Statement for the Record

Of

The American College of Obstetricians and Gynecologists

Before the

House Committee on Energy & Commerce

Subcommittee on Health

Regarding the Hearing

Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care

September 10, 2019

Chairwoman Eshoo, Dr. Burgess, Chairman Pallone, Ranking Member Walden, and distinguished members of the House Energy & Commerce Subcommittee on Health, thank you for holding today's hearing entitled "Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care." The American College of Obstetricians and Gynecologists (ACOG), is pleased to submit this statement for the record in support of your efforts to advance bipartisan legislation to improve maternal health outcomes. ACOG, with a membership of more than 58,000, is the leading physician organization dedicated to advancing women's health. Key to that mission is our core value that all women should have access to affordable, high-quality, safe health care.

Background

As you know, the United States has a maternal mortality crisis. More than 700 women die each year in the United States from pregnancy-related or pregnancy-associated complications.[i] We have a higher maternal mortality rate than any other developed country. At a time when 157 of 183 countries in the world report decreases in maternal mortality, ours is rising.[ii] Black women and Native American/Alaska Native women are two to three times more likely to experience a pregnancy-related mortality than white women.[iii] For every maternal death in the United States, there are 100 women who experience severe maternal morbidity, or a "near miss." This is all unacceptable, and the time for action is now. ACOG is committed to our goal of eliminating preventable maternal deaths, and we are eager to continue our strong partnership with this Committee and other valuable partners to achieve this important goal.

We know, and the Centers for Disease Control and Prevention (CDC) has confirmed, that over 60 percent of maternal deaths are preventable.[iv] Common causes include hemorrhage, cardiovascular and

coronary conditions, cardiomyopathy, and infection. Overdose and suicide, driven primarily by the opioid epidemic, are also emerging as leading causes of maternal mortality in a growing number of states.[v] If we have a clear understanding of why these deaths are occurring, and what we can do to prevent them in the future, we can save women's lives.

We applaud this Committee and your colleagues in the US Congress for taking an important first step last year in passing the Preventing Maternal Deaths Act, P.L. 115-344, to encourage states to create and expand maternal mortality review committees (MMRCs). MMRCs are multidisciplinary groups of local experts in maternal and public health, as well as patient and community advocates, that closely examine individual maternal deaths and identify locally-relevant ways to prevent future deaths, saving mothers' lives. While traditional public health surveillance using vital statistics can tell us about trends and disparities, MMRCs are best positioned to comprehensively assess and characterize maternal deaths, to understand the causes and contributing factors and identify opportunities for prevention.

The CDC recently announced the first round of funding for the newly established Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, supporting 25 states in their efforts to coordinate and manage MMRCs. This rapid implementation of P.L. 115-344 enables us to look ahead to how we can support states in their efforts to translate the findings of their MMRCs to meaningful action and improved maternal health outcomes.

Accelerating Evidence-Based Patient Safety Changes

Once those opportunities for prevention are identified by MMRCs, states can best target resources toward needed interventions. The Alliance for Innovation on Maternal Health, or the AIM program, is

helping translate MMRC findings and recommendations into action at the state and facility levels. The AIM program is a national cross-sector, data-driven maternal safety and quality improvement initiative working in partnership with states, birthing facilities, and communities to increase adoption of evidence-based maternal safety best practices. Launched in 2014, the AIM program is funded through a cooperative agreement from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB). Program activities are implemented with oversight and program management from ACOG staff members.

The goal of AIM is to reduce maternal deaths and severe maternal morbidity by engaging provider organizations, state-based public health systems, consumer groups, and other stakeholders within a national partnership to assist state-based teams in implementing evidence-based maternal safety best practices. AIM's vision is to offer every pregnant woman in the US a safe birthing experience by improving the culture and delivery of maternity care services. AIM's goal is accomplished through 1) promoting safe and respectful maternal care for every US birth, 2) engaging multidisciplinary partners at the national, state and hospital levels, 3) developing and implementing evidence-based maternal safety best practices, 4) utilizing data-driven quality improvement strategies, and 5) aligning existing safety efforts and developing, collecting, and promoting the use of maternal safety resources.

To participate in the AIM program, states must have an MMRC or another state-focused initiative that collects, analyzes, and reports maternal health outcome data. Also key to the successful implementation of the AIM program are state perinatal quality collaboratives (PQCs), largely considered the implementation arm of MMRCs. The CDC provides oversight and resources to PQCs through its National Network on Perinatal Quality Collaboratives (NNPQC), which is focused on accelerating improvement efforts for both maternal and infant health outcomes. This coordinated collaboration at the federal level

helps to support and enhance the ability of PQCs to adopt and implement AIM maternal safety bundles. Hospitals and health systems implementing AIM's evidence-based maternal safety best practices, such as obstetric hemorrhage, severe hypertension in pregnancy, and obstetric care for women with opioid use disorder, aren't bound by a single protocol, but instead have a standard framework for each facility to develop protocols specific to its resources and patients. Currently in the pilot phase is a maternal safety best practice tool specific to reduction of racial/ethnic disparities, with the goal of incorporating into each AIM patient-safety best practice.

Implementation of a particular program is not enough to achieve meaningful, sustained change in outcomes. AIM promotes a culture of safety and teamwork, encouraging multidisciplinary drills for ob-gyns, anesthesiologists, certified nurse-midwives, nurses, and laboratory staff, to ensure readiness of the team for complications that may be rare, but are life-threatening.

AIM is now in 27 states, reaching roughly 1300 birthing facilities in the US. Early indications support AIM as a critical way we as a Nation can help ensure high quality maternity care for every woman, regardless of her race, income, or location.

At the same time, we must address the rural access gap, exacerbated by the rapid rate of rural hospital closures and the shuttering of obstetric units, and its impact on adverse maternal health outcomes. ACOG is working closely with the American Academy of Family Physicians and the National Rural Health Association to ensure access to high quality maternity care for every woman, regardless of if you live in a rural, urban, or suburban community. As the Committee considers potential actions to address maternal mortality, we urge you to keep this access concern front of mind, support policies that increase the

number of physicians and nurses practicing in rural communities, and ensure that no actions unintentionally exacerbate rural access gaps.

Addressing Racial Disparities

While there is an AIM bundle specific to reducing perinatal racial and ethnic disparities, we know that is just a start, providing the guidance for collection of data, utilization of a disparities dashboard in all birthing facilities and clinics, and examination of bias. We intend to incorporate mechanisms to address disparities in all AIM bundles.

To help achieve that in a meaningful way, ACOG is working with our partners at the National Birth Equity Collaborative and the California Maternal Quality Care Collaborative to eliminate preventable maternal mortality by raising up the voices and experiences of Black women through Mother's Voices Driving Birth Equity, a project funded by the Robert Wood Johnson Foundation. This work is being led by Black scholars to better understand Black women's birth experiences in different geographic regions.

Through this project, we'll be able to incorporate patient voices and lived experiences in our patient safety work. If we hope to change how care is delivered, we must ensure that the methods hospitals and clinicians use to address implicit bias and racism align with Black women's needs, values, and preferences. Black women's feedback must be a driver for quality improvement measures.

We recognize that we – and all care providers – have work to do and are committed to addressing implicit bias and increasing the provision of culturally competent care to our patients.

Extending Medicaid Coverage Postpartum

Medicaid is the largest single payer of maternity care in the US, covering 42.6% of births.[vi][1] Yet that coverage ends roughly 60-days postpartum. As MMRCs have increasingly revealed, many deaths related to pregnancy occur after this time. In fact, the CDC estimates that 33% of maternal deaths occur one week to 12 months after delivery, which is likely underestimated as the CDC assessment did not account for deaths from overdose, suicide, homicide, or unintentional injury.[vii] Accordingly, a number of MMRCs have recommended extending Medicaid coverage for women to a full year postpartum.[viii,ix,x,xi,xii] Already, federal statute requires that a baby born to a mother on Medicaid is covered under Medicaid through the first year of life.

As Congress explores additional ways to improve health outcomes, closing this critical gap in coverage during this incredibly vulnerable time can mean the difference between life and death for some women.

What Can Congress Do: Enact a MOMNIBUS

Thank you for enacting the Preventing Maternal Deaths Act, a critical step in our efforts to eliminate preventable maternal mortality. We urge this Committee and the Congress to build on its commitment to healthy moms and babies, and take important next steps.

[1] The percent of births financed by Medicaid is higher in certain states. For instance, based on the latest available data, Medicaid financed 58% of births in Alabama (2010) and 54% of births in Georgia (2014). Source: Vernon K. Smith, Kathleen Gifford, Eileen Ellis, and Barbara Edwards, Health Management Associates; and Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse and Allison Valentine, Kaiser Commission on Medicaid and the Uninsured. Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, The Henry J. Kaiser Family Foundation, October 2016.

As the Committee considers actions to take in the 116th Congress, ACOG urges you to prioritize four key initiatives to accelerate evidence-based patient safety changes:

1. **Support the AIM program**, as included in HR 1897, the MOMMA's Act, sponsored by Representative Robin Kelly (D-IL) and HR 4215, the Excellence in Maternal Health Act, sponsored by Representatives Larry Bucshon, MD (R-IN) and Andre Carson (D-IN). Help achieve AIM's vision to offer every pregnant woman in the US a safe birth by changing the culture of maternity care with authorization of the program.
2. **Support state-based perinatal quality collaboratives**, as included in HR 1551, the Quality Care for Moms and Babies Act, sponsored by Representatives Eliot Engel (D-NY) and Steve Stivers (R-OH), HR 1897, the MOMMA's Act, and HR 4215, the Excellence in Maternal Health Act. Collaboratives bring together local experts to accelerate adoption of best practices, including recommendations of MMRCs and AIM safety protocols. Additional federal investment would help ensure collaboratives have the resources they need to continue to spearhead state and regional quality improvement work.
3. **Support efforts to end racial and ethnic disparities in maternal outcomes**, as included in HR 2902, the Maternal CARE Act, sponsored by Representative Alma Adams (D-NC), HR 1897, the MOMMA's Act, and HR 4215, the Excellence in Maternal Health Act. While ACOG's work continues, we support proposals to establish implicit bias and cultural competency training programs for medical students, residents, and practicing health care professionals.
4. **Extend Medicaid coverage to 12-months postpartum**, as included in HR 1897, the MOMMA's Act and HR 2778, the Healthy MOM Act, sponsored by Representative Bonnie Watson Coleman (D-NJ). Notably, the CDC, in its recent *Vital Signs* report, included extending Medicaid coverage as a strategy to prevent pregnancy-related deaths.[xiii]

We’re extremely pleased that so many congressional leaders have recognized and are committed to this important issue, with a number of key bills supporting the initiatives listed above. Packaged together as a “MOMNIBUS,” these provisions would have a meaningful impact on women and families and improve maternal health outcomes.

Thank you for the opportunity to share our work with you today. We are making significant and meaningful progress on the path to better maternal outcomes for all moms, and look forward to working together with you to achieve our goal of eliminating preventable maternal mortality.

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[i] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

[ii] Lu MC. Reducing Maternal Mortality in the United States. JAMA. Published online September 10, 2018. doi:10.1001/jama.2018.11652

[iii] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3

[iv] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

[v] Ibid.

[vi] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

[vii] Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: http://dx.doi.org/10.15585/mmwr.mm6818e1

[viii] Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, September 2018. Retrieved from https://www.dshs.texas.gov/mch/pdf/MMMTFJointReport2018.pdf.

[ix] Illinois Maternal Morbidity and Mortality Report. Illinois Department of Public Health. (October 2018). Retrieved from http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf.

[x] Maternal Mortality Report. Georgia Department of Public Health. (2014). Retrieved from https://reviewtoaction.org/sites/default/files/portal_resources/Maternal%20Mortality%20BookletGeorgia.FINAL_.hq_.pdf.

[xi] Perinatal Mortality Review: Maternal Mortality in Utah 2015-2016. Utah Department of Health. (July 2018). Retrieved from https://mihp.utah.gov/wp-content/uploads/PMR-Update-0718.pdf.

[xii] Maternal Mortality Review: A Report on Maternal Deaths in Washington 2014-2015. Washington State Department of Health. (July 2017). Retrieved from https://www.doh.wa.gov/Portals/1/Documents/Pubs/140-154-MMRReport.pdf.

[xiii] Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: http://dx.doi.org/10.15585/mmwr.mm6818e1