PolicyLab

March 20, 2020

Senate Committee on Finance

219 Dirksen Senate Office Building

Washington, DC 20510-6200

SUBJECT: Solutions to Improve Maternal Health

Dear Senators Grassley and Wyden:

As child health researchers at PolicyLab at Children's Hospital of Philadelphia, we welcome this opportunity to provide recommendations for improving maternal and child health, and to offer feedback on the Congressional proposals on maternal health highlighted by the Senate Finance Committee. PolicyLab is also currently drafting recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding maternal and infant health care in rural areas. We would be happy to share this additional resource with the Senate Finance Committee when it is complete.

Utilize pediatric settings to improve maternal mental and physical health, and encourage coordination between pediatrics and other maternal/infant health settings

Fifty-two percent of pregnancy-related deaths occur after the day of delivery, making postpartum care for new mothers essential.[1] Despite this, an estimated 40% of new mothers do not attend the clinically recommended visit with an obstetrician at 6-8 weeks postpartum.[2] Ensuring that new mothers receive mental health and substance use screening and services is also essential. One in nine mothers experience depression after birth, and it is estimated that more than 2 out of every 100 births are to mothers impacted by substance use disorder.[3-4] Untreated or poorly managed maternal mental health conditions and substance use disorders can lead to increased maternal mortality, increased short-term work disability and decreased workplace productivity.[5] Infants of mothers experiencing maternal depression are less likely to achieve developmental milestones, receive preventive health care services and are at increased risk for involvement in child protective services because of safety events.[5-7]

For many new mothers, their primary contact with the health care system comes through visits to the pediatrician with their infant. In recent research at PolicyLab, we examined the Medicaid claims of nearly 600,000 mothers and their infants in 12 diverse states to determine their health care service utilization across both adult and pediatric settings.[8] We determined that infant-mother pairs were more likely to receive preventive care in pediatric settings than in adult settings. While 38% of mother-infant

Children's Hospital of Philadelphia

Roberts Center for Pediatric Research
2716 South Street

P 267-426-5300
F 267-426-0380

PolicyLab@email.chop.edu
policylab.chop.edu

pairs had no *adult* preventive visits, 90% of mother-infant pairs had at least one preventive *pediatric* visit.

Ensuring the necessary delivery and payment reform to integrate maternal screenings and preventive services into pediatric settings could help to improve access to health care for new mothers. The American Academy of Pediatrics' "Bright Futures Guidelines" encourages pediatricians to support caregivers through parental mental health screenings, smoking cessation support and essential vaccines.[9] In most states, Medicaid reimburses providers for maternal depression screenings during a well-child visit.[10]

We encourage efforts to support intergenerational family services in pediatrics given the robust evidence that pediatrics represents a significant health care touch-point for mothers in the postpartum period.

In addition to encouraging maternal care in pediatrics, we also emphasize the importance of coordinating across systems. New families access medical care in a variety of settings including OB-GYN, adult care systems, behavioral health settings, pediatrics, and other social service agencies. Without closer integration, providers may provide duplicative services while at the same time making referrals that prove ineffective.[8] For instance, recent PolicyLab research found that nearly 90% of mothers with positive postpartum depression screens and referrals through pediatrics did not successfully connect to mental health services within six months.[5] Thus, there is a need to push for coordination and service integration models that extend beyond traditional screening and referral practice. Efforts to support the delivery of mother-infant care within pediatrics should consider incentivizing innovation in payment models to support maternal screening, care coordination models, and integration of mental health and other community-based services through pediatrics.

Funding streams that support value-based payment and patient-centered medical homes (PCMH) may help integrate mental health services and strengthen connections to community resources. For instance, PCMH dollars have been used to support care coordination within pediatrics for children with complex medical needs.[11] This model could inform how to establish funding streams across diverse settings for high-risk families.

The Center for Medicare and Medicaid Innovation's Maternal Opioid Misuse (MOM) model is another example.[12] The MOM model seeks to address fragmented care and lack of access to services through pregnancy and the postpartum period. This program has extended funding to states to support integrated care and create sustainable payment strategies.

Children's Hospital of Philadelphia™

Roberts Center for Pediatric Research
2716 South Street

P 267-426-5300
F 267-426-0380

PolicyLab@email.chop.edu
policylab.chop.edu

Expanding access to telehealth services can also facilitate care coordination and integration models, particularly in rural areas.

Support evidence-based maternal and child home visiting programs

Maternal and child home visiting programs are voluntary, home-based services. They have been shown to support a range of positive impacts on maternal and child well-being prenatally, and during the crucial early childhood development period. Home visiting programs connect families in need of support with trained professionals for home visits on a regular basis over the course of a multi-year relationship between the home visitor and family.[13] Home visitors identify and address physical, social, and mental health needs of both the child and caregivers—including screening for maternal depression, intimate partner violence, child developmental milestones and social resources. Home visiting has been associated with improved parenting self-efficacy, engagement with preventive health care visits, child school readiness and family connectedness to resources.[14]

PolicyLab is the lead evaluator, in partnership with the Pennsylvania Department of Human Services' Office of Child Development and Early Learning, for maternal and child home visiting programs throughout the Commonwealth of Pennsylvania. Our research has affirmed the benefits of home visiting. Relative to eligible mothers not receiving evidence-based home visiting programs, we found that service recipients had a higher likelihood of quitting smoking, improved pregnancy spacing, receiving adequate prenatal care and bringing their child for recommended well-child visits.[15] Families living in rural areas particularly valued how the program enables social connectedness and ameliorates feelings of isolation.

We welcome that many current proposals in the Senate recognize the importance of home visitors to mothers living in under-resourced communities. The Lower Health Care Costs Act (S1895) and the Maternal Outcomes Matter Act of 2019 (S2586) emphasize the importance of home visiting services in coordinating care. The MOMMIES Act (S1343) proposes a maternity care home demonstration project. Under the Act's proposed model, states may use funds to train staff in home visiting skills and to provide home visiting services. The MOMMAs Act (S916) and Maternal Care Act (S1600) encourage partnerships with home visiting agencies for regional centers of excellence and state pregnancy medical homes, respectively.

Support paid parental leave

The United States is one of only three countries in the world that lacks national maternal paid leave policies.[16] New mothers, particularly the most financially

vulnerable, are often pressured to return to work shortly after birth. Roughly 23% of employed mothers return to work within 10 days of giving birth.[17] In addition, 34 out of 41 countries in the Organization for Economic Cooperation offer paid paternity leave, which has been associated with improved personal and economic family well-being.[18] In 2015, however, only 13% of U.S. workers reported having any form of paid family leave available, and only 4% of the lowest-income workers (those in the lowest decile) reported having paid family leave.[16]

Research to date has focused primarily on maternity leave, and the literature reveals significant positive outcomes of paid maternity leave for both mothers and infants. Paid maternity leave is associated with improved physical and mental health of both mothers and children.[16] Benefits include a decrease in postpartum maternal depression and intimate partner violence, improved infant attachment and child development, reduced infant mortality, fewer mother and infant re-hospitalizations, improved attendance at pediatric visits, and higher rates and duration of breastfeeding.[16-17,19]

The American College of Obstetricians and Gynecologists (ACOG) has endorsed paid parental leave as essential to the health of mothers and children.[2] Recognizing the importance of maternal and caregiver well-being on infant and family health, the American Academy of Pediatrics also supports paid parental leave and endorsed support for the FAMILY Act.[21] In addition to researchers and professional medical organizations, survey data indicate that most Americans support paid family leave in many forms.[22] Specifically, 82% of Americans support paid leave for mothers after birth or adoption of a child.[22]

Several bills addressing paid family leave have been referred to the Senate Finance Committee, including the FAMILY Act (S463), New Parents Act of 2019 (S920) and the Paid Family Leave Pilot Extension Act (S1628). We encourage the Senate Finance Committee to support paid family leave as a means to improve maternal and infant health. In comparing proposals for paid family leave, we encourage the Senate Finance Committee to carefully consider how well respective policies would support the needs of lower-income families.

In addition to our recommendations above, we offer the following feedback with regards to proposals being considered by the Senate Finance Committee:

Extend Medicaid and Children's Health Insurance Program (CHIP) coverage through one year after birth

We support efforts to extend Medicaid and CHIP coverage through the postpartum period. In the year after birth, mothers often experience high levels of disruption in health care access and fragmentation of care.[23] One in three mothers in the United States experience a health insurance disruption in the year of a birth.[22] These disruptions are particularly risky because women require more services during this time, and women are vulnerable to new onset and pre-existing mental and physical health conditions during and after pregnancy.[3,24]

Medicaid covers nearly half of all births in the United States, but in 13 states, mothers currently lose Medicaid coverage after 60 days.[24] Even in states that have expanded Medicaid (where mothers could theoretically acquire their own Medicaid coverage), mothers may face significant barriers in enrollment, particularly given the emotional and physical demands of the postpartum period. In states that have not expanded Medicaid, women may be limited to plans on the health insurance exchanges, which may be unaffordable and pose their own logistical challenges. PolicyLab research has documented the rise in unaffordability of health insurance coverage for families.[25] Privately insured women may also face substantial barriers because of cost sharing.[24]

While states may choose to extend Medicaid for pregnant women, we emphasize the need for a federally mandated extension of Medicaid and CHIP through one year after birth.

Ensure the full range of comprehensive benefits for pregnant and postpartum women

In order for maternal health care to be truly comprehensive, covered benefits must address the needs of the "fourth trimester." This term typically refers to the 12 weeks immediately after birth.[26] During this early phase of the postpartum period, new mothers and families can face significant challenges including fatigue, unrealistic infant and self-expectations, limited support services, lack of attention to relationships and the financial difficulties of caring for an infant.[27]

For many mothers, the typical postpartum visit at six weeks has been insufficient to address their needs and, as mentioned earlier, many do not attend this visit. When mothers do not receive necessary care, their children suffer in turn. For instance, infants of mothers experiencing maternal depression are more likely to face developmental delays and are more likely to experience adverse safety events that put them at increased risk for involvement in child protective services.[5,7,28]

Roberts Center for Pediatric Research
2716 South Street
P 267-426-5300
F 267-426-0380
PolicyLab@email.chop.edu
policylab.chop.edu

PolicyLab

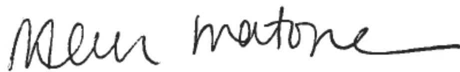
In 2018, the American College of Obstetricians and Gynecologists (ACOG) provided new guidance that emphasizes ongoing care during the fourth trimester and lays out specific services that are essential for maternal and infant well-being.[2]

When considering benefits for pregnant and postpartum women, we encourage the Senate Finance Committee to review the postpartum recommendations from ACOG and to consider all of the recommended services in the fourth trimester. Supporting "fourth trimester" care in line with ACOG practice recommendations would also extend care beyond clinical settings and into community-based services (e.g., home visiting) and beyond traditionally licensed medical providers towards consideration of doulas, midwives, community health workers and peer-support recovery specialists.

Thank you for taking the time to consider our feedback. As mentioned, we would be happy to share with you our upcoming proposals to CMS for improving maternal and infant health in rural areas, and we welcome opportunities to continue to engage with you.

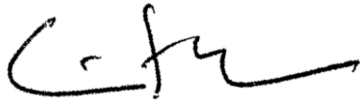
Sincerely,

David Rubin, MD, MSCE
Director, PolicyLab
Attending Physician and Professor of Pediatrics
Children's Hospital of Philadelphia



Meredith Matone, DrPH, MHS
Scientific Director, PolicyLab
Children's Hospital of Philadelphia

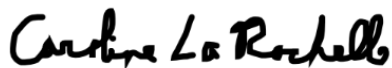
PolicyLab



Emily Gregory, MD, MHS
Faculty Member, PolicyLab
Instructor of Pediatrics, Division of General Pediatrics
Children's Hospital of Philadelphia

Rhonda C. Boyd, PhD
Faculty Member, PolicyLab
Associate Professor of Clinical Psychology
Department of Child and Adolescent Psychiatry and Behavioral Sciences
Children's Hospital of Philadelphia

Rebecka Rosenquist, MSc
Policy Director, PolicyLab
Children's Hospital of Philadelphia



Caroline La Rochelle, MPH
Policy and Strategy Senior Associate, PolicyLab
Children's Hospital of Philadelphia

References

1. Stuebe A, Moore JE, Mittal P, Reddy L, Low LK, Brown H. Extending Medicaid Coverage for Postpartum Moms. *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/hblog20190501.254675/full/ Published May 6, 2019. Accessed March 17, 2020.
2. ACOG Committee Opinion Number 736. American College of Obstetricians and Gynecologists. Number 736. www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care Published May 2018. Accessed March 11, 2020.
3. Depression Among Women. Centers for Disease Control and Prevention. www.cdc.gov/reproductivehealth/depression Updated December 5, 2019. Accessed March 17, 2020.
4. Schiff DM, Nielsen T, Terplan M, et al. Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. *Obstet Gynecol*. 2018 Aug;132(2):466-474. doi:10.1097/AOG.0000000000002734
5. Kallem S, Matone M, Boyd RC, Guevara JP. Mothers' Mental Health Care Use After Screening for Postpartum Depression at Well-Child Visits. *Acad Pediatr*. 2019 Aug;19(6):652-658. doi:10.1016/j.acap.2018.11.013
6. Matone M, Minkovitz C, Quarshie W, Rubin DM. Chronic Disease Prevalence and Discontinuation of Medications Among Young Mothers with a Relationship to the Child Welfare System. *Child Youth Serv Rev*. 2016 May;64:66-72. doi:10.1016/j.childyouth.2016.02.017
7. Sontag-Padilla L, Schultz D, Reynolds KA, Lovejoy SL, Firth R. Maternal Depression: Implications for Systems Serving Mother and Child. Rand Corporation. www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR404/RAND_RR404.pdf Published 2013. Accessed March 17, 2020.
8. Gregory EF, Passarella MS, Levine LD, Fiks AG, Lorch, SA. Preventive Health Care Utilization Among Mother-Infant Dyads With Medicaid Insurance in the Year Following Birth. Medical Care. 6 Mar 2020. doi: 10.1097/MLR.0000000000001310
9. Hagan JF, Shaw JS, Duncan PM, eds. *Bright futures: Guidelines for health supervision of infants, children and adolescents*. 4th ed. American Academy of Pediatrics; 2017.
10. National Academy for State Health Policy. State Medicaid Policies for Maternal Depression Screening During Well-Child Visits. https://healthychild.nashp.org/screening/maternal-depression-screening/ Accessed March 12, 2020.
11. O'Dell ML. What is a Patient-Centered Medical Home? *Mo Med*. 2016 Jul-Aug;113(4):301-304.
12. Maternal Opioid Misuse (MOM) Model. Centers for Medicare and Medicaid Services. https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model Updated December 9, 2019. Accessed March 19, 2020.
13. Matone M, Kellom K, Whittaker J. Moving Home Visiting Forward: Lessons and Directions from Pennsylvania's MIECHV Evaluation. https://policylab.chop.edu/blog/moving-home-visiting-forward-lessons-and-directions-pennsylvania%E2%80%99s-miechv-evaluation Published September 13, 2018. Accessed March 16, 2020.
14. National Conference of State Legislatures. Home Visiting: Improving Outcomes for Children. https://www.ncsl.org/research/human-services/home-visiting-improving-outcomes-for-children635399078.aspx Published November 15, 2019. Accessed March 16, 2020.

15. Whittaker J, Kellom K, Matone M, Cronholm P. A Community Capitals Framework for Identifying Rural Adaptation in Maternal-Child Home Visiting. *J Public Health Manag Pract*. 2019 Jul 3. doi: 10.1097/PHH.0000000000001042. [Epub ahead of print]
16. Jou J, Kozhimannil KB, Abraham JM, Blewett LA, McGovern PM. Paid Maternity Leave in the United States: Associations with Maternal and Infant Health. *Matern Child Health J*. 2018 Feb;22(2):216-225. doi: 10.1007/s10995-017-2393-x.
17. Van Niel MS, Bhatia R, Riano NS, de Faria L, Catapano-Friedman L, Ravven S, Weissman B, Nzodom C, Alexander A, Budde K, Mangurian C. The Impact of Paid Maternity Leave on the Mental and Physical Health of Mothers and Children: A Review of the Literature and Policy Implications. *Harv Rev Psychiatry*. 2020 Mar/Apr;28(2):113-126. doi: 10.1097/HRP.0000000000000246.
18. U.S. Department of Labor. Paternity Leave: Why Parental Leave for Fathers Is So Important for Working Families. *https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/PaternityBrief.pdf* Accessed March 19, 2020.
19. Mandal B. The Effect of Paid Leave on Maternal Mental Health. *Matern Child Health J*. 2018 Oct;22(10):1470-1476. doi: 10.1007/s10995-018-2542-x.
20. Pihl AM, Basso G. Did California Paid Family Leave Impact Infant Health? *J Policy Anal* Manage. 2019;38(1):155-80.
21. American Academy of Pediatrics. Leading Pediatric Groups Call for Congressional Action on Paid Family Leave. *https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAPPPCFamilyLeaveAct.aspx* Published February 7, 2017. Accessed March 18, 2020.
22. Horowitz JM, Parker K, Graf N, Livingston G. Americans Widely Support Paid Family and Medical Leave, but Differ Over Specific Policies. *https://www.pewsocialtrends.org/2017/03/23/support-for-paid-leave-policies/* Published March 23, 2017. Accessed March 17, 2020.
23. Daw JR, Kozhimannil KB, Admon LK. High Rates Of Perinatal Insurance Churn Persist After The ACA. Health Affairs Blog. doi:10.1377/hblog20190913.387157 Published September 16, 2019. Accessed March 17, 2020.
24. Ranji U, Gomez I, Salganicoff A. Expanding Postpartum Medicaid Coverage. Kaiser Family Foundation. *www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage* Published May 22, 2019. Accessed March 17, 2020.
25. Strane D, Kanter GP, Matone M, Glaser A, Rubin DM. Growth of public coverage among working families in the private sector. *Health Affairs*. 2019;38(7). *http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05286*.
26. Goldfarb IT. The fourth trimester: what you should know. *https://www.health.harvard.edu/blog/the-fourth-trimester-what-you-should-know-2019071617314* Published July 16, 2019. Accessed March 17, 2020.
27. University of North Carolina Jordan Institute for Families. The 4th Trimester Project. *https://jordaninstituteforfamilies.org/collaborate/community-initiatives/4thtrimesterproject/* Accessed March 17, 2020.
28. Krohn J, Matone S. Supporting Mothers with Mental Illness: Postpartum Mental Health Service Linkage as a Matter of Public Health and Child Welfare Policy. *J Law Health*. 2017 Mar 22;30(1):1-19. *www.ncbi.nlm.nih.gov/pubmed/30889321* Accessed March 18, 2020.

Roberts Center for Pediatric Research
2716 South Street
P 267-426-5300
F 267-426-0380
PolicyLab@email.chop.edu
policylab.chop.edu