May 29, 2020

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Washington, DC 20201
Via electronic submission: ruralmaternalrfi@cms.hhs.gov

RE: Request for Information (RFI) Regarding Maternal and Infant Health Care in Rural Communities

Dear Administrator Verma:

On behalf of the Association of Maternal & Child Health Programs (AMCHP), thank you for the opportunity to respond to CMS’ request for information regarding maternal and infant health care in rural communities and opportunities to improve health care access, quality, and outcomes for women and infants in rural communities before, during, and after pregnancy. AMCHP is a national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth, and families, including those with special health care needs. AMCHP members administer the Title V Maternal and Child Health (MCH) Services Block Grant program in each state, which provides a foundation for supporting systems for improving health and health care for all women, children, and families. AMCHP is happy to provide responses to the following questions:

1. **What barriers exist in rural communities in trying to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care?**

   **Hospital closures:** The acceleration of rural hospital closures has a devastating impact on access to care and birth outcomes for women living in rural communities. Hospital closures limit access to labor and delivery services, and contribute to the growing shortage of providers, including OB-GYNs, midwives, family physicians and behavioral health specialists. Additionally, as geographical distances increase, women in rural communities face barriers obtaining pregnancy and post-partum care due to transportation challenges.

   **Coverage:** Insurance coverage is closely associated with positive birth outcomes. High rates of uninsured in rural states, particularly those that have not expanded their Medicaid programs, poses a significant barrier to continuity of care for pregnant and postpartum women. In non-expansion states, women with pregnancy-related Medicaid generally lose their coverage 60 days postpartum. In addition, Medicaid coverage is not typically available for doula care and other paraprofessional services, such as home visiting and community health worker support, which provide additional access points for obtaining care in rural communities.
Mental health and substance use disorder (MH/SUD) services: Rural states have been disproportionately impacted by the opioid crisis, as evidenced by high rates of drug use among pregnant and parenting women, and infants diagnosed with neonatal abstinence syndrome. Yet in rural communities, MH/SUD service systems are often fragmented and include a limited pool of providers who specialize in caring for pregnant and postpartum women.

Racial equity and social determinants of health: For women of color living in impoverished rural communities, barriers to access and quality health care are intensified by inadequate housing and transportation, food insecurity, deteriorating economies and persistent racism. Implicit biases that many providers hold about women of color, poor patients, and patients with low education levels all create barriers to improving access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care.

2. What opportunities are there to improve the above areas (i.e., access, quality, and outcomes)?

Opportunities to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care include:

Regulatory opportunities: With provider shortages and geographical challenges, pregnant and postpartum women in rural communities can benefit by safely reducing in-person medical visits through changes in durable medical equipment (DME) regulations. With greater access to and training on DME, women can conduct home evaluations and remote monitoring with equipment to conduct urinalysis, measure-blood pressure, weight, temperature, and fundal height, and be empowered to manage their care at home. Women could also receive covered in-person support from home visitors during pregnancy to meet non-clinical needs and to help with using DME. In some states, midwives cannot order DME for their patients; removing these restrictions would be beneficial to improving access to care.

Provider opportunities: Regionalizing perinatal care is an effective strategy to improve maternal and perinatal outcomes by establishing a system that assigns risk levels to hospitals and specifies where infants are born based on the risk factor. In this system, Level III+ hospitals should be assessed on the educational support they provide to the rural hospitals. Additionally, the Alliance for Innovation in Maternal Health (AIM) has created 10 obstetric patient safety bundles to improve maternal health outcomes in hospitals. Rural hospitals should receive targeted technical assistance and financial support to implement the AIM bundles and ensure vital services are maintained.

MH/SUD opportunities: Establishing a coordinated continuum of care with multiple access points is vital to addressing MH/SUD needs of pregnant and postpartum women in rural communities. A coordinated system will allow for the appropriate referral of women to MH/SUD care and promote the safe use of psychiatric medication or medication-assisted treatment (MAT) during pregnancy. This coordinated system of care requires an expansion of training opportunities for behavioral health providers. MH/SUD treatment typically functions outside of the perinatal health care system. It is therefore essential for health care leaders and policymakers to map out the structures of the distinct systems to fully understand how to optimize coordination.
3. What initiatives, including community-based efforts, have shown a positive impact on addressing barriers or maximizing opportunities?

The following are examples of promising state and community-based initiatives to reduce barriers and maximizing opportunities to improve maternal and infant health care in rural communities:

Community-based support for mental health and doula services.
Examples:
- Engaging Mothers for Positive Outcomes With Early Referrals (EMPOWER) (MA)
- SistasCaring4Sistas (NC)

Co-location of OB/GYN care with MH/SUD services.
Example: West Virginia’s Drug Free Moms and Babies

Freestanding birth centers with full scope midwifery practices.
Example: Breath of My Heart Birthplace (NM)

Loan forgiveness/repayment programs to incentivize health professionals to practice in rural areas.
Example: New Mexico Health Professional Loan Repayment Program

4. How can CMS/HHS support these efforts?

Through federal policy efforts, CMS/HHS can support programs such as those above, as well as other promising approaches to improve access, quality and outcomes for pregnant and postpartum women and their infants in rural areas. AMCHP recommends:

- Extending postpartum Medicaid coverage from the traditional six weeks to one year postpartum for all Medicaid-eligible women
- Promoting expansion of Medicaid to the 14 states that have not adopted it. Expanding Medicaid now has the dual benefit of offering continuous coverage for low-income, reproductive age women, as well as sustainable funding to support the health care needs of low-income adults who have lost employer-sponsored insurance due to the COVID-19 pandemic.
- Promoting state adoption of scope of practice policies that allow providers to practice to the full extent of their licensure/credentialing.
- Promoting integration of MH/SUD services with perinatal care in rural communities, and work with SAMHSA to expand MAT prescription privileges to nurse practitioners and other qualified providers.
- Providing technical assistance and funding to rural hospitals to support the implementation of AIM bundles.
- Exploring options for reducing the national variability in Medicaid reimbursement rates to improve funding for perinatal care in rural communities.
• Exploring options for increasing Medicaid reimbursement rates for all obstetric providers (OB-GYNs, midwives, family physicians, NPs, PAs, RNs) to incentivize participation in Medicaid and address health provider shortages in rural areas.

• Exploring options for Medicaid coverage of paraprofessionals, including doulas, home visitors, and community health workers, who provide perinatal services to women in rural communities.

• Promoting the expansion of telehealth services for women and infants in rural areas through federal investment in telehealth infrastructure.

• Exploring options for Medicaid coverage of DME such as blood pressure monitors, thermometers, urinalysis equipment, scales, and measuring tools, and expanding provider prescription privileges for DME to include midwives as prescribers.

• Exploring options for incorporating anti-racism training into CMS hospital credentialing processes.

We welcome the opportunity to serve as a continued resource to CMS on this and other maternal and child health issues. If you have specific questions or would like additional information, please contact Amy Haddad, Director of Policy and Government Affairs, at 202-266-3045 or ahaddad@amchp.org.

Sincerely,

Jonathan Webb, MPH, MBA
Chief Executive Officer