

STATEMENT OF  
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BEFORE THE  
U.S. COMMISSION ON CIVIL RIGHTS  
RACIAL DISPARITIES IN MATERNAL HEALTH PUBLIC BRIEFING  
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Chairperson Lhamon and distinguished commissioners, thank you for the invitation to provide information on the critical topic of racial disparities in maternal health. My written statement is focused primarily on the Medicaid population.

The U.S. has the highest rates of maternal mortality in the developed world with a disproportionate number of Black women accounting for most deaths. In addition to contributing to inequitable health outcomes, these disparities increase health care costs. In one analysis of 14 states, an estimated \$114-\$214 million of savings to Medicaid would be realized if racial and ethnic disparities in maternal outcomes were reduced (Zhang et al., 2013). The rate of severe maternal morbidity is 1.4 times higher for Medicaid-covered deliveries than for with women with commercial insurance (Fingar et al., 2018).

Medicaid plays a critical role in the health of low-income, reproductive aged (15-49) women. More than 25 million women are covered through Medicaid, approximately 70 percent of whom are of reproductive age (Kaiser Family Foundation, 2017). Nearly half of all births in the U.S. are covered by Medicaid, with the share in each state ranging between 20 and 71 percent (MACPAC, 2020; KFF, 2020). By federal law, all states must provide Medicaid coverage

to pregnant people with incomes up to 133 percent of the federal poverty level (FPL), with some states establishing more expansive criteria (Adams et al., 2003; Gifford et al., 2017). Federal law also requires that Medicaid coverage include, among others, hospital and physician care. Medicaid's covered benefits are generally quite comprehensive.

The Public Health Services Act Section 2706, within the Affordable Care Act (ACA), provides that Medicaid health plans cannot discriminate against any licensed or certified provider, such as a certified nurse-midwife. The ACA also includes provisions related to freestanding birth centers under Section 2301, requiring all states with licensed or otherwise state-approved birth centers to cover birth center services under Medicaid. Medicaid coverage of maternity services from nonphysician providers such as midwives, and out-of-hospital births such as at freestanding birth centers, varies by state and is dependent on licensure and credentialing laws (Gifford et al., 2017). Despite these provisions, midwifery-led care and freestanding birth centers have become a luxury limited to mostly White women in the U.S. with commercial insurance coverage or who can afford to pay out-of-pocket. Furthermore, frequent eligibility redeterminations, confusing and inaccessible application processes, and work requirements have been adopted to varying degrees by states to constrain enrollment.

State flexibility, a legitimate value that promotes program design and administration that reflects local circumstances, is a defining feature of the Medicaid program. However, the neutral sounding term "flexibility" is often used to perpetuate policies with racist roots akin to the invocation of "states' rights" during the Civil War and the Civil Rights Movement.

Pregnant people enrolled in Medicaid face additional barriers accessing high-quality care early in pregnancy and in the postpartum period. These barriers create an inequitable

health system that ultimately affects health outcomes. For example, approximately 55 percent of women with Medicaid coverage at delivery experienced a coverage gap in the subsequent six months after delivery (Daw et al., 2017). Gaps in care, such as during the postpartum period, limit access to postpartum services. According to a Centers for Disease Control and Prevention (CDC) report of pregnancy-related maternal mortality reviews, more than two-thirds of the deaths were preventable (Davis et al., 2019). Nearly half of the documented maternal deaths occurred after hospital discharge and one quarter occurred after six weeks postpartum, which is approximately when many women enrolled in Medicaid lose coverage (Davis et al., 2019). Given that around 50% of maternal mortality occurs after the day of delivery, establishing policies that allow states to extend Medicaid coverage through the first year after childbirth, beyond the 60 day cut off point that many states utilize, has the potential to reduce adverse maternal outcomes.

Pregnant people enrolled in Medicaid face significant challenges obtaining the high-quality, evidence-based care that is most likely to yield favorable outcomes. Most births in the U.S. are low- to medium-risk and appropriate for high-value, evidence-based maternal models of care such as midwifery-led care and freestanding birth centers. Yet, most pregnant people enrolled in Medicaid currently do not have access to or coverage for these models of maternity care (Alliman & Phillippi, 2016; NIHCE, 2015).

The underutilization of appropriate care models is a problem that confronts all women in the U.S., but it places a particular burden on those enrolled in Medicaid. Medicaid enrollees are unable to purchase their own way into alternative or preferred care models. They are likely

to have less choice in selecting their providers, settings for care, or health systems than their commercially insured counterparts.

The safety, quality, and high-value of midwifery-led care has been well documented by research studies over the past 30 years (Heins et al., 1990; Oakley et al., 1996; Shaw-Battista et al., 2011; Johantgen et al., 2012; Nijagil, 2015; Altman et al., 2017; Jolles et al., 2017; Weisband et al., 2018; Attanasio & Kozhimannil, 2018). In 2014, The Lancet published a series of papers that acknowledged the vital and cost-effective contribution of midwives to high-quality care and projected that scaling up the model worldwide would improve many maternal and newborn outcomes, including mortality and morbidity, concluding that “midwifery is a vital solution to the challenges of providing high-quality maternity and newborn care for all women and newborn infants, in all countries” (Renfrew et al., 2014a; Renfrew et al., 2014b).

Recognizing the extensive evidence on the value of the midwifery-led model of care, the World Health Organization launched a global campaign in 2020 termed, the “Year of the Nurse and Midwife,” to raise awareness and encourage adoption of the model to improve birth outcomes around the world (WHO, n.d.).

Most recently, the National Academies of Science, Engineering, and Medicine convened a special committee to identify common barriers and opportunities in various practice settings for midwives including hospitals and freestanding birth centers. The report concluded that all the settings had risks and benefits for either the pregnant individual or the newborn, but the overall evidence is clear that midwifery-led care leads to better birth outcomes and is underutilized, especially for those with Medicaid coverage, in the U.S. (NASEM, 2020).

The freestanding birth center offers low-risk individuals an option to arrive in active labor, receive limited use of medical interventions and support for normal, physiologic birth, and be discharged home several hours postpartum. Although the focus is on evidence-based, low intervention care to ensure the best birth outcomes, the freestanding birth center is fully stocked with medical supplies including those needed for an emergency. This birth setting is used successfully in other high-income countries and in 2014 was recommended by the National Institute for Health and Care Excellence (NICE) in the United Kingdom as a valuable option for healthy individuals with normal pregnancies (NIHCE, 2015). In contrast to European nations where midwifery-led care and freestanding birth centers are well integrated into the healthcare system and considered the standard of care, there is a lack of consistent integration in the U.S.

The Strong Start for Mothers and Newborns Initiative was authorized by the ACA and is managed by the Center for Medicare and Medicaid Innovation (CMMI). The initiative sought to address the underuse of evidence-based, non-medical interventions in care for those enrolled in Medicaid, such as childbirth and breastfeeding support, through midwifery-led models of care including in the hospital and freestanding birth centers. The evaluation of the five-year program found significantly better outcomes for women receiving care in midwifery-led freestanding birth centers compared with matched population controls, including a decrease in the birth rates for cesarean, preterm, and low-birthweight births (Hill et al., 2018). Importantly, costs decreased by 21 percent for infants in the first year of life and were 16 percent lower for women receiving care from midwife-led care in freestanding birth centers, with the dyad saving

an average of \$2,010. Focus groups with participants also found higher levels of satisfaction over hospital birth settings.

States with regulations that allow midwives to practice to the full extent of their training and license have a larger nurse-midwifery workforce and a greater proportion of certified nurse-midwives who attend births (Yang, Attanasio, & Kozhimmannil, 2016). These states also have overall better birth outcomes such as lower odds of a cesarean delivery, preterm birth, and low birthweight compared to states with more restrictive regulations (Stapleton, Osborne, & Illuzzi, 2013).

Medicaid reimbursement for covered certified nurse-midwife services is allowed in all states and the District of Columbia (Kinzelman & Bushman, n.d.). Each state Medicaid agency, in collaboration with CMS guidance, determines the service codes that are covered as reimbursable benefits for those enrolled in Medicaid (HRSA, 2016). The actual dollar amount to be reimbursed for each service is often derived from the Medicare fee schedule. For example, a state may determine a Medicaid service code will be reimbursed significantly more (120%) than the Medicare Fee Schedule or significantly less (60%). However, nurse-midwives in 22 states receive less than 100 percent of the established fee, compared to their physician colleagues, creating a disincentive to bill their services separately (Kinzelman & Bushman, n.d.). Although a midwife may be licensed to function independently, accepting the oversight of a physician and using “incident to billing” practices in which a nurse-midwife provides the service but bills under a physician colleague maximizes their reimbursement.

Additionally, hospitals are paid more, oftentimes threefold, than freestanding birth centers for providing the same services for an uncomplicated vaginal birth using the same

billing codes (IMI, 2020). While hospitals can bill professional and facility fees for both the birthing person and newborn, a freestanding birth center cannot bill facility fees for newborn care even though it is provided. Furthermore, if a patient is transferred from a freestanding birth center to the hospital, regardless of the duration or level of care provided before the transfer, the birth center cannot bill for the facility fee. The facility fee is only paid to the entity where the birth occurs, not where resources were expended during labor. This further disincentivizes freestanding birth centers from accepting any insurance payment.

Since Medicaid payment for maternity care services can be as low as 30 percent of commercial payment rates, the economics for low-volume freestanding birth centers with high personnel costs, malpractice insurance, and other operating and facility costs have driven birth centers to concentrate on self-pay, out-of-pocket payment (IMI, 2020). If a freestanding birth center accepts health insurance payment, oftentimes they will only accept employer-sponsored commercial payer. It is rare that a freestanding birth center will accept Medicaid if they want to remain solvent.

Despite being the source of insurance coverage for almost half of all births in the U.S., Medicaid fails to meet the critical needs of pregnant and birthing women, thereby contributing to the nation's maternal mortality crisis. From limited, unstable eligibility to an emphasis on hospital and obstetrician-led care at the expense of meeting social needs and patient preferences, Medicaid reflects weaknesses that permeate the health care system. Given the economic and social disadvantage of the population Medicaid serves, these weaknesses translate into human suffering and lives lost. Can Medicaid live up to its potential as a source of financing for high-quality, appropriate maternity care that respects the preferences and needs

of pregnant and birthing people, with the ultimate effect of reducing severe maternal morbidity and mortality? There are several opportunities for the federal government to consider:

- Support Medicaid coverage during the first year of the postpartum period when most maternal deaths occur.
- Develop evidence-based federal clinical and programmatic guidelines to set expected standards of care.
- Establish a national framework on access and coverage in Medicaid to midwifery-led models of care.
- Provide federal guidance to state Medicaid agencies on how to support birth equity in Medicaid.
- Develop performance measures based on guidelines to drive improvement, inform consumers, and drive payment.
- Develop supportive funding strategies aimed at reducing or eliminating financial barriers to midwifery-led care models and freestanding birth center provisions in the ACA and enable implementation of guidelines and performance measures.

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