

Maternity Care in the US Statement of the Problem

- Maternal and infant health outcomes in the United States rank poorly compared to other developed countries in the world, despite higher per capita health care expenditures (CDC, 2013; WHO, 2012; Sakala & Corry, 2008).
- The US spends far more than all other countries on maternity care, without improving outcomes of that care (IFHC, 2010). US spending on maternity care is twice that of most developed countries (IFHC, 2010).
- Currently, the US is ranked 27th in the world in infant mortality (MacDorman et al., 2013) and 46th in maternal mortality (WHO, 2012).
- Maternal mortality rates have doubled in the US since 1990 (WHO, 2012).
- Considerable racial disparities exist in pregnancy-related mortality. African American women are 3.2 times more likely to die due to pregnancy/childbirth than white women.
- Cesarean section is the most common operating room procedure in the US (AHRQ, 2013). Additionally, six of the most common hospital procedures performed are associated with maternal and infant care (AHRQ, 2013).
- In 2008, pregnancy, delivery and newborn care represented 26.1% of all hospital inpatient charges to Medicaid and 13.5% of inpatient charges to private insurers. Such care represents the single largest category of charges to both Medicaid and private insurers. (AHRQ, 2011). In addition, Medicaid currently covers nearly half of all births in the U.S. (Markus, 2013).
- MACPAC states, "both Medicaid and CHIP have a stake in improving birth outcomes and in being prudent purchasers of care" (MACPAC, 2013).
- Almost 1/3 of all Medicaid births were by cesarean, which costs twice as much as vaginal birth and is associated with more adverse outcomes (MACPAC, 2013; Truven, 2013). The World Health Organization has recommended a 15% cesarean rate.
- Innovative maternity care programs and services that are associated with improved outcomes are available, but significant barriers exist to their wide implementation. One highly significant barrier to access and implementation is the failure of CMS and of many state plans to enforce the mandate requiring state plans to provide freestanding birth center services and professional services in freestanding birth centers. Neither CMS nor state plans are requiring managed care organizations or accountable care organizations to contract with midwives or freestanding birth centers as participating providers. (Midwifery-led care, freestanding birth centers, doula support, group prenatal care, peer support)

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Recommendation 1: The Secretary should ensure all women and families are aware of the changes to maternity care brought on by the Affordable Care Act. This includes information on how women can access services, especially as women transition between Medicaid plans and private health insurance plans provided in the marketplace.

The CQMC believes a need exists to educate women on their choices in these extremely complicated areas of eligibility and coverage, particularly as it relates to pregnancy.

Between 1984 and 1990, the Congress expanded Medicaid eligibility for poor and low-income pregnant women and children, creating new mandatory and optional eligibility groups. States are required to provide pregnancy related coverage to pregnant women below 133 percent of the federal poverty level (FPL); a majority of states provide coverage to women above that level.

Although CHIP originally did not include coverage for pregnant women, states can offer CHIP-financed services to pregnant women through Section 1115 waivers or through an option to cover services for unborn children. A law enacted in 2009 allowed states to cover pregnant women through state plan amendments.

Depending on the eligibility pathway, services covered under Medicaid and CHIP range from full Medicaid benefits to coverage of only services related to the pregnancy to emergency coverage for labor and delivery. Many states offer benefits to pregnant women that are not offered to other Medicaid adult enrollees, including dental services, prenatal risk assessments, home visiting programs, targeted case management, preconception counseling, psychosocial counseling, and substance abuse treatment.

Under the ACA, in 2014 states that currently provide pregnancy related Medicaid coverage to women with incomes greater than 133 percent of FPL will have the option of eliminating Medicaid coverage for this population, effectively sending them to the Health Insurance Marketplaces where they will presumably obtain subsidized coverage defined by the essential health benefits (EHB).

The ACA, as interpreted by the Supreme Court, allows states the option of expanding their Medicaid programs to cover all adults up to 138 percent of FPL. For women, this situation could complicate their choices when it comes to pregnancy coverage. The benefit package for the expansion population is to be based on the EHB, which differs from that described in statute for the pre-expansion populations. CMS has indicated in regulation that if a woman is not pregnant and enrolls in expansion Medicaid, when she later becomes pregnant she should have the option of remaining in the expansion benefit, or switching to the pre-expansion benefit.¹ Women in this situation need to understand that the pre-expansion and expansion benefit packages differ. For example, the ACA requires coverage of birth center services under the pre-expansion benefit. However, the EHB, and the expansion Medicaid benefit packages based thereon, are not subject to this same requirement and consequently birth centers may not be part of the expansion Medicaid benefit package. We note that states will be motivated to keep women in the expansion benefit, given the increased FMAP available for that population.

¹ See 42 CFR 440.315 and also the preamble discussion to the March 23, 2012 final rule at 77 FR 17149. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm>

To further complicate things, the IRS has ruled that pregnancy related Medicaid coverage does not qualify as minimum essential coverage. This means that women covered under that package would potentially be subject to the shared responsibility penalty, although the IRS has said it will not apply the penalty in 2014 and will issue guidance on that topic in the future.² Conversely, women with pregnancy related Medicaid coverage could also potentially qualify for subsidized coverage through the Marketplace, since subsidies are available to those without minimum essential coverage. They would consequently need to understand the variation in covered benefits and cost sharing between those benefits as well as the differences in provider networks.

Another option may also exist, the Basic Health Option, which will serve individuals between 138 and 200 percent of FPL, to the extent their state decides to implement such a program. Where states offer Medicaid coverage above 133 percent of FPL and also offer a Basic Health Option, this is simply another layer of complexity in coverage options.

MACPAC's report highlights that since separate eligibility pathways based on pregnancy will continue, the possibility of churning exists as women gain and lose eligibility based on their pregnancy status, and cycle among Medicaid, CHIP, and private coverage available through health insurance exchanges, or to an uninsured status.

Recommendation 2: The Secretary should ensure that Medicaid coverage for contraceptive items and services reflects what is now required of commercial insurers.

Our organizations support increasing access to contraceptive items and services. We believe the MACPAC should recommend that the Medicaid program resemble what is required in the commercial world under guidance issued by the Health Resources and Services Administration (HRSA). HRSA's guidance requires non-grandfathered insurers to cover, without cost-sharing, "All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity," as prescribed.³ Not all states provide Medicaid reimbursement for all U.S. Department of Health and Human Services (HHS) recommended family planning items and services, and the Affordable Care Act definitions within women's clinical preventive services will not apply to Medicaid beneficiaries.

We believe that the ACA requirement for commercial insurers should be applied to coverage offered to Medicaid beneficiaries, whether covered under fee-for-service Medicaid or a managed Medicaid plan.

Recommendation 3: The Secretary should improve implementation of policies to provide coverage for education and support related to breastfeeding throughout pregnancy, inclusive of the prenatal, intrapartum and postpartum periods of patient care.

We urge the MACPAC to recommend an aggressive approach on the part of the Secretary to promote and enhance breastfeeding education and support.

² See IRS Bulletin 2013-39, available at: http://www.irs.gov/irb/2013-39_IRB/ar09.html

³ See HRSA's "Women's Preventive Services Guidelines," available on-line at: <http://www.hrsa.gov/womensguidelines/> Last accessed November 25, 2013.

Rates of successful breastfeeding within the Medicaid population lag significantly behind other populations, despite the positive impact on health outcomes. Public policy, including payment policies, can lead to higher rates of breastfeeding, improved health and lower costs for Medicaid. While Medicaid has put out some briefs encouraging state Medicaid plans to cover breastfeeding items and services, it is not required.⁴

Consequently, states may have coverage policies for breastfeeding equipment/supplies/training that differ from those outlined in HRSA's guidance for the commercial plans. Under the ACA and guidance based thereon, non-grandfathered commercial insurers are required to cover "Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment."⁵ Medicaid should be required to cover breastfeeding pumps/supplies/training in the same way that commercial plans are now required to do, per HRSA guidance.

Recommendation 4: The Secretary should work to identify optimal payment policies for maternity care based upon evidence-based practice.

We urge the MACPAC to recommend utilization of optimal payment policies for maternity care to enhance to the quality of care provided and reduce overall costs.

In 2010, Medicaid and the State Children's Health Insurance Program (CHIP) paid for almost half of all births in the United States (about 1.8 million hospital births). Medicaid spending in the 12 months before and 2 months following childbirth for women in 2008 was about \$11 billion. We believe substantial savings and quality improvement are achievable through maternity care payment reform under Medicaid.

The current payment mechanisms for maternity care are perverse, paying more for volume and intervention than for evidence-based quality and value. Patients may not be transferred to the most appropriate setting in as timely a manner as possible if a global reimbursement is transferred to another clinician after months of diligent care. Potentially unnecessary procedures also are incentivized financially. Further, Medicaid billing and reimbursement policies are complex, varying widely within programs that may include several managed care plans with variable prior authorizations and other requirements, which also differ substantially from private industry.

One alternative that should be explored is unbundling global maternity services to promote appropriate regionalization of maternal and neonatal care, ensuring that hospitals appropriately transfer mothers to facilities equipped to handle neonates with high needs. Also, the Secretary should develop value-based payment strategies related to maternity care, with emphasis on quality and performance measures tied to outcomes that include cost.

⁴ See "Medicaid Coverage of Lactation Services," CMS, available on-line at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf
Last accessed November 25, 2013.

⁵ Women's Preventive Services Guidelines, HRSA.

The Secretary should ensure that state Medicaid plans and any MCOs or ACOs with which those plans contract provide pregnant women all medical services mandated by section 1902(a)(10)(A) of the Social Security. We specifically note the need to fully implement the existing coverage requirement for birth centers. Birth centers have a demonstrated record of providing quality care at very low cost.⁶ Specifically, MACPAC should recommend that the Secretary add a new section to its regulations at 42 CFR Part 440 that would define freestanding birth center services, just as all other mandated (and optional) Medicaid services under section 1905(a) are already defined in regulations under this Part.

MACPAC should put special emphasis on revisions to payment policies that encourage and reward potentially unnecessary interventions, particularly cesarean deliveries. The existing substantial financial incentive for performing a cesarean does not serve women well and contributes to an unacceptable rate for this surgery in the U.S. Cesarean sections are reimbursed at substantially higher rates than are normal physiologic births, incentivizing their use. MACPAC should develop recommendations to deal with this situation.

We also encourage MACPAC to consider recommending coverage for innovative and alternative means of providing care with a proven record of improving outcomes and decreasing costs such as Centering Pregnancy. Centering Pregnancy is an outcome-driven, cost-effective, patient-centered model of care that brings patients out of the individual exam room into a group setting, and bundles all elements of care that women need into one package, which includes health assessment, interactive learning, and community building.

The model achieves remarkable improvements in health outcomes, notably a 33% reduction in the risk of preterm birth for women in Centering group care compared to those in traditional care in a large randomized controlled trial.⁷ Similar or even better results have been reported in subsequent small studies and practice site data. In addition to a reduction in preterm birth, studies have shown better attendance at prenatal and postpartum visits, increased rates of breastfeeding, and high levels of patient and provider satisfaction.⁸

Savings associated with the reduction in preterm births are significant. UnitedHealth Center for Health Reform and Modernization recently concluded that, “Nationally, if half of pregnant women enrolled in Medicaid received care through a group model over a five year period, we estimate savings to the Medicaid program overall would be about \$12 billion over the next decade.”⁹

But under our current payment system, those savings accrue to *payers*, not sites that implement the model. And the process of redesigning a prenatal care system and training in group facilitation represents a significant investment for the clinical site.

⁶ Stapleton, Susan Rutledge, CNM, DNP, Cara Osborne, SD, CNM, Jessica Illuzzi, MD, MS, “Outcomes of Care in Birth Centers: Demonstration of a Durable Model,” *Journal of Midwifery and Women’s Health*, vol. 58, issue 1, pp. 3-15, January/February 2013.

⁷ Ickovics, et al. *Obstetrics and Gynecology*, 2007

⁸ An annotated bibliography is available on the CHI website: <https://www.centeringhealthcare.org/pages/centering-model/bibliography.php>

⁹ 100 Percent of our Future: Improving the health of America’s children. Working paper 10, August 2013. Available at <http://www.unitedhealthgroup.com/~media/UHG/PDF/2013/UNH-Working-Paper-10.ashx>

Payment reform, including enhanced payment for evidence-based models of care, can help drive the change necessary to improve outcomes. Enhanced care is a sound investment, but is more likely to be sustainable if accompanied by enhanced payment.

Recommendation 5: The Secretary should work to address the existing and expanding shortage of maternity care providers by establishing a maternity care shortage area designation under the Public Health Service Act.

As the MACPAC report highlights, having coverage for maternity services does not guarantee access to care. Access to maternity care professionals is a significant issue in many areas of the country due to the changing demographics of maternity care providers, variation among practice environments, and restructuring, regionalization and closure of many maternity care units.

The Bureau of Labor Statistics within the U.S. Department of Labor reports that as of May 2012 there were nearly 27,000 maternity care providers (5,710 certified nurse-midwives and 20,880 obstetricians/gynecologists) employed in the U.S.¹⁰ The preliminary number of births for the United States in 2012 was nearly 4 million according to a recent report from the Center for Disease Control and Prevention within the U.S. Department of Health and Human Services.¹¹

Shortages of maternity care providers can result in long waiting times for appointments and/or long travel times to prenatal care and/or birthing sites. Maternity care providers have become particularly prone to workforce challenges due to concerns surrounding professional liability and unpredictable working hours. These factors have contributed to inadequate access to maternal and reproductive care, especially in underserved communities.

To address this concern, we urge the MACPAC to recommend the creation of a new health professional shortage area designation for maternity care under the Public Health Service Act, similar to the current primary care, dental and mental health shortage designations. A maternity care shortage designation would help identify and then address maternity care shortages and encourage more providers to practice in rural and urban underserved areas. With such a designation, existed resources from the National Health Service Corp could be directed to address the needs of pregnant women and their families.

Recommendation 6: The Secretary should work to reduce preterm birth and adverse pregnancy outcomes.

We urge the MACPAC to recommend continuing work to reduce preterm birth and adverse pregnancy outcomes, building on existing efforts.

Policies and procedures should be implemented to encourage the earliest possible appropriate patient risk screening for preterm birth and other adverse pregnancy outcomes. Support should be provided for integrated systems of prenatal care that reflect both medical and psychosocial risk factors. Financial incentives must be developed to ensure appropriate administration of

¹⁰ Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment Statistics, May 2012.

¹¹ Centers for Disease Control and Prevention, National Vital Statistics Report, September 2013.

progesterone for patients at risk of preterm birth, as well as enhanced prenatal care for those at risk for significant medical complexity and other pregnancy outcomes.