospitals with labor and delivery units in California, Washington and Oregon. More than 200 hospitals in the collaborative submit patient discharge data – data that they already collect – to the MDC, which instantaneously links discharge data to birth certificates or clinical data. The result is a low-burden tool that gives clinicians the perinatal performance metrics and benchmarking data they need to drive quality improvement.⁶¹ Since the Collaborative’s inception, established by Blue Shield of California, California has seen maternal mortality decline by 55 percent between 2006 to 2013, while the national maternal mortality rate continued to rise.⁶²

⁵⁸ Blue Cross Blue Shield Association Announces New Designation to Recognize Hospitals for Quality, Affordable Maternity Care in the U.S. (10 February 2016). Retrieved 2 March, 2020, from <https://www.bcbs.com/news/press-releases/blue-cross-blue-shield-association-announces-new-designation-recognize>

⁵⁹ Blue Cross Blue Shield. (n.d.). Retrieved 2 March, 2020, from <https://www.bcbs.com/blue-distinction-specialty-care>

⁶⁰ Big Ideas Community Roots, 2018 Community Report. (2018). CareFirst BlueCross BlueShield. Retrieved from 23 March 2020, from: <https://www.carefirst.com/carefirst-resources/cfc/attachments/news/publications/community-report-2018.pdf>

⁶¹ Maternal Data Center. (n.d.). Retrieved 2 March, 2020, from <https://www.cmqqc.org/maternal-data-center>

⁶² Ascend at the Aspen Institute. (2019, April 18). Giving Kids a Healthy Start to Life: a Briefing Series for New State Policymakers. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2019/04/maternal-and-child-health.html>

We appreciate your consideration of our comments and look forward to working with the Committee as you develop a legislative package to address maternal mortality and morbidity and improve maternal health outcomes. If you have any questions or want additional information, please contact Ashley Gray, Director, Medicaid Policy, at Ashley.Gray@bcbsa.com or 202.626.8612.

Sincerely,

A handwritten signature in black ink that reads "Justine Handelman". The signature is written in a cursive, flowing style.

Justine Handelman
Senior Vice President
Office of Policy and Representation