COMMITTEE ON
ENERGY & COMMERCE
CHAIRMAN FRANK PALLONE, JR.

MEMORANDUM

September 6, 2019

To: Subcommittee on Health Members and Staff

Fr: Committee on Energy and Commerce Majority Staff

Re: Hearing on "Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care"

On **Tuesday, September 10, 2019, at 10 a.m. in room 2123 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing entitled, "Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care."

I. BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), women in the United States are more likely to die from childbirth or pregnancy-related causes than other women in the developed world.[1] Although approximately 60 percent of pregnancy-related deaths are preventable, about 700 women in the United States die every year from complications of pregnancy.[2] The deaths are roughly evenly split between those that occur during pregnancy (31 percent of deaths), during delivery or in the week after (36 percent of deaths), and between one week and one year postpartum (33 percent of deaths).[3] There are significant disparities in maternal health and mortality; black and American Indian/Alaska Native women are about three times more likely to die from pregnancy-related causes than white women.[4]

Causes of pregnancy-related deaths differ. While heart disease and stroke cause most deaths overall, obstetric emergencies, such as severe bleeding and amniotic fluid embolism,

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[1] Centers for Disease Control and Prevention, *Pregnancy Related Deaths* (accessed Aug. 26, 2019) (www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm).

[2] Centers for Disease Control and Prevention, *Vital Signs: Pregnancy-related Deaths: Saving Women's Lives Before, During and After Delivery* (May 7, 2019) (www.cdc.gov/vitalsigns/maternal-deaths/index.html).

[3] *Id.*

[4] *Id.*

cause the most deaths at delivery. Severe bleeding, high blood pressure, and infection are the leading causes in the week after delivery and weakened heart muscle is the leading cause in deaths one week to one year postpartum.[5]

To better understand the causes of pregnancy-related deaths, states have established Maternal Mortality Review Committees (MMRCs). Nationally collected data estimates of maternal mortality, such as the Pregnancy Mortality Surveillance System operated by CDC, include broad surveillance data which provides basic information about the causes of death of women during pregnancy and the postpartum period. However, this data is insufficiently granular to allow researchers to identify specific factors that contributed to individual deaths.[6] In contrast, state MMRCs identify, review, and analyze maternal deaths on an individualized basis. The goal of MMRCs is to prevent pregnancy-related death and to put in place recommendations for action that support health and wellness during pregnancy, childbirth, and postpartum.[7] For example, the Texas Maternal Mortality and Morbidity Taskforce recommended that the state increase access to health services during the year after pregnancy to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing.[8]

Recognizing the need for better data collection and the promotion of state MMRCs, in December 2018 Congress passed and President Trump signed into law H.R. 1318, the Preventing Maternal Deaths Act of 2018.[9] Since the passage of the Preventing Maternal Deaths Act, all 50 states either have a MMRC or are in the process of developing a MMRC.

States are also improving coordination of data and best practices through the use of perinatal quality collaboratives (PQCs). PQCs are state or multi-state networks working to improve the quality of care for mothers and babies. States may choose to focus exclusively on maternal health or neonatal health, or both. PQCs may include health care providers, hospitals, and state and federal public health officials. CDC supports coordination of PQCs through the National Network of Perinatal Quality Collaboratives (NNPQC) to support state PQCs in implementing better data collection and best practice implementation.[10]

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[5] *Id.*

[6] Review to Action, *What Makes Maternal Mortality Review Unique?* (accessed Aug. 26, 2019) (reviewtoaction.org/learn/what-makes-maternal-mortality-review-unique).

[7] *Id.*

[8] Texas Department of Health and Human Services, Maternal Mortality and Morbidity Task Force, *Joint Biennial Report* (Sept. 2018).

[9] Pub. L. No. 115-344 (2019).

[10] Centers for Disease Control and Prevention, *Developing and Sustaining Perinatal Quality Collaboratives: A Resource Guide for States* (March 4, 2016) (www.cdc.gov/reproductivehealth/maternalinfanthealth/pdf/Best-Practices-for-Developing-and-Sustaining-Perinatal-Quality-Collaboratives_tagged508.pdf).

In addition to data collection improvements at CDC, and wider adoption of MMRCs, the Health Resources and Services Administration (HRSA) operates the Alliance for Innovation on Maternal Health and Safety (AIM) Initiative in 26 states and with 1,300 hospitals, which implements best practices to improve the quality and safety of maternity care, with the goal of preventing 100,000 maternal deaths and severe morbidity.[11] The AIM Imitative has spurred the implementation of "Maternal Safety Bundles," or evidence-based best practices for maternity care that are used to improve patient outcomes when performed in a health care setting, such as specific action measures to address obstetrical hemorrhage and severe preeclampsia.[12] Implementing the safety bundles has shown results in several areas. For example, Illinois has reduced severe maternal morbidity by 22.1 percent and reduced morbidity due to hypertension by nearly 20 percent after reducing the time it took to treat women after their first high blood pressure reading.[13] Michigan decreased severe maternal morbidity by over eight percent after decreasing hemorrhage rates by 18 percent and severe hypertension by roughly five percent.[14]

II. PRIOR COMMITTEE ACTION

In the 115th Congress, the Subcommittee on Health of the Energy and Commerce Committee held a hearing on September 27, 2018, entitled "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S."[15] This hearing builds on the discussions from last Congress and continues the Committee's effort to address the causes of maternal mortality and severe maternal morbidity.

III. LEGISLATION

A. H.R. 1897, the "Mothers and Offspring Mortality and Morbidity Awareness Act" or "MOMMA's Act"

The MOMMA's Act, introduced by Rep. Robin Kelly (D-IL), addresses the maternal mortality and morbidity crisis through a number of public health programs as well as the extension of health coverage. The legislation requires CDC to coordinate with HRSA in providing technical assistance to states and the issuance of best practices to state MMRCs on how to best identify, review, and prevent maternal mortality. The bill also authorizes the AIM program as well as funding for state-based PQCs. To address disparities in care, the legislation

[11] Health Resources & Services Admin., *Maternal Morbidity & Mortality* (Aug. 2019) (www.hrsa.gov/maternal-mortality/index.html).

[12] The American College of Obstetricians and Gynecologists, *Alliance for Innovation on Maternal Health* (June 2015) (www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/What-is-AIM).

[13] *Id.*

[14] *Id.*

[15] House Committee on Energy and Commerce, *Hearing on Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.*, 115th Cong. (Sept. 27, 2018).

authorizes funding to establish or support Regional Centers of Excellence for implicit bias and cultural competency education.

In addition to these public health initiatives, the bill provides access to maternal health care postpartum through the extension of insurance coverage. Under current law, certain women are eligible for Medicaid and CHIP coverage during pregnancy and through 60 days postpartum. This legislation would extend this coverage beyond 60 days to one year postpartum and would include Medicaid support of oral health services for pregnant and postpartum women.

B. H.R. 1551, the "Quality Care for Moms and Babies Act"

The Quality Care for Moms and Babies Act, introduced by Rep. Eliot Engel (D-NY) and Rep. Steve Stivers (R-OH), directs the Department of Health and Human Services (HHS) to work with providers, specialty organizations, and other stakeholders to identify and publish a core set of maternity care quality measures for childbearing women and newborns, and authorizes the expansion of maternal and perinatal quality collaboratives to improve care. Additionally, H.R. 1551 directs the Agency for Healthcare Research and Quality (AHRQ) to develop and use surveys to measure the care experiences of childbearing women and newborns where appropriate.

C. H.R. 2902, the "Maternal Care Access and Reducing Emergencies Act" or the "Maternal CARE Act"

The Maternal CARE Act, introduced by Rep. Alma Adams (D-NC), establishes a grant program to fund implicit bias training programs for nursing schools, medical schools, and other health professional programs. Implicit bias training provides health care professionals with tools to recognize unconscious bias in the delivery of care and reduce inequities in care through awareness. Additionally, H.R. 2902 includes grant funding for a state pregnancy medical home demonstration to integrate health care services for pregnant women and new mothers. Finally, this bill would require the Secretary of HHS to request a study from the National Academy of Medicine to make recommendations for incorporating bias recognition in clinical skills testing for accredited schools of medicine.

D. H.R. 2602, the "Healthy MOMMIES Act"

The Healthy MOMMIES Act, introduced by Rep. Ayanna Pressley (D-MA), extends Medicaid coverage for postpartum women beyond the 60 days already in law to one year postpartum, and would include oral health services for pregnant and postpartum women. The bill would also require Medicaid programs to pay primary care providers, including obstetrics and gynecology providers, no less than the Medicare rate for certain services. Additionally, the bill establishes a maternity care home demonstration project for coordination of care and to improve maternity and infant care outcomes.

H.R. 2602 would also require the Medicaid and CHIP Payment and Access Commission (MACPAC) to issue a report on the coverage of doula care under state Medicaid programs, and would require the Centers for Medicare and Medicaid Services (CMS) to issue guidance to states

on increasing access to doula care under Medicaid. Finally, the bill requires the Government Accountability Office (GAO) to issue a report on the use of telemedicine by state Medicaid programs to increase access to maternity care.

IV. WITNESSES

Wanda Irving
Mother of Dr. Shalon Irving

Patrice Harris, M.D.
President, Board of Trustees
American Medical Association

Elizabeth Howell, M.D., M.P.P.
Director, Blavatnik Family Women's Health Research Institute
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David Nelson, M.D.
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