MACPAC

Advising Congress on
Medicaid and CHIP Policy

March 30, 2020

The Honorable Chuck Grassley
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Grassley and Ranking Member Wyden:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), this letter is in response to your request for information (RFI) regarding maternal health outcomes. We appreciate your attention to this important issue.

Over the past year, MACPAC has been engaged in an intensive effort to describe Medicaid's role in maternity care across multiple dimensions. We published *Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes* (April 2019) and *Financing Maternity Care: Medicaid's Role* (January 2020); commissioned external research; and convened three panels of state, federal, and academic experts to share insights at our public meetings. The first phase of this effort will culminate in publication of two chapters in our June 2020 report to Congress, one on maternity care generally, and the other focused on pregnant women with substance use disorder (SUD) and infants with neonatal abstinence syndrome.

Our work has documented Medicaid's substantial role in financing maternity care and areas where the program is performing well and where improvement is needed. Key findings from our analysis of data from the Centers for Disease Control and Prevention WONDER database, the National Survey of Drug Use and Health, and Healthcare Costs and Utilization Project, include:

- Medicaid paid for 43 percent of all births in 2018. Compared to other sources of coverage, the program paid a greater share of births in rural areas, among young women (under age 19), and women with lower levels of educational attainment. Medicaid also paid for a greater share of Hispanic, African American, American Indian, and Alaska Native women's births (MACPAC 2020a).

Medicaid and CHIP Payment
and Access Commission

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- The share of births covered by Medicaid varies across states, ranging from about 25 percent in North Dakota to about 63 percent in Louisiana and Mississippi. Medicaid paid for more than half of births in six states: Arizona, Louisiana, Mississippi, New Mexico, Oklahoma, and Tennessee (MACPAC 2020a).
- Almost all births financed by Medicaid occurred in a hospital setting. This did not vary considerably by state, with most states having less than 1 percent of Medicaid births occurring outside a hospital (MACPAC 2020a).
- While more than 90 percent of Medicaid-financed births were attended by a physician, there was wide variation across states. In 23 states, more than 10 percent of births were attended by a certified nurse midwife, with approximately 30 percent of births attended by a certified nurse midwife in Alaska and New Mexico (MACPAC 2020a).
- Over two-thirds (68.3 percent) of women whose births were financed by Medicaid started prenatal care during the first trimester and more than three-quarters (76.3 percent) received nine or more prenatal care visits over the course of their pregnancy (MACPAC 2020a).
- Almost one-third of women covered by Medicaid delivered their infants via cesarean section, ranging from about 20 percent in Alaska to about 37 percent in Mississippi (MACPAC 2020a). This is consistent with rates of cesarean sections among women with private coverage, although higher than the rate of 10 to 15 percent recommended by the World Health Organization (WHO 2015).
- Eleven percent of infants born to Medicaid-covered mothers were preterm (delivered prior to 37 weeks) and about 10 percent were low birthweight (less than 2,500 grams) (MACPAC 2020a). For comparison, about 10 percent of all infants are born preterm and about 8 percent are low birthweight (Martin et al. 2019).
- Medicaid beneficiaries have an 82 percent greater chance of severe maternal morbidity compared to those with private insurance. Among Medicaid beneficiaries, women of color and those living in rural areas are at greater risk. The racial and geographic disparities seen in Medicaid are similar to those in the general population (Kozhimannil 2020).
- Pregnant Medicaid beneficiaries are more likely to abuse or have a substance use dependency than pregnant women with other forms of coverage. Almost 6 percent of pregnant women with Medicaid reported illicit drug dependence or abuse in the last year compared to about 2 percent of pregnant women with other coverage. However, they are more likely to have ever received treatment for their SUD (McMullen and Huson 2020).
- Less than one-quarter of substance use treatment facilities have specialized programming for pregnant and postpartum women (McMullen and Huson 2020).

Expert panelists sharing insights at the Commission's public meetings focused on:

- activities of the Centers for Medicare & Medicaid Services, including the Strong Start for Mothers and Newborns Initiative and the Administration's focus on rural access to maternal health services (MACPAC 2019);
- state efforts to address SUD among pregnant women and neonatal abstinence syndrome featuring panelists from Maine, Tennessee, and West Virginia (MACPAC 2020b); and

- a wide range of state activities related to the five areas mentioned in your RFI featuring presentations by Medicaid officials from Michigan, New Jersey, and North Carolina (MACPAC 2020c).

We also published an inventory of state and territory Medicaid policies compiled under a contract with Mathematica (MACPAC 2020d). The inventory summarizes efforts to address maternal health in Medicaid and may inform your work to promote evidence-based practices. Areas covered in the inventory include:

- covered benefits (e.g., covering services such as screening for postpartum depression and home visiting);
- payment models (e.g., encouraging use of long-acting reversible contraception immediately postpartum and reducing payment or not paying for procedures that do not follow clinical guidelines, such as early elective delivery);
- beneficiary and provider education (e.g., contacting pregnant women for case management services; educating providers on how to identify high-risk women);
- managed care contracting strategies (e.g., requiring quality measure reporting or tying capitation payments to outcomes);
- eligibility and enrollment (e.g., covering lawfully residing immigrant pregnant women without imposing a five-year waiting period, or using presumptive eligibility); and
- models of care (e.g., offering pregnancy medical homes or group prenatal care).

The next steps in our work will be analysis of key policy solutions to address concerns about access to care and health outcomes for pregnant and postpartum Medicaid beneficiaries. Over the next year, we anticipate looking more closely at issues such as:

- continuity of coverage in the postpartum period (up to 12 months) and between pregnancies;
- the availability of maternity providers, including nurse midwives and family physicians;
- access concerns related to hospital closures and their effects on the availability of maternity services, particularly in rural areas;
- the relationship between Medicaid coverage of family planning and maternal health;
- coverage of non-clinical services associated with improved maternal and birth outcomes; and
- use of alternative payment models, including the models states have adopted, the challenges to implementation, and the effectiveness of the model, if known.

These areas dovetail with the five types of policies noted in your request for information. As has been our practice, we will keep your staffs posted on our progress.

Sincerely,

Melanie Bella, MBA
Chair

Attachments
Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes
Financing Maternity Care: Medicaid's Role

References

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