

WRITTEN TESTIMONY OF

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

SUBMITTED BY:

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HOUSE COMMITTEE ON OVERSIGHT AND REFORM

REGARDING THE HEARING

BIRTHING WHILE BLACK: EXAMINING AMERICA'S BLACK MATERNAL HEALTH CRISIS

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Chairwoman Maloney, Chairwoman Kelly, Ranking Member Comer, and Members of the House Oversight and Reform Committee, thank you for inviting me to speak with you today on behalf of the American College of Obstetricians and Gynecologists (ACOG) at this hearing entitled “Birthing While Black: Examining America’s Black Maternal Health Crisis.” It is an honor to be here today to testify and discuss how we can address the Black maternal mortality crisis and improve maternal health.

As an obstetrician-gynecologist practicing in Washington, DC, I have dedicated my career to ensuring patients have happy and healthy pregnancies and births in my clinical practice and through my advocacy and work to improve the quality of maternity care nationwide. I currently serve as a member of ACOG’s Board of Directors and am pleased to testify before the Committee on behalf of the College today. ACOG represents more than 60,000 physicians and partners dedicated to advancing women’s health. Confronting our nation’s rising maternal mortality rate, which disproportionately impacts Black and Indigenous women, is one of ACOG’s paramount priorities. We are grateful for the Committee’s partnership in this commitment. I also currently serve as Vice Chair of the Council on Patient Safety in Women’s Health Care—an effort convened by ACOG to improve patient safety, promote equity, and drive culture change in women’s health care through key stakeholder collaboration in the development, dissemination, and implementation of programs and tools to help reduce variation in care and foster an equitable patient-centered health care culture based on mutual trust, respect, transparency, accountability, teamwork, and inclusion.

As members of the Committee are aware, the United States is the only industrialized nation with a maternal mortality rate that is on the rise, increasing 26 percent between 2000 and 2014.<sup>i</sup> According to the Centers for Disease Control and Prevention (CDC), approximately 700 to 900 pregnancy-related deaths occur in the U.S. each year.<sup>ii</sup> It is estimated that more than half of these deaths are preventable.<sup>iii</sup> Especially concerning are the stark racial inequities in maternal mortality: Black women and Indigenous women are 3.3 and 2.5 times more likely, respectively, to die from pregnancy-related causes than non-Hispanic white women.<sup>iv</sup> Of the pregnancy-related deaths that occur in the U.S. each year, an estimated one-third occur one week to one year after a pregnancy ends.<sup>v</sup> For every maternal death in the U.S., there are approximately 100 women who experience severe maternal morbidity, or a “near miss.”<sup>vi</sup>

Maternal health experts caution that the COVID-19 pandemic may be exacerbating the maternal mortality crisis. According to the CDC pregnant people are at an increased risk for severe illness and death from COVID-19 when compared to non-pregnant people, and may be more likely to require hospitalization, intensive care, and ventilation.<sup>vii</sup> The CDC also reports that Black individuals have died and required hospitalization due to COVID-19 at almost 2 and 3 times the rates, respectively, of white, non-Hispanic individuals.<sup>viii</sup> While additional data is needed to determine the full impacts of the COVID-19 pandemic on Black maternal mortality and morbidity, it is clear that the pandemic has disproportionately caused negative outcomes for communities of color. It is critical that continued emphasis is placed on mitigating the impacts of the COVID-19 pandemic on the maternal mortality crisis and existing inequities in outcomes.

Many health disparities are directly related to systemic inequities in income, housing, education, and job opportunities. Although some inequities diminish after taking these factors into account, many remain because of factors at the patient, health care system, and practitioner levels.<sup>ix</sup> Racism and implicit bias on the part of health care professionals contributes to racial and ethnic disparities in health outcomes.<sup>x</sup> It is critical to change the culture of medicine by addressing racism and implicit bias across the health care system. ACOG is committed to eliminating disparities in women’s health, confronting implicit bias and racism, and increasing the provision of culturally congruent and respectful care.

ACOG recognizes its position as a leading national organization of physicians and partners dedicated to women’s health and treats this responsibility with reverence and humility. ACOG’s clinical guidance has

long recognized the significant racial inequities in the delivery of health care and health care outcomes and has supported our members in addressing them.<sup>xi</sup> More recently, in December 2019, ACOG issued a *Commitment to Changing the Culture of Medicine & Eliminating Racial Disparities in Women's Health Outcomes* and enhanced our partnership and work with individuals and stakeholders working to promote health equity.<sup>xii</sup> Since that time ACOG has led more than twenty medical organizations in women's health in launching a *Collective Action Addressing Racism*, detailing the steps that ACOG and the broader obstetrics and gynecology community are taking to address racism and inequities.<sup>xiii</sup> Congress plays a critical role in bolstering this work to address the maternal mortality crisis and the unacceptable racial inequities in health care delivery and outcomes. This testimony highlights several areas where Congressional action is urgently needed to confront racial health inequities and improve Black maternal health outcomes, including **providing support for training programs to confront implicit bias and racism among clinicians**. While we recognize that there is not a single solution to address these deeply rooted issues, continued investment in these training programs, including those offered during medical school and residency training, help to eliminate and prevent discrimination in the provision of health care services, foster the provision of respectful care, and improve cultural congruency in patient-physician communications and the provision of care.<sup>xiv</sup>

This is a multifactorial crisis that requires multifactorial solutions. ACOG has endorsed a multitude of bills aimed at addressing the maternal mortality crisis and eliminating racial health inequities, including the Maternal Health Quality Improvement Act, the Black Maternal Health Momnibus, the Helping Medicaid Offer Maternity Services (Helping MOMS) Act, and the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act. These bills represent foundational steps to improving Black maternal health and ending preventable pregnancy-related deaths. ACOG urges Congress to act swiftly to enact these bills. This testimony highlights many of the evidence-based programs and policies included in these bills that are critical to moving the needle on maternal mortality.

### Invest in Quality Improvement Initiatives

**The Alliance for Innovation on Maternal Health (AIM) Program, funded through a cooperative agreement between ACOG and the Health Resources and Services Administration, is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary evidence-based practices to improve maternal safety and outcomes.** This program provides technical assistance, capacity building, and data support for the adoption of evidence-based patient safety best practices, or bundles. Patient safety bundles offer standardized approaches for delivering well-established, evidence-based care, intended to be implemented with complete consistency, for every patient, every time – resulting in improved patient outcomes. The core safety bundles, addressing clinical issues like Obstetric Care for Women with Opioid Use Disorder, Obstetric Hemorrhage, Safe Reduction of Primary Cesarean Birth, and Severe Hypertension in Pregnancy, were designed to improve the quality and safety of maternity care with the goal of reducing maternal deaths and severe maternal morbidity, for all pregnant and postpartum people. This is accomplished by engaging health care organizations, state-based public health systems, consumer and patient advocacy groups, and other stakeholders within a national partnership to assist state-based teams in implementing evidence-based maternal safety best practices. Ongoing work of AIM includes the development of a new bundle titled Cardiac Conditions in Obstetrical Care, an additional leading cause of maternal mortality, particularly in the postpartum period, and incorporating elements focused on provision of equitable, safe, and supportive respectful patient care into each of the existing core patient safety bundles. The majority of states and 85 percent of U.S. hospitals providing inpatient obstetric care are now engaged with AIM. **Continued investment in this program is necessary to achieve implementation of AIM's evidence-based patient safety bundles in every birthing facility across the country.**

In my role as Vice Chair of the Council on Patient Safety in Women's Health Care, I help lead a group of stakeholders in our efforts to further support the important work led by the AIM program through the development of tools and resources to support state and hospital-based teams in the implementation and utilization of AIM's patient safety bundles.

**Perinatal quality collaboratives (PQCs), which mobilize state or multi-state networks to implement quality improvement efforts and improve care for mothers and babies, are critical to advancing the quality of standardized care in birthing facilities.** PQCs focus on improving maternal and neonatal outcomes using known prevention strategies such as reducing severe pregnancy complications associated with high blood pressure and hemorrhage, improving the quality of neonatal care, and improving outcomes for infants experiencing neonatal opioid withdrawal syndrome (NOWS). PQCs, together with maternal mortality review committees (MMRCs) and the tools and technical assistance of the AIM program, are key to our efforts to eliminate preventable maternal mortality. For years, state-based PQCs have improved health outcomes for women and infants and lowered health care costs. For example, from September 2008 to March 2015, Ohio's PQC achieved an estimated cost savings of over \$27,789,000 associated with a shift of 48,400 births to 39 weeks gestation or greater and a 68 percent decline in the rate of deliveries at less than 39 weeks gestation without a medical indication.<sup>xv</sup> When appropriately resourced, PQCs can provide the network and infrastructure to facilitate system-wide implementation of MMRC recommendations. While many states have established a PQC, only 13 states receive CDC funding to maintain and expand PQCs.

#### Support Maternal Mortality Review Committees

As Congress considers solutions to our Nation's maternal mortality crisis and racial inequities in health outcomes, the work of Maternal Mortality Review Committees (MMRCs) can play an important role in helping to inform your efforts. MMRCs are multidisciplinary committees—made up of representatives from public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental and behavioral health, patient advocacy groups, community-based organizations, and more—in states and some cities tasked with identifying, reviewing, and analyzing maternal deaths. Upon completion of their analysis, MMRCs make recommendations based on their findings. At present, nearly every state and the District of Columbia has a functioning MMRC, is implementing an MMRC, or planning an MMRC. This represents a dramatic increase from the 22 MMRCs that existed in 2010.<sup>xvi</sup> The value of these committees cannot be overstated.

MMRCs help to illuminate the wide-ranging causes of maternal death by examining not just deaths that are pregnancy-related but also those that are pregnancy-associated. For example, MMRCs have revealed overdose and suicide as leading causes of maternal mortality in a growing number of states, including Colorado, Maryland, New York, Texas, Utah, Virginia, and West Virginia.<sup>xvii,xviii,xix,xx,xxi,xxii,xxiii</sup> This information has helped to inform state-based team's selection of which AIM patient safety bundle to implement and offered direction to their state PQCs on identified priority areas. In addition, MMRCs are able to identify with more precision, the timing of maternal deaths, which is important for informing policy recommendations and directing resources. Continued support for MMRCs through the CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program (as authorized by P.L. 115-344) will assist our efforts to ensure MMRCs have the support they need to implement uniform, evidence-based practices, and advance the critical work to eliminate preventable maternal mortality. **ACOG urges Congress to provide MMRCs needed additional assistance, in the form of funding and technical assistance, to aid adoption of best practices, ensure sustainability of their operations, and enable consistency in data collection, analysis, and reporting across states.**

#### Ensure All Medicaid-Eligible Individuals Have Coverage Through 12 Months Postpartum

**ACOG strongly urges Congress to prioritize closing the postpartum coverage gap experienced by individuals who rely on Medicaid for pregnancy-related care.** Medicaid covers 43 percent of births in the United States—it is the single largest payor of maternity care.<sup>xxiv</sup> Specifically, Congress should adopt 12 months of continuous postpartum coverage for all individuals who rely on the Medicaid program for pregnancy-related care, which will enable people with low incomes to access the care they need to address health concerns after their pregnancies end. The time-limited nature of pregnancy-related Medicaid leaves many individuals uninsured at a vulnerable period in their life. In fact, one in three women in the United States experience a disruption in insurance coverage before, during, or after pregnancy.<sup>xxv</sup> This phenomena, known as “churn”—or the cycling on and off and between health insurance—occurs most often in the postpartum period.<sup>xxvi</sup> Perinatal insurance churn is prominent across states regardless of Medicaid expansion status. Indeed, half of women in non-expansion states and nearly one in three women in Medicaid expansion states experience churn in the perinatal period.<sup>xxvii,xxviii</sup> These coverage disruptions also disproportionately affect indigenous, Hispanic, and non-Hispanic Black women. Nearly half of all non-Hispanic Black women had discontinuous insurance from prepregnancy to postpartum, and half of Hispanic Spanish-speaking women became uninsured in the postpartum period.<sup>xxix</sup>

Lapses in insurance coverage and related systems of care issues have been credited as one of many contributing factors to our nation’s growing maternal mortality crisis.<sup>xxx</sup> The importance of continuous access to health insurance—particularly during the postpartum period—has become more apparent as our nation learns more about the timing and causes of maternal death. The postpartum period is a time of heightened vulnerability: nearly 70 percent of women describe at least one physical problem in the first year after delivery.<sup>xxxi</sup> Moreover, one in seven women experience symptoms of postpartum depression in the year after giving birth, and evidence suggests those with substance use disorder are more likely to experience relapse and overdose in the late postpartum period.<sup>xxxii,xxxiii</sup> In fact, a study of pregnant and postpartum individuals in Massachusetts found that overdose events were lowest in the third trimester—a time during which resources, treatment, and access to care are prioritized for pregnant women with opioid use disorder—but risk of overdose events increased in the 7-12 months postpartum. This was due, in part, to the decreased availability of and access to special services in the postpartum period.<sup>xxxiv</sup> Despite this clinical evidence, Medicaid coverage for pregnant individuals ends 60 days after the end of pregnancy.<sup>xxxv</sup> This arbitrary 60 day cliff leaves many postpartum individuals with an unsafe gap in insurance coverage shortly after experiencing a major medical event. This is especially concerning given that Medicaid beneficiaries have an 82 percent greater chance of severe maternal morbidity compared to those with private insurance.<sup>xxxvi</sup> It is clear that these coverage disruptions are contributing to poor maternal health outcomes, including maternal mortality.

National and state data demonstrate that maternal deaths occur well beyond Medicaid’s arbitrary 60-day postpartum coverage period. According to the CDC, approximately 30 percent of pregnancy-related deaths—*not* counting those that were caused by suicide or overdose—occur 43 to 365 days postpartum.<sup>xxxvii</sup> Cardiac disease—the leading cause of maternal mortality in the U.S. according to CDC data—is particularly prominent in the late postpartum period up to one year after the end of pregnancy.<sup>xxxviii</sup> State analyses of maternal deaths, which include behavioral health-related causes, often find that 50 percent or more of deaths occur between 43 and 365 days after the end of pregnancy.<sup>xxxix</sup> For example, the 2018 Texas Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report found that 56 percent of all maternal deaths in Texas occurred after the 60-day cutoff.<sup>xl,xli</sup> In West Virginia, 62 percent of all maternal deaths occurred more than 60 days postpartum.<sup>xlii</sup>

This reality has led multiple MMRCs to recommend extending Medicaid coverage beyond 60 days to 12 months postpartum. MMRCs see extending coverage as a way to reduce preventable maternal deaths, including those linked to cardiovascular disease, cardiomyopathy, and overdose and suicide. The most

recent Illinois Maternal Morbidity and Mortality Report, issued by the Illinois Department of Public Health in October 2018, for example, recommends that Illinois “expand Medicaid eligibility for the postpartum period from 60 days to one year after delivery.”<sup>xliii</sup> Similarly, recent MMRC reports from more than twenty states, including Georgia, Texas, Utah, and Washington State, and many more, all call for extending postpartum Medicaid coverage.<sup>xliv,xlv,xlvi,xlvii,xlviii</sup>

Not only is this policy rooted in clinical evidence, but it is also likely to lower health care costs for both the states and the federal government. According to a March 2014 report from the Medicaid and CHIP Payment and Access Commission (MACPAC), reducing churn in the Medicaid program lowers monthly per capita spending.<sup>xlix</sup> In addition, keeping women in the health care system presents the opportunity to address any ongoing health concerns, including those unrelated to pregnancy, before any subsequent pregnancies. This is especially important for women on Medicaid who are more likely to have had a prior preterm birth, low birthweight baby, and experience certain chronic conditions, like substance use disorder.<sup>1</sup> In March of this year, MACPAC issued recommendations to Congress to extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income, with a 100 percent federal matching rate to support states in this effort.<sup>li</sup>

In the time since Congress established the 60-day postpartum period for Medicaid coverage for pregnant women in 1986, much has been learned about maternal deaths and the delivery of postpartum care.<sup>lii</sup> Additionally, federal statute guarantees that infants born to women on Medicaid are covered through the first year of life.<sup>liii</sup> The health and survival of babies and their mothers are inextricably linked.<sup>liv</sup> It is time for the statute to be updated to reflect current evidence and best practices.<sup>lv</sup> ACOG enthusiastically supports the state plan option passed as part of the American Rescue Plan Act earlier this year, which made a significant step in increasing Medicaid coverage for postpartum individuals by providing states with a streamlined pathway to extend continuous coverage through the full 12-month postpartum period.

Interest among state and federal policymakers in extending postpartum coverage has grown exponentially since a version of this policy was first introduced in the Missouri state legislature in January 2018.<sup>lvi,lvii</sup> Now, three years later, six states across the political and geographic spectrum have submitted Section 1115 demonstration waivers to the Centers for Medicare & Medicaid Services (CMS) seeking authority to extend postpartum coverage. Illinois, Georgia, and Missouri have gained approval from CMS to implement their waivers. Several more are in the pipeline. **While significant progress has been made as some states have advanced efforts to implement this policy, many have yet to act, leaving thousands of postpartum individuals uninsured during a critical and vulnerable time in their health. Congress must do more to ensure that every postpartum individual covered by the Medicaid program retains coverage through 12 months after the end of pregnancy.** Closing the critical gap in coverage during this vulnerable time can help protect the mother-baby dyad and can mean the difference between life and death.

### Address the Social Determinants of Health

Social and structural determinants of health describe environmental conditions, both physical and social, that influence health outcomes.<sup>lviii</sup> Physical conditions such as lack of access to safe housing, clean drinking water, nutritious food, and safe neighborhoods contribute to poor health. Socio-political conditions such as institutional racism; violence and racism in the criminal legal system; gender inequity; discrimination against lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals; poverty; lack of access to quality education and jobs that pay a livable wage; and mass incarceration all shape behavior and biological processes that ultimately influence individuals’ health and the health of communities.<sup>lix,lx,lxi,lxii</sup> Such social conditions not only influence individual health but also work to create cycles that perpetuate intergenerational disadvantage.<sup>lxiii</sup>

Addressing social determinants of health is critical to reducing inequities in health status. Evidence suggests that improving access to social services reduces the risk of developing chronic diseases and other health conditions, and may also lower health care costs.<sup>lxiv,lv,lxvi</sup> Social determinants of health have been shown to affect many conditions treated by obstetrician-gynecologists, including but not limited to preterm birth, unintended pregnancy, infertility, cervical cancer, breast cancer, and maternal mortality.<sup>lxvii</sup> Congress should increase investment in the provision of social services, particularly those that address and mitigate the effects of the social determinants of health. This may include efforts to incentivize and maximize referrals to social services to help improve individuals' abilities to fulfill these needs.<sup>lxviii</sup>

## **ACOG urges Congress to invest in and expand social service programs that promote the health and wellbeing of women, children, and families.**

### Expand Access to Maternity Care in Rural Areas

The lack of access to high quality maternal health services in rural communities is the result of many factors, including hospital and obstetric department closures and workforce shortages, which have contributed to disparities in maternal health care for rural women and their babies. These access challenges can result in adverse maternal health outcomes including premature birth, low birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression. In 2018, people of color made up about 22 percent of the rural population and are disproportionately impacted by existing health inequities.<sup>lxix</sup> A 2019 study that analyzed severe maternal morbidity and mortality during childbirth hospitalizations among rural and urban residents found that when controlling for sociodemographic factors and clinical conditions, rural residents had a 9 percent greater probability of severe maternal morbidity and mortality, compared with urban residents.<sup>lxx</sup> It is critical that the challenges faced by rural patients and health facilities be prioritized in order to reduce maternal morbidity and mortality in rural areas.<sup>lxxi</sup> **Continued investments should be made to programs that expand access to maternity care in rural areas by providing grants to establish regional innovation networks, expanding existing telehealth programs to include birth and postpartum services, supporting training for physicians and other health care professionals to serve rural communities, and investing in data collection.**

Additionally, the risk classification system, Levels of Maternal Care (LoMC), which is designed to standardize and integrate perinatal regionalization and risk-appropriate maternal care, can assist with increasing coordination of care across accredited birth centers and hospitals. The goal of levels of maternal care is to reduce maternal morbidity and mortality, including existing inequities, by fostering systems for the provision of risk-appropriate care specific to maternal health needs.<sup>lxxii</sup> Regionalized maternal care is intended to maintain and increase access to care by developing, strengthening, and better defining relationships among facilities within a region. In turn, this facilitates consultation and transfer of care when appropriate so that low- to moderate-risk women can stay in their communities while pregnant women with high-risk conditions receive care in facilities that are prepared to provide the required level of specialized care. Women with complex high-risk conditions often benefit from giving birth in facilities that offer a broad array of specialty and subspecialty services. This system encourages state and regional authorities to work together with the health care facilities within a region, and with the input from their obstetric care providers, to determine the appropriate coordinated system of care and to implement policies that promote and support a regionalized system of care. These relationships enhance the ability of women to give birth safely in their communities while providing support for circumstances when higher level resources are needed.<sup>lxxiii</sup>

Development of levels of maternal care programs are increasing across the country. Several states, including Georgia, Indiana, Texas, and Iowa, passed legislation or changed their administrative codes to

establish a specific maternal level of care designation for all birthing facilities that provide maternity care. **ACOG encourages Congress to support states in efforts to adopt and implement levels of maternal care programs.**

### Expand Access to Telehealth Services

Amid the COVID-19 public health emergency, telehealth has proven its value, and has served as an important tool used by obstetrician-gynecologists and other medical professionals to reduce exposure while ensuring access to timely, evidence-based health care for patients. In response to the increased need for telehealth services amid the pandemic, the federal government has provided flexibilities for the use of telehealth services to expand access to care. The potential of telehealth to improve access to care beyond the pandemic is dependent in part on policies to increase equitable access. ACOG strongly supports the permanent implementation of many of the flexibilities put in place during the pandemic, and other policies to expand equitable access to telehealth services.

Postpartum telehealth visits could also improve access to behavioral health services for women with depression, substance use disorder, and other mental illnesses. To ensure access to behavioral health services, Medicaid programs could be incentivized or required to develop networks of mental health practitioners, including those available via telehealth. Telehealth could also improve visit attendance for individuals who face transportation, childcare, and other barriers to attending in-person visits, especially for those with risk factors who may require more frequent visits; and improve identification of risk factors for mortality and morbidity.

**ACOG urges Congress to support continued access to audio-visual and audio-only telehealth visits, lift originating site requirements, allow for remote patient monitoring, expand access to appropriate durable medical equipment including blood pressure cuffs and scales, and increasing access to broadband.** Continued investment in expanding the use of and equitable access to telehealth is necessary to address barriers access to care for many women and help improve maternal health outcomes.

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Thank you again for the opportunity to provide the evidence, data, and medical expertise as the Committee examines the Black maternal health crisis and Congress continues to develop and advance evidence-based solutions. We appreciate your continued commitment to improving health outcomes and eliminating preventable maternal deaths and inequities in maternal health. We look forward to working with you and serving as a resource to the Committee as your work continues in this space.

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