



The Honorable Chuck Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen
Washington, DC 20510

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

March 19, 2020

Re: Request for Information Regarding Maternal and Infant Health Care

To Senators Grassley and Wyden:

I am writing on behalf of Trust for America's Health (TFAH) to provide information in response to the committee's request for information regarding opportunities to improve health care access, quality, and outcomes for women in rural areas before, during, and after pregnancy. Medicaid is a critical program in this effort, paying for nearly half of all births in the U.S. and covering over a quarter of all women of reproductive age who live in rural areas.¹ As a non-profit, non-partisan organization that promotes optimal health for every person and community, TFAH appreciates the Committee's attention this issue.²

TFAH strongly believes that a concerted public health approach is essential to improving maternal health outcomes, especially in rural, and often underserved, areas. A public health approach will bring together diverse sectors with the goal of ensuring that pregnant and postpartum women as a community receive continuous, high-quality care and support. With that overarching approach in mind, this letter focuses on three particular opportunities to improve the care of pregnant and postpartum women: vaccinations; mental health care, including opioid and other substance use disorder (SUD) treatment; and access to care. This letter also discusses gaps in the availability of data regarding maternal health that we strongly encourage the Administration and Congress to help fill. This letter concludes with a series of specific recommendations that Congress could take to address maternal health care needs.

Although pregnancy should be a hopeful time for families, pregnancy can raise numerous health risks, some of which can be severe. As we detail below, pregnant women are more likely than their peers to contract and experience severe symptoms of infectious disease, including pandemic infections such as COVID-19. Women already struggling with mental health or substance use disorders may be doubly impacted—not only by the associated health risks of pregnancy but also

¹ Alina Salganicoff, Strengthening Maternity Coverage for Women in Rural Communities (2019) *Kaiser Family Foundation*, available at: <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/14-Maternal-Health-Forum-Strengthening-Maternity-Coverage-for-Women-in-Rural-Communities.pdf>

² Births Financed by Medicaid, Kaiser Family Foundation, retrieved 3/11/20 at: <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/>

by a system poorly equipped to support their needs. A healthy pregnancy is best facilitated through consistent monitoring and support. Without stable insurance and access to care, complications can go unnoticed and untreated with devastating consequences. In rural areas with limited access to services, strategies to address these needs are sorely needed.

Women in rural areas have particularly acute needs. Rural pregnant women are at significantly higher risk of co-occurring substance use disorder, depression, diabetes, and chronic respiratory disease than their urban counterparts.³ Unfortunately, rural areas often lack the providers necessary to ensure that these women have adequate health care. Rural women of color have disproportionately low access to care, both during and preceding pregnancy, and commonly report experiencing discriminatory treatment when they receive care; both of which put them at a relatively higher risk of poor health outcomes.⁴ Approximately 18 million women of reproductive age live in rural areas, and nearly half a million babies are born each year in rural hospitals.⁵ Attention to the particular needs and risk factors of these women is essential to improving the rates of maternal wellbeing nationwide.⁶

Vaccinations

Pregnant woman and newborns are particularly susceptible to infections. Vaccinations have conferred to these women and children unparalleled protection. Yet, vaccination rates are low among pregnant women, and particularly among those with Medicaid and those living in rural areas.^{7,8}

The stress that pregnancy puts on a woman's body increases her susceptibility to common illnesses, as well as the potential severity of these illnesses.^{9,10} Pregnant women are over twice as likely to be hospitalized for the flu than nonpregnant women.¹¹ Whereas at any given time, approximately 9% of women ages 15-44 are pregnant, from 2010-2017 pregnant woman

³ Katy Backes Kozhimannil, et al., Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15, (2019) *Health Affairs*, 38(2), <https://doi.org/10.1377/hlthaff.2019.00805>

⁴ Research Overview of Maternal Mortality and Morbidity in the United States, *Center for Reproductive Rights*, available at:

https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf

⁵ Improving Access to Maternal Health Care in Rural Communities (2019) *CMS*.

⁶ Alina Salganicoff, Strengthening Maternity Coverage for Women in Rural Communities (2019) *Kaiser Family Foundation*, available at: <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/14-Maternal-Health-Forum-Strengthening-Maternity-Coverage-for-Women-in-Rural-Communities.pdf>

⁷ Low Rates of Vaccination During Pregnancy Leave Moms, Babies Unprotected [press release], *CDC Newsroom*, Oct 8 2019, Available at: <https://www.cdc.gov/media/releases/2019/p1008-vaccination-moms-babies-unprotected.html>

⁸ Parinaz Ghaswalla, et al., Maternal Immunization in the U.S.: A Nationwide Retrospective Cohort Study (2019) *American Journal of Preventive Medicine*, 57(3): e87-e93, available at: [https://www.ajpmonline.org/article/S0749-3797\(19\)30207-7/pdf](https://www.ajpmonline.org/article/S0749-3797(19)30207-7/pdf)

⁹ Saad B. Omer, Maternal Immunization (2017) *New England Journal of Medicine*, 376: 1256-1267, DOI: [10.1056/NEJMra1509044](https://doi.org/10.1056/NEJMra1509044)

¹⁰ Geeta K. Swamy and R. Phillips Heine, Vaccinations for Pregnant Women, (2015) *Obstetrics and Gynecology*, 125(1): 212-226, doi: [10.1097/AOG.0000000000000581](https://doi.org/10.1097/AOG.0000000000000581)

¹¹ Supra n. 2 (CDC)

accounted for 24-34% of all influenza-related hospitalizations among women of childbearing age.¹² Receiving the flu vaccine has been shown to decrease this risk by 40%.¹³

When a mother gets vaccinated, she also lowers her newborn's risk of infection. She transfers her antibodies to the infant; if she is pregnant, through transplacental transport, or after delivery via breastfeeding. No vaccine is indicated for children younger than six months old. By passing along her own immunity, the mother protects her child during those critical months.¹⁴ Maternal immunization reduces a young child's risk of hospitalization due to influenza by 72% and has reduced the incidence of pertussis in newborn infants by up to 90%.^{15,16} In light of these benefits, the CDC recommends that all pregnant women be vaccinated against influenza and pertussis with each pregnancy.¹⁷

Yet, we are failing to vaccinate a large proportion of pregnant women. At last count, only 54-55% of pregnant women reported getting either a flu or pertussis vaccine, respectively, before or during pregnancy.¹⁸ Of them, the majority had received only one of the two vaccines. Taking into account the Healthy People 2020 goal of vaccinating 80% of pregnant women against seasonal influenza, it is clear our current maternal vaccination rates are unacceptably low.¹⁹

Vaccination rates in Medicaid are worse: According to a recent study published in the CDC's Morbidity and Mortality Weekly Report (MMWR), of pregnant women seen at a facility in Florida between 2016 and 2018, only 13.4% of those with Medicaid received the pertussis vaccine, compared to 68.6% with private insurance; roughly half of those with Medicaid got the flu vaccine, compared to 70.4% of those with private insurance.²⁰ Though rates vary among states, women in Medicaid are consistently less likely to be vaccinated than women with private insurance.²¹

There are multiple reasons that maternal vaccination rates are so low. Numerous studies have found that a lack of coverage and/or copays are associated with lower maternal vaccination

¹² Megan C. Lindley, et al., Vital Signs: Burden and Prevention of Influenza and Pertussis Among Pregnant Women and Infants — United States (2019) *MMWR*, 68(40): 885-892, available at: https://www.cdc.gov/mmwr/volumes/68/wr/mm6840e1.htm?s_cid=mm6840e1_e&deliveryName=USCDC_921-DM10321

¹³ Mark G Thompson, et al., Influenza Vaccine Effectiveness in Preventing Influenza-associated Hospitalizations During Pregnancy: A Multi-country Retrospective Test Negative Design Study, 2010–2016 (2019) *Clinical Infectious Diseases*, 68(9): 1444–1453, <https://doi.org/10.1093/cid/ciy737>

¹⁴ Kirsten Maertens, et al., Vaccination during pregnancy: current and possible future recommendations (2020) *European Journal of Pediatrics*, 179: 235-242, doi: <https://doi.org/10.1007/s00431-019-03563-w>

¹⁵ Vital Signs, Vaccinating Pregnant Women, *CDC*, Oct 2019, Available at: <https://www.cdc.gov/vitalsigns/maternal-vaccines/index.html>

¹⁶ Phillipe Buchy, et al. Vaccinating Pregnant Women Against Influenza Needs to Be a Priority for All Countries: An Expert Commentary, (2020) *International Journal of Infectious Diseases* 92: 1-12, DOI: [10.1016/j.ijid.2019.12.019](https://doi.org/10.1016/j.ijid.2019.12.019)

¹⁷ Pregnancy and Vaccination, Why Maternal Vaccines are Important, *CDC*, available at: <https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/important-maternal-vaccines.html>

¹⁸ Low Rates of Vaccination During Pregnancy Leave Moms, Babies Unprotected [press release], *CDC Newsroom*, Oct 8 2019, Available at: <https://www.cdc.gov/media/releases/2019/p1008-vaccination-moms-babies-unprotected.html>

¹⁹ Healthy People 2020, IID-12.14, Immunization and Infectious Diseases: Objectives, available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases/objectives>

²⁰ Taylor A. Merritt, et al., Variation in Pertussis and Influenza Vaccination Coverage Among Pregnant Women by Insurance Type – Florida, 2016-2018 (2020) *MMWR*, 69(3): 72-76.

²¹ Parinaz Ghaswalla, et al. Maternal Immunization in the United States: A Nationwide Retrospective Cohort Study (2019) *American Journal of Preventive Medicine*, 57(3): e87-e93, <https://doi.org/10.1016/j.amepre.2019.04.013>

rates.^{22,23,24} By federal law, states may exclude adult vaccinations from their benefit packages or impose cost-sharing on covered vaccines.^{25,26} The Affordable Care Act (ACA) overruled this precedent by requiring coverage of all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines at no cost to consumers in the private market and, through a later CMS determination, for Medicaid expansion populations.²⁷ However, federal law does not require states to cover or eliminate cost-sharing for vaccines for its traditional Medicaid populations. This means that states can elect not to cover vaccinations for pregnant women, or can cover them but impose cost-sharing.²⁸ Although publicly-available information about adult vaccine coverage in state Medicaid programs is limited, many states with larger rural populations have historically failed to cover all recommended adult vaccines.^{29,30} For example, at the time of the study cited above, Florida Medicaid did not cover vaccines for pregnant women; accordingly, women covered by Florida Medicaid were significantly less likely to get vaccinated.³¹ As Medicaid covers approximately half of all pregnancies in the U.S., removing this coverage and cost barrier could significantly increase access to vaccination for pregnant women.

Barriers are also erected at doctors' offices when providers fail to educate and encourage their patients to get vaccinated. Women who receive a recommendation and offer of the tetanus, diphtheria, and pertussis (Tdap) or influenza vaccine are more likely to be vaccinated. Unfortunately, according to the CDC, only 64% of pregnant women are offered the Tdap vaccine by their physician.³² Accordingly, it is common for pregnant women to report that they did not get a pertussis vaccination because they did not realize they needed one.³³

Unfortunately, misinformation also inhibits vaccination rates. When pregnant women consciously forgo vaccination, they commonly do so because they doubt its efficacy or fear its effects on their child.³⁴ Anti-vaccination sentiments are prevalent throughout (though certainly

²² *Supra n. 7 (MMWR)*

²³ Charles Stoeker, Alexandra M. Stewart, and Megan C. Lindley, The Cost of Cost-Sharing: The Impact of Medicaid Benefit Design on Influenza Vaccination Uptake (2017) *Vaccines*, 5(1), DOI: [10.3390/vaccines5010008](https://doi.org/10.3390/vaccines5010008)

²⁴ *Supra n. 7 (Swamy and Heine)*

²⁵ Vaccine Coverage Requirements in the U.S., *Avalere*, Available at: https://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1508351278_20171018_Merck_Vaccine_Coverage_White_Paper.pdf

²⁶ Quality of Care Vaccines, *Medicaid*, Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/quality-of-care-vaccines/index.html>

²⁷ *Id.*

²⁸ Quality of Care Vaccines, *Medicaid*, Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/quality-of-care-vaccines/index.html>

²⁹ Alexandra M. Stewart, MEDICAID and ADULT VACCINATIONS: Coverage and Provider Reimbursement Policy for Non-Institutionalized Adults, National Adult and Influenza Immunization Summit, May 10 2016, available at: <https://www.izsummitpartners.org/content/uploads/2016/05/2b-1-Stewart-Medicaid-Adult-Vax-Coverage-and-Reimbursement.pdf>

³⁰ Sara Rosenbaum, et al., The Epidemiology Of U.S. Immunization Law: A National Study For The National Immunizations Program, Centers For Disease Control And Prevention Medicaid Coverage Of Immunizations For Non-Institutionalized Adults (2003) *Center for Health Services Research and Policy*, available at: https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_5F6FC614-5056-9D20-3D48DB884F5C18C8.pdf

³¹ *Supra n. 32*

³² Pregnancy and Vaccination, Maternal Vaccination Coverage, *CDC*, Available at: <https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/maternal-vaccination-coverage.html>

³³ *Supra n. 10 (Lindley, et al.)*

³⁴ CDC, Vaccinating Pregnant Women, *Vital Signs*, Oct 2019, available at: <https://www.cdc.gov/vitalsigns/maternal-vaccines/index.html>

not confined to) many parts of rural America.³⁵ Better education is essential to deconstructing these barriers. To be clear—vaccines are safe and effective for pregnant women. Influenza and (Tdap) vaccines are recommended for all pregnant women; Pneumococcal, Meningococcal, Hepatitis A and B vaccines are recommended for pregnant women in certain higher-risk populations.^{36,37,38,39,40} Prominent health groups including the American College of Obstetrics and Gynecology (ACOG), American Academy of Pediatrics (AAP), and others strongly encourage physicians to recommend and, as appropriate, administer vaccines to their pregnant patients.^{41,42} Even so, with misinformation about vaccination so rampant, physicians and public health workers need support to help inform women about the safety and benefits of vaccination.

Making vaccines more accessible, affordable, and better understood will likely improve vaccination rates among pregnant women, which is essential to the goal of protecting maternal health. This need is as great among rural women as it is nationwide. We strongly encourage congress to work with CMS to be at the forefront of improving maternal vaccination rates by improving access and countering misinformation.

Substance Use Disorder and Mental Health

Wellbeing is closely tied to behavioral health. In 2017, TFAH's Pain in the Nation Report highlighted accelerating rates of “deaths of despair”—drug overdoses, alcohol-related deaths, and suicide—across the nation.⁴³ Rural communities have been hit particularly hard by opioid use and suicide over the past 15 years.⁴⁴ Although little research has been done on maternal mental health among rural populations, available evidence suggests a high level of need.⁴⁵

Rates of suicide and drug use have skyrocketed in recent years, and pregnant and postpartum women have not been immune. Approximately 15% of pregnant and postpartum women struggle

³⁵ Jaqueline K. Olive, et al. The state of the antivaccine movement in the United States: A focused examination of nonmedical exemptions in states and counties (2018) *PLoS Medicine*, 15(6): e1002578.

<https://doi.org/10.1371/journal.pmed.1002578>

³⁶ Sukumaran L, McCarthy NL, Kharbanda EO, et al. Safety of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis and influenza vaccinations in pregnancy. *Obstet Gynecol* 2015;126:1069-1074

³⁷ Influenza Vaccination During Pregnancy, Committee Opinion No. 732, American College of Obstetricians and Gynecologists (2018) *Obstetrics and Gynecology*, 131: e109-114

³⁸ Update on immunization and pregnancy: tetanus, diphtheria, and pertussis vaccination, Committee Opinion No. 718, American College of Obstetricians and Gynecologists (2017) *Obstetrics and Gynecology*, 130: e153-157.

³⁹ Immunization, Infectious Disease, and Public Health preparedness Expert Work Group, ACOG Committee Opinion—Maternal Immunization (2018) *The American College of Obstetricians and Gynecologists*, 741.

⁴⁰ Immunization Action Coalition, Evidence Shows Vaccines Unrelated to Autism, available at:

<http://www.immunize.org/catg.d/p4028.pdf>.

⁴¹ *Supra n. 15 (ACOG)*

⁴² Recommendations for Prevention and Control of Influenza in Children 2019-2020, *American Academy of Pediatrics*, Sept 2 2019, available at: <https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/Recommendations-for-Prevention-and-Control-of-Influenza-in-Children-2019-2020.aspx>

⁴³ Pain in the Nation (2017) *Trust for American's Health*, Available at: <https://www.tfah.org/report-details/pain-in-the-nation/>

⁴⁴ Ivey-Stephenson AZ, Crosby AE, Jack SP, Haileyesus T, Kresnow-Sedacca M. Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death — United States, 2001–2015 (2017) *MMWR Surveill Summ*, 66(SS-18):1–16. DOI:

<http://dx.doi.org/10.15585/mmwr.ss6618a1>

⁴⁵ Yoshie Sano, Cory Bolkan, and Sheila Mammen, Maternal depression and family health context: tracking depression trajectories of rural, low-income mothers (2020) *Journal of Family Social Work*,

<https://doi.org/10.1080/10522158.2019.1709244>

with mood disorders, which puts them at a higher risk of self-harm.⁴⁶ An estimated 5% to 25% of all pregnant, postpartum, and parenting women have some type of depression, depending on the population surveyed; rates are higher among low-income women, reported to be between 40% to 60%.⁴⁷ Additionally, approximately 21,000 pregnant women used opioids non-medically between 2007 and 2012.⁴⁸ This disturbing association highlights the importance of substance use prevention efforts and mental health care for pregnant women and new mothers. The postpartum period is a particularly vulnerable period for women, and it is essential that their mental health is supported during this time.

We commend the work that has already been done to extend coverage for mental health care to postpartum women through the Early and Periodic Screening, Diagnosis, and Testing (EPSDT) benefit in Medicaid.⁴⁹ With the understanding that maternal mental illness and substance use put the child, as well as the mother, at risk, CMS issued guidance specifying that states may cover a maternal depression screening as part of a well-child visit, even if the woman is no longer eligible for Medicaid.⁵⁰ However, women who receive screening through their child's EPSDT benefit may not have access to subsequent needed services. Although community and other low-cost service providers might exist, it is unrealistic to assume that women in underserved areas will have access to the quality and consistency of care they need. A more efficient solution would be to extend coverage of mental health screening, diagnosis, and treatment to pregnant and postpartum women with Medicaid. Women would also benefit from extending the current postpartum eligibility period beyond its current 60 days, as discussed in the following section.

Even where resources are available, stigma and a punitive approach to addressing substance use during pregnancy continue to deter pregnant women who struggle with opioid and other SUD from receiving help. TFAH's Pain in the Nation Report explored the effect of punitive policies that target pregnant women with SUD. Twenty-four states and DC consider substance use during pregnancy to be child endangerment, and three consider it grounds for civil commitment. When drug use is suspected, 23 states and DC require physicians to report it; 24 states and DC consider substance use during pregnancy to be grounds for civil commitment. Meanwhile, twelve states neither have a drug treatment program for pregnant women nor grant pregnant women priority enrollment in such programs. Many of these states with strict legal penalties but limited available services also have large rural populations.⁵¹ When women are penalized and unable to receive help for a SUD, they lack an incentive to seek help and may put themselves and their child at risk of harm.

We strongly encourage CMS to promote a public health approach to addressing maternal health needs, including healthcare-sector interventions to address substance use and self-harm. Evidence shows that even a single discussion and intervention can help reduce adverse

⁴⁶ Kimberly Mangla, et al., Maternal self-harm deaths: an unrecognized and preventable outcome (2019) *American Journal of Obstetrics and Gynecology*, 221(4): 295-303, <https://doi.org/10.1016/j.ajog.2019.02.056>

⁴⁷ Vikki Wachino, CMCS Informational Bulletin, RE: Maternal Depression Screening and Treatment: A critical Role for Medicaid in the Care of Mothers and Children, May 11 2016, available at: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051116.pdf>

⁴⁸ *Supra n. 31 (TFAH)*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Pain in the Nation (2017) Trust for American's Health*, Available at: <https://www.tfah.org/report-details/pain-in-the-nation/>

outcomes.⁵² This is why mental health and SUD treatment parity is required in virtually all private and public health insurance plans, including Medicaid.⁵³ These laws must be enforced; private insurers still attempt to undercut the spirit of mental health parity laws, leaving beneficiaries without sufficient coverage or access to treatment.^{54,55} The best option for mother and baby is to be able to access affordable mental health care and support, as well as to feel safe asking for help.

Access to Care

The American College of Obstetricians and Gynecologists recommends that women maintain uninterrupted access to preventive care, in order to reduce avoidable adverse health outcomes, increase early diagnosis of disease and complications, and reduce maternal mortality rates.⁵⁶ Unfortunately, pregnant women with Medicaid, particularly those who live in rural areas, face numerous barriers to accessing adequate prenatal, delivery, and postnatal care. Although we appreciate the efforts that CMS has already undertaken to address rural maternal health care needs, the needs of pregnant and postpartum women in rural areas require continued attention.^{57,58}

At the heart of this issue is a lack of hospitals, clinics, and providers. By 2050, rural areas are expected to bear a disproportionate burden of the 22,000 national provider shortage.⁵⁹ As rural hospitals close and physician shortages grow, it becomes more difficult for pregnant and postpartum women to get the care they need. Since 2010, more than 100 rural hospitals have closed; 77 since 2014.⁶⁰ Many of those that stayed open closed their obstetric (OB) units, leaving over half of rural counties (and 69% of the most isolated areas) without such units.⁶¹ Hospital and provider shortages are predicted to worsen over the coming years.⁶²

In line with the trend in hospital closures, the closures of reproductive health clinics have had a deleterious effect on maternal mortality rates in affected regions. A recent article published in the American Journal of Preventive Medicine found that “clinic closures negatively impacted all

⁵² *Supra n. 31 (TFAH)*

⁵³ CMS, Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP, March 2016, available at: <https://www.medicaid.gov/sites/default/files/2019-12/fact-sheet-cms-2333-f.pdf>

⁵⁴ Daria Pelech and Tamara Hayford, Medicare Advantage and Commercial Prices for Mental Health Services (2019) *Health Affairs*, 38(2), available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05226>

⁵⁵ Graison Dangor, ‘Mental Health Parity’ is Still and Elusive Goal in U.S. Insurance Coverage, *NPR*, June 7, 2019, available at: <https://www.npr.org/sections/health-shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage>

⁵⁶ Committee Opinion: Benefits to Women of Medicaid Expansion Through the Affordable Care Act (2013) *ACOG*, 552, available at: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Benefits-to-Women-of-Medicaid-Expansion-Affordable-Care-Act>

⁵⁷ CMS Rural Health Strategy(2018) *CMS*, available at: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>

⁵⁸ Fact Sheet: Medicaid and CHIP (MAC) Scorecard, *CMS*, available at: <https://medicaid.gov/state-overviews/downloads/scorecard/factsheet.pdf>

⁵⁹ *Supra n 3. (CMS)*

⁶⁰ *Supra n. 3 (CMS)*

⁶¹ Health Affairs policy brief, September 2017, Vol. 36, No. 9: “Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14”

⁶² Stuart Heiser, New Findings Confirm Predictions on Physician Shortage [press release], *Association of American Medical Colleges*, April 23 2019, Available at: <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>

women, increasing mortality by 6%–15% across racial/ethnic groups” using data from 38 states and DC Approximately 35% of Planned Parenthood clinics closed in 27 states between 2007 and 2015; in some states, 100% of clinics closed.⁶³ These reproductive health clinics may be among the only providers available to women of childbearing age. Their loss can significantly reduce access to care, particularly in rural areas.

Reproductive health clinics not only provide prenatal care but also commonly offer the only access to contraception available in the communities they serve.⁶⁴ Without contraception, it becomes much more difficult for women to control when they get pregnant. Accordingly, the loss of these clinics can lead to a spike in the birth rate.⁶⁵ Access to appropriate and high-quality care, early diagnosis of complications, and knowledge among patients and providers around the warning signs of pregnancy complications are essential to protecting pregnant women and mothers.⁶⁶ An unplanned pregnancy coupled with limited access to routine care is dangerous. Especially in areas with low access to care, it is important that discussions regarding laws and policies that may limit funding to or effectively force the closure of reproductive health clinics consider the risk that such changes may compromise maternal health and safety.

Now, fewer than half of all rural counties have any practicing obstetrician or gynecologist (OB/GYN).⁶⁷ As a result, 2.4 million women of reproductive age live in a rural county without in-hospital OB care.⁶⁸ The availability of non-physician providers, such as midwives, to fill this gap is already stretched thin. Although midwives represent 10% of the maternal care provider workforce, they attend 30% of rural births.⁶⁹ A lack of prenatal care increases pregnant women’s risk of pregnancy-related mortality 300% to 400%.⁷⁰

Certain state Medicaid programs are already working to maximize access to prenatal and postpartum care. For example, although home visiting is not a named service in the federal Medicaid statute, states may elect to reimburse for services that are part of a home visit (e.g. screenings, case management).⁷¹ These programs generally serve low-income women and their

⁶³ Summer Sharburne Hawkins, et al., Impact of State-Level Changes on Maternal Mortality: A Population-Based, Quasi-Experimental Study (2020) *American Journal of Preventive Medicine*, 58(2): P165-174, <https://doi.org/10.1016/j.amepre.2019.09.012>

⁶⁴ Jennifer J. Frost, Letter to Lisa Ramirez-Branum, RE: “Response to Inquiry Concerning Geographic Service Availability From Planned Parenthood Health Centers,” *Guttmacher Institute*, Aug 14, 2015.

⁶⁵ Amanda J. Stevenson, et al., Effect of Removal of Planned Parenthood from the Texas Women’s Health Program (2016) *New England Journal of Medicine*, 374: 853-860, DOI: [10.1056/NEJMsa1511902](https://doi.org/10.1056/NEJMsa1511902)

⁶⁶ Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths [press release] *CDC*, Sept 5 2019, Available at: <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>

⁶⁷ NC Rural Health Research Program, 166 Rural Hospital Closures: January 2005 – Present (124 since 2010), *University of North Carolina Sheps Center for Health Services Research*, (Accessed 2/25/2020) Available at: <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

⁶⁸ Peiyin Hung, et al., Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14, (2017) *Health Affairs*, 36(9), <https://doi.org/10.1377/hlthaff.2017.0338>

⁶⁹ *Supra n. 3 (CMS)*

⁷⁰ Corinne Lewis, Isabel Paxton, and Laurie Zephyrin, The Rural Maternity Care Crisis, *The Commonwealth Fund – To the Point*, August 15, 2019, Available at: <https://www.commonwealthfund.org/blog/2019/rural-maternity-care-crisis>

⁷¹ Centers for Medicare and Medicaid Services and Health Resource Services Administration, Coverage of maternal, infant, and early childhood home visiting services, Joint Information Bulletin, March 2016. Available at: <https://www.medicare.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB-03-02-16.pdf>

children, and have contributed to improvements in health outcomes among those served.⁷² We encourage Medicaid to continue working with states to implement existing strategies that expand access to care, particularly in rural areas.

Unfortunately, efforts to reach women through Medicaid may miss a significant number of those in need of services. Because low-income women in many states do not become eligible for Medicaid coverage until they become pregnant, they often lack prenatal care in their first trimester.⁷³ According to a Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of women with Medicaid, private insurance, and without insurance, “Twenty percent of women reported having Medicaid coverage prior to pregnancy and around 40 percent had Medicaid coverage for delivery,” suggesting a high need for coverage among would-be mothers.⁷⁴

Unmet needs continue after delivery. The postpartum period is a critical time for women. Over half of all pregnancy-related deaths happen after a woman has given birth, a quarter of which occur after 42 days postpartum.⁷⁵ Yet, 19 states end Medicaid coverage after 60 days postpartum.⁷⁶ After delivery, insurance rates among new mothers drops from 14% to 2.7%. This dip corresponds with a 13.1% decline in Medicaid coverage among the same population, suggesting that at least some of the loss of coverage is due to women losing their Medicaid coverage after giving birth.⁷⁷ Extending coverage to one year could substantially improve women’s access to care.⁷⁸

Compounding the problem of women prematurely losing coverage is the fact that many pregnant and postpartum low-income women lack coverage in states that have not expanded Medicaid. Research shows that Medicaid expansion has increased coverage rates among new mothers and increased access to postpartum care.⁷⁹ Utilization rates were highest among women with significant morbidity after childbirth, indicating that this coverage significantly improved, if not saved, mothers’ lives.⁸⁰

A lack of care can be particularly dangerous for rural low-income women, who are at a significantly higher risk than those with private coverage of having previously experienced a complicated birth (e.g. preterm and/or low birthrate), being underweight, overweight or obese, or having health risk factors that can make a pregnancy more difficult or dangerous.⁸¹ That women need health care coverage during pregnancy and for a year postpartum cannot be overstated.

⁷² Johnson K. Medicaid Financing for Home Visiting: The State of States’ Approaches. Johnson Group Consulting, Inc. 2019.

⁷³ Access in Brief: Pregnant Women and Medicaid (2018) MACPAC, Available at: <https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf>

⁷⁴ *Id.*

⁷⁵ Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-related mortality in the United States, 2011-2013. *Obstet Gynecol.* 2017;130(2):366-73.

⁷⁶ Allison Stuebe, et al., Extending Medicaid Coverage for Postpartum Moms, *Health Affairs Blog*, May 6 2019, doi: [10.1377/hblog20190501.254675](https://doi.org/10.1377/hblog20190501.254675)

⁷⁷ *Id.*

⁷⁸ Emily Eckert, It’s Past Time To Provide Continuous Medicaid Coverage For One Year Postpartum, *Health Affairs Blog*, Feb 6 2020, doi: [10.1377/hblog20200203.639479](https://doi.org/10.1377/hblog20200203.639479)

⁷⁹ Sarah H. Gordon, Effects of Medicaid Expansion on Postpartum Coverage and Outpatient Utilization (2020) *Health Affairs*, 39(1), <https://doi.org/10.1377/hlthaff.2019.00547>

⁸⁰ *Id.*

⁸¹ *Id.*

Data Limitations

There is a clear and well-documented need for better and more systematic data collection, analysis, and transparency around maternal health care and outcomes. The voluntary child and adult core set of measures is a good first step but remain voluntary and are insufficient to provide the full set of data that this issue necessitates. The 2020 Adult Core Set metrics include depression screening, flu vaccination, and postpartum care, among others.⁸² Surveillance of this issue is still nascent. Death certificates did not include “the pregnancy checkbox” in all states until mid-2017. Earlier this year, the maternal mortality ratio was updated for the first time in over ten years.⁸³ The public health community, including CMS and HHS, should remain focused on addressing gaps in the collection and analysis of maternal health and mortality data.

There is no national registry or database of suicide and overdose deaths that records pregnancy status. A recent review in the *American Journal of Obstetrics and Gynecology* noted that “The rates of maternal death secondary to self-harm, including suicide and overdose, have been omitted from published rates of maternal mortality,” creating a gap in our understanding of the mental health needs of pregnant women and new mothers.⁸⁴ With the understanding that maternal deaths may be strongly associated with maternal substance use and mood disorders, it is essential that this data is collected and made available for research.⁸⁵ If suicide and overdose were counted in maternal mortality statistics, the rates of maternal death might be even higher.

The introduction of complementary ICD-10 codes and death certificates has enabled better tracking of maternal deaths.⁸⁶ Collecting and analyzing this data has been foundational to the current attention around maternal mortality. In light of evidence of rampant reporting errors, a new system of recording was implemented in 2018.⁸⁷ These changes restricted the use of the pregnancy checkbox to deceased people ages 10-44 unless the death of an older person is reported alongside an ICD-10 code indicating a pregnancy or obstetric condition. A maternal death code will also be assigned as an underlying cause, unless the cause of death was something external or incidental, such as a car crash.⁸⁸ It is not clear whether these changes will be sufficient to improve the quality of maternal mortality data. The process of assessing and improving the quality of current maternal mortality surveillance should remain a priority.

In addition, as maternal mortality review boards (MMRBs) are formed across the nation, the information assembled and considered by these boards should be collected and made available for research. Although rural maternal health disparities are well-documented, their underlying factors are not thoroughly studied. For example, limited information exists about vaccination among pregnant and postpartum women in rural areas. The geographic distribution of maternal

⁸² 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), CMS, available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-core-set.pdf>

⁸³ Donna L. Hoyert, Sayeeda F.G. Uddin, and Arialdi M. Minoiño, Evaluation of the Pregnancy Status Checkbox on the Identification of Maternal Deaths (2020) *National Vital Statistics Report*, 69(1).

⁸⁴ *Supra n. 27 (Mangla, et al.)*

⁸⁵ *Id.*

⁸⁶ Maternal mortality and related concepts. *Vital Health Stat.* 2007; 3: 1–13. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/17460868>

⁸⁷ *Supra n. 52 (Hoyert, et al.)*

⁸⁸ *Id.*

deaths associated with drug overdoses are similarly poorly documented. Such information will be needed to create and support cogent policies and programs.

Opportunities

Given the challenges discussed above, TFAH offers the following recommendations:

Vaccines

Expand Access to Maternal Immunization Services for Uninsured and Underinsured Women—Vaccines are too essential to maternal, child, and public health for them to be unaffordable to those in need. We encourage CMS to work with states to ensure that all state Medicaid programs provide coverage of recommended vaccines for all pregnant women. CMS could strengthen this coverage by requiring or encouraging state Medicaid plans that cover immunization to do so with no cost sharing for pregnant and postpartum women.

Vaccine Counseling and Administration Reimbursement—Alongside efforts to provide free vaccines to pregnant women, we encourage CMS and its partner agencies to develop payment mechanisms to reimburse for the costs associated with counseling a patient and vaccine administration. It is essential that women are educated about the benefits and safety of vaccination for themselves as well as for their children.

Improve Provider Billing for Maternal Immunization Services—We encourage the HHS Office of the Assistant Secretary for Health (ASH), in coordination with CMS, HRSA, and payers, to improve upon current process issues related to billing, coding and payment for maternal immunizations, including a review of challenges around vaccine purchase, storage, and handling.

Innovative Payment Models—We encourage CMS to prioritize maternal immunizations in bundled payment arrangements and initiatives by working with states to incorporate vaccines into their bundled rates and managed care contracts.

“Vaccines for Pregnant Women”— To supplement broader coverage of vaccines, the Vaccines for Children (VFC) could be expanded to pregnant and postpartum women. The VFC program provides free vaccines to children under 19 years old with an inability to pay, who otherwise would be significantly less likely to get vaccinated.^{89,90} Over 44,000 physicians across 40,000 locations participate in VFC.⁹¹ By facilitating access, the CDC estimates that the VFC program prevented 419 million illnesses and prevented 936,000 deaths from its inception in 1994 through 2018.⁹² We encourage CMS to consider expanding VFC or developing a similar program to supply all recommended maternal vaccines to pregnant and postpartum women who lack other vaccination coverage.

⁸⁹ CDC, About VFC, *Vaccines for Children Program* [website], Available at: <https://www.cdc.gov/vaccines/programs/vfc/about/index.html>

⁹⁰ Holly A. Hill, et al., Vaccination Coverage Among Children Aged 19–35 Months — United States, 2017 (2018) *MMWR*, 67(40): 1123-1128, Available at: https://www.cdc.gov/mmwr/volumes/67/wr/mm6740a4.htm?s_cid=mm6740a4_w

⁹¹ *Supra n. 27 (CDC)*

⁹² *Id*

Mental Health and Substance Use

Cover Mental Health Care and Substance Abuse Treatment as a Maternal Care Benefit—

The concerning correlation between maternal mental health and mortality requires a solution that enables women to get access to mental health care and substance use disorder treatment.

Coverage for mental health screening and care under EPSDT is an imperfect solution that fails to ensure women coverage for the care they need. The simplest and most efficient solution is to ensure that Medicaid coverage includes comprehensive mental health and substance use benefits for pregnant women and for postpartum women.

Incentivize Provider Mental Health Screening and Intervention—With too many pregnant women struggling with mental illness and related issues, physicians should be deliberately screening and helping women in need access support and services. Twelve years ago, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a comprehensive report detailing existing and potential incentives to encourage mental health screening and referrals to care in Medicaid and Medicare.⁹³ We encourage HHS, through SAMHSA, to revisit these recommendations and reassess the landscape of provider incentives, in order to identify and actualize opportunities to improve mental health care for pregnant and postpartum women.

Create Opportunities for Pregnant and Postpartum Women with SUD to Get Care—The opioid and substance use epidemics have strained the health care and substance use treatment systems. Pregnant and postpartum women struggling with these disorders require targeted treatments that are designed to acknowledge the unique stigma and burdens that these women face as mothers. CMS should work with states and provider organizations, including hospitals, clinics, and community providers, to expand the availability of substance use disorder treatment and recovery for low-income pregnant and postpartum women.

Enforce Mental Health Parity Laws—HHS, in coordination with the Department of Labor (DOL) and the Treasury, have been tasked with enforcing mental health parity laws.^{94,95} We strongly support the investigations, oversight, and planning that have been undertaken thus far, and encourage HHS to continue these efforts. HHS should also work to inform consumers about their rights, help them understand their health insurance coverage options, and facilitate consumers' access to legal support when necessary.

Access to Care

Expand Insurance Coverage for Pregnant and Postpartum Women—Expanding insurance coverage is essential to the task of improving prenatal, delivery, and postnatal access to care among low-income women. We encourage CMS to work with those states that have not expanded Medicaid to extend coverage to low-income pregnant women, and to work across the country to extend postpartum coverage for one year after giving birth.

⁹³ Danna Mauch, Cori Kautz, and Shelagh Smith, Reimbursement of Mental Health Services in Primary Care Settings (2008) SAMHSA, available at:

https://www.integration.samhsa.gov/reimbursement_of_mental_health_services_in_primary_care_settings.pdf

⁹⁴ <https://www.hhs.gov/sites/default/files/parity-action-plan-b.pdf>

⁹⁵ <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf>

Defend Communities Against the Loss of Clinics, Hospitals, and Other Providers—At a time of rampant provider shortages, the loss of a hospital, clinic, or private practice can devastate a rural community. We encourage HHS to continue its work to strengthen these communities through efforts such as the Health Center Program and to expand incentives to maximize the availability of primary and OB/GYN care in rural areas.

Data Collection and Education

Improve Maternal Mortality Data Collection and Reporting—HHS, through the National Center for Health Statistics (NCHS), should prioritize the activities recommended by Hoyert and Miniño in their recent article in the *National Vital Statistics Report*: issuing guidance for certifiers about proper death certificate reporting and working to ensure the accurate incorporation of original maternal mortality records into vital statistics data.⁹⁶ In addition, NCHS should take steps to collate suicide and overdose data with maternal mortality data so that this troubling association can be better measured, studied, and addressed.

Work in collaboration with CDC’s Office of Minority Health and Health Equity (CDC OMHHE) and the CMS Office of Maternal Health (CMS OMH)—We encourage CDC OMHHE to team up with CMS OMH to further educate providers and the public about the unique needs of pregnant and postpartum women as well as to address the maternal health disparities found between women of color and other groups. CMS could also work with the CDC Division of Reproductive Health on the CDC’s Safe Motherhood and Infant Health Initiative.

Medicaid Data Report—We encourage HHS to study coverage and access to care among pregnant and postpartum women. The study should identify the insurance statuses of pregnant women across the United States, with special attention to coverage of immunization services and mental health care, as well as baseline coverage rates for women with Medicaid. Within this report, HHS should assess the feasibility of providing ACIP-recommended vaccines to pregnant and postpartum women at no charge through VFC or a similar program.

Conclusion

Maternal health is one of the key markers of a nation’s health; a high maternal mortality rate is a serious failure of public health and health care efforts. This premise has been acknowledged by entities such as the American Public Health Association for years.⁹⁷ Accordingly, we commend your attention to rural maternal health and appreciate this opportunity to provide information about the issue as well as our recommendations for future action to improve maternal health in underserved rural areas and nationwide. We look forward to working with you on this important issue.

Thank you for your consideration of these comments. If you have any questions, please do not hesitate to contact Cecelia Thomas at cthomas@tfah.org.

Sincerely,

⁹⁶ *Id.*

⁹⁷ Reducing U.S. Maternal Mortality is a Human Right, *American Public Health Association*, Nov 1 2011, available at: <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/11/15/59/reducing-us-maternal-mortality-as-a-human-right/>

A handwritten signature in black ink that reads "John Auerbach". The signature is fluid and cursive, with the first name "John" and last name "Auerbach" clearly legible.

John Auerbach
President and CEO
Trust for America's Health