



**FOR  
MOMS & BABIES**

# Delivering and Paying for Quality Maternity Care Services: Policy Options for States

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*Midwestern Legislative Conference  
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July 22, 2024*



A story in two acts...

Act 1: mid 70's



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Act 2: May 2006





WE MUST DO  
BETTER!!!



**MOST DANGEROUS**

country among wealthy nations to

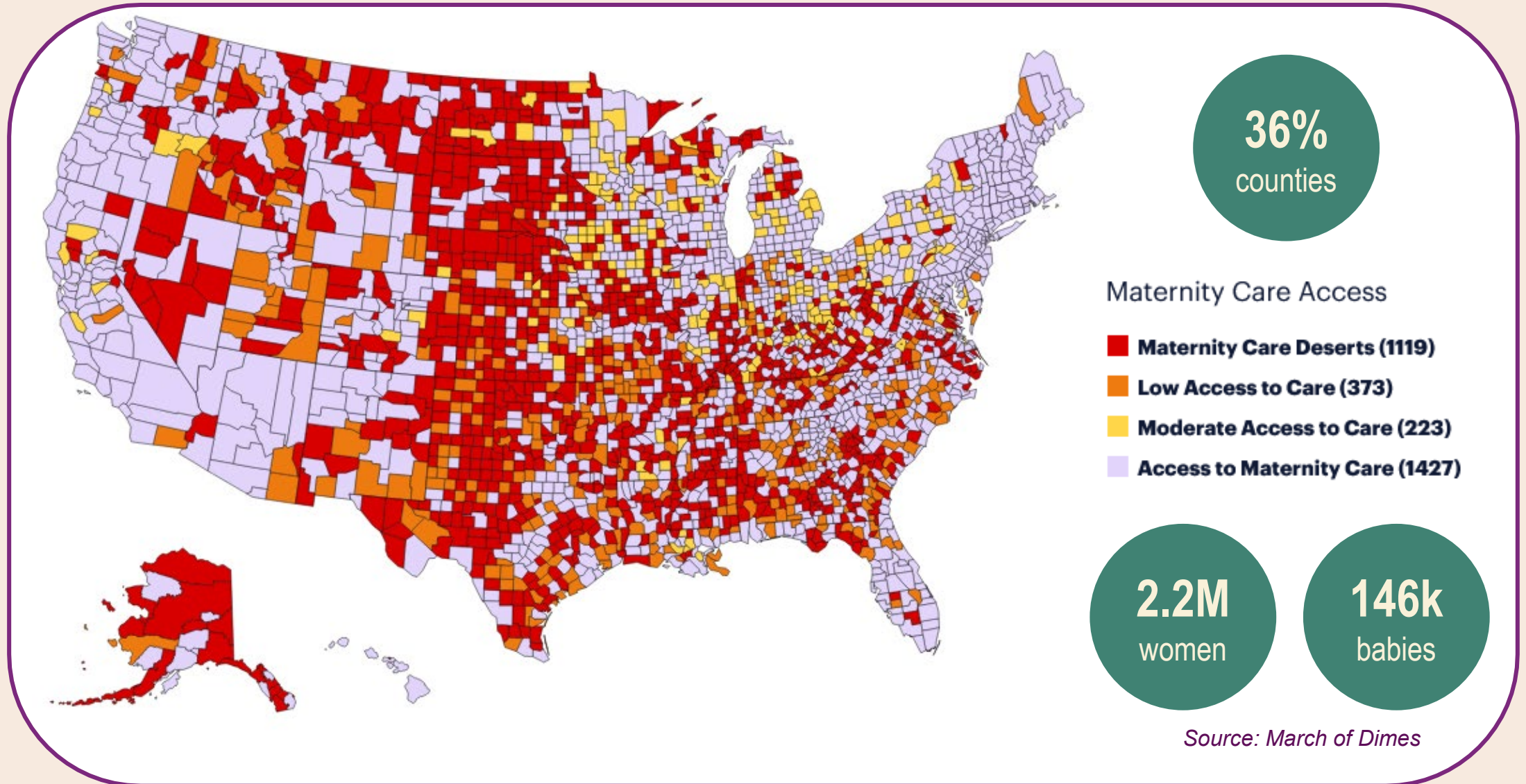
**GIVE BIRTH**

# Our Maternal Health Crisis

## HIGH MORTALITY

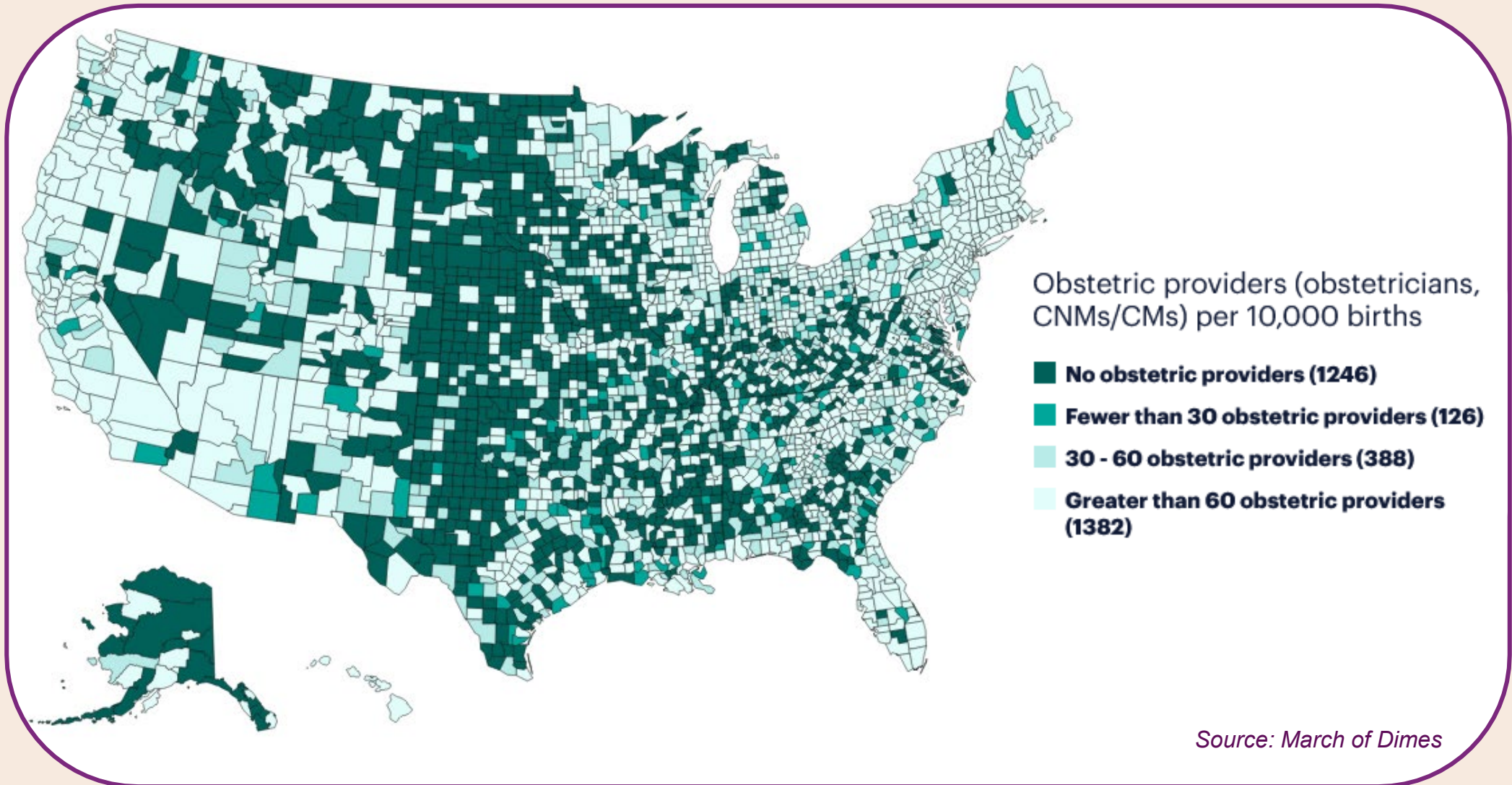
- ◆ Highest death rate of high-income nations
  - US: 22.3 per 100,000 births (2022)
  - Chile: 14.3 (50% higher)
  - Canada: 8.4 (2.7 times)
  - UK: 5.5 (4x)
- ◆ As of June, 2023 pandemic spike seemed nearly resolved—still slightly higher compared to January 2020 (3%)
- ◆ More than 80% of pregnancy related deaths are preventable

# Driver: Maternity Care Deserts, 2020

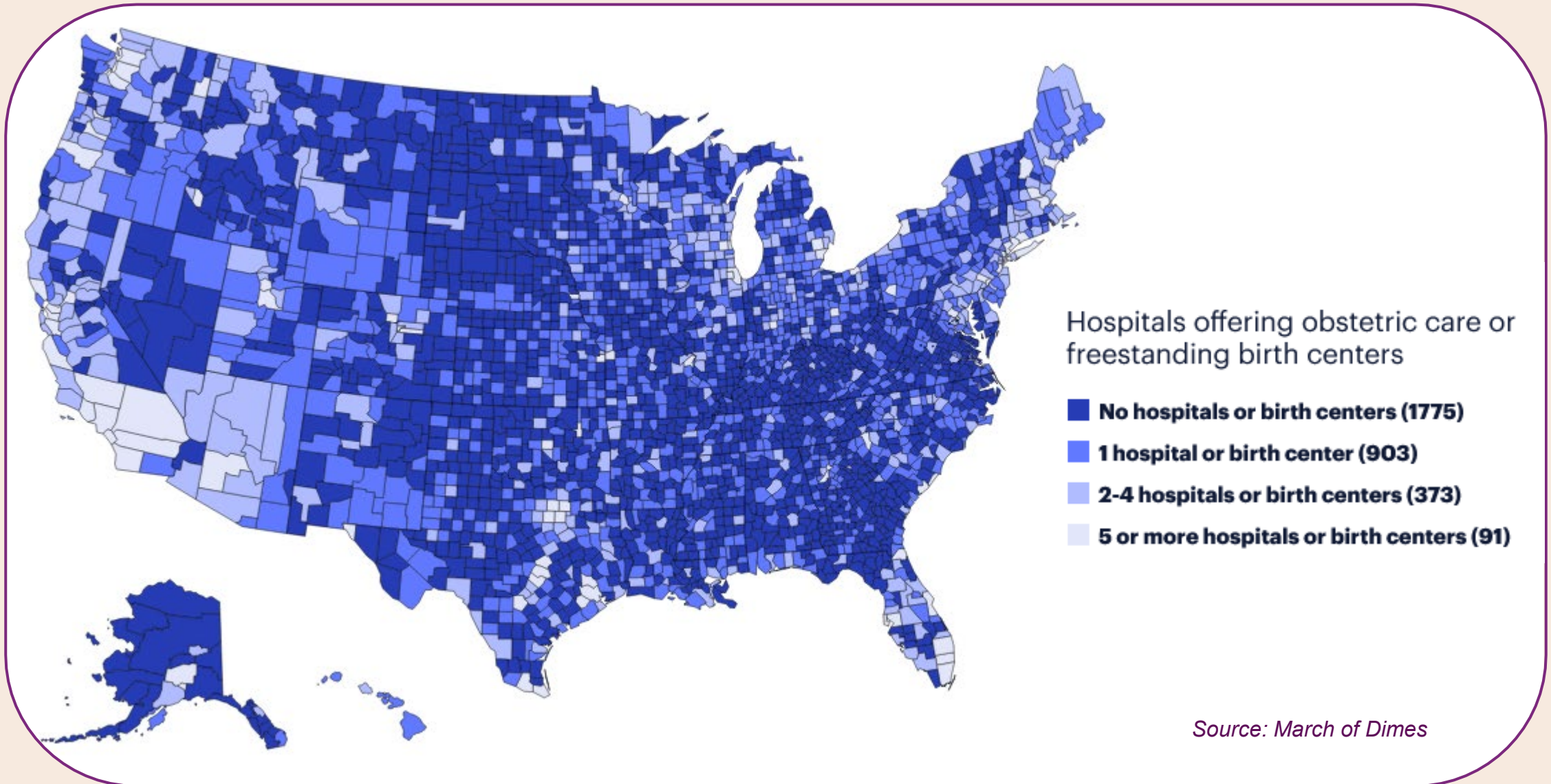




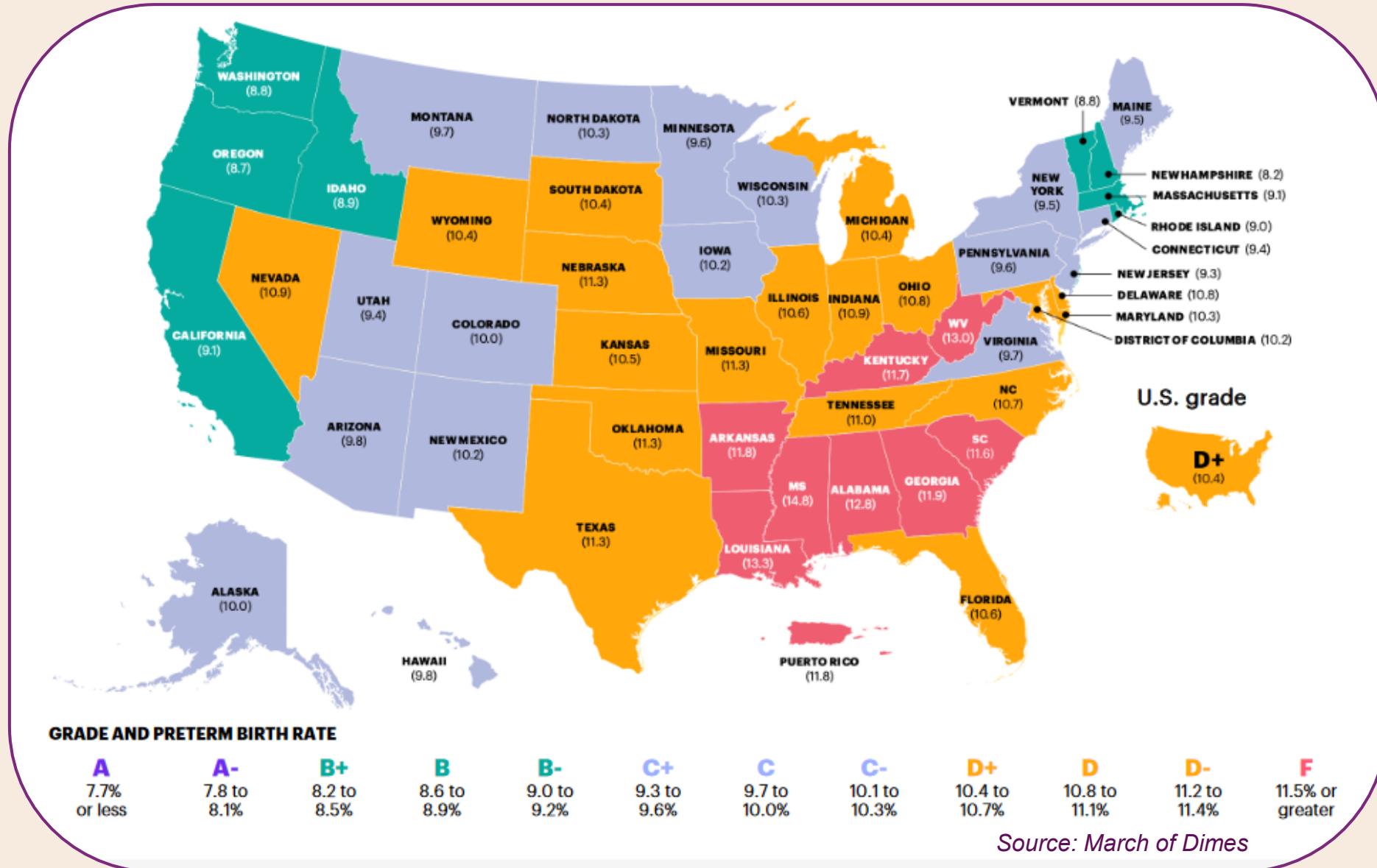
# Driver: Available Obstetric Providers, 2019



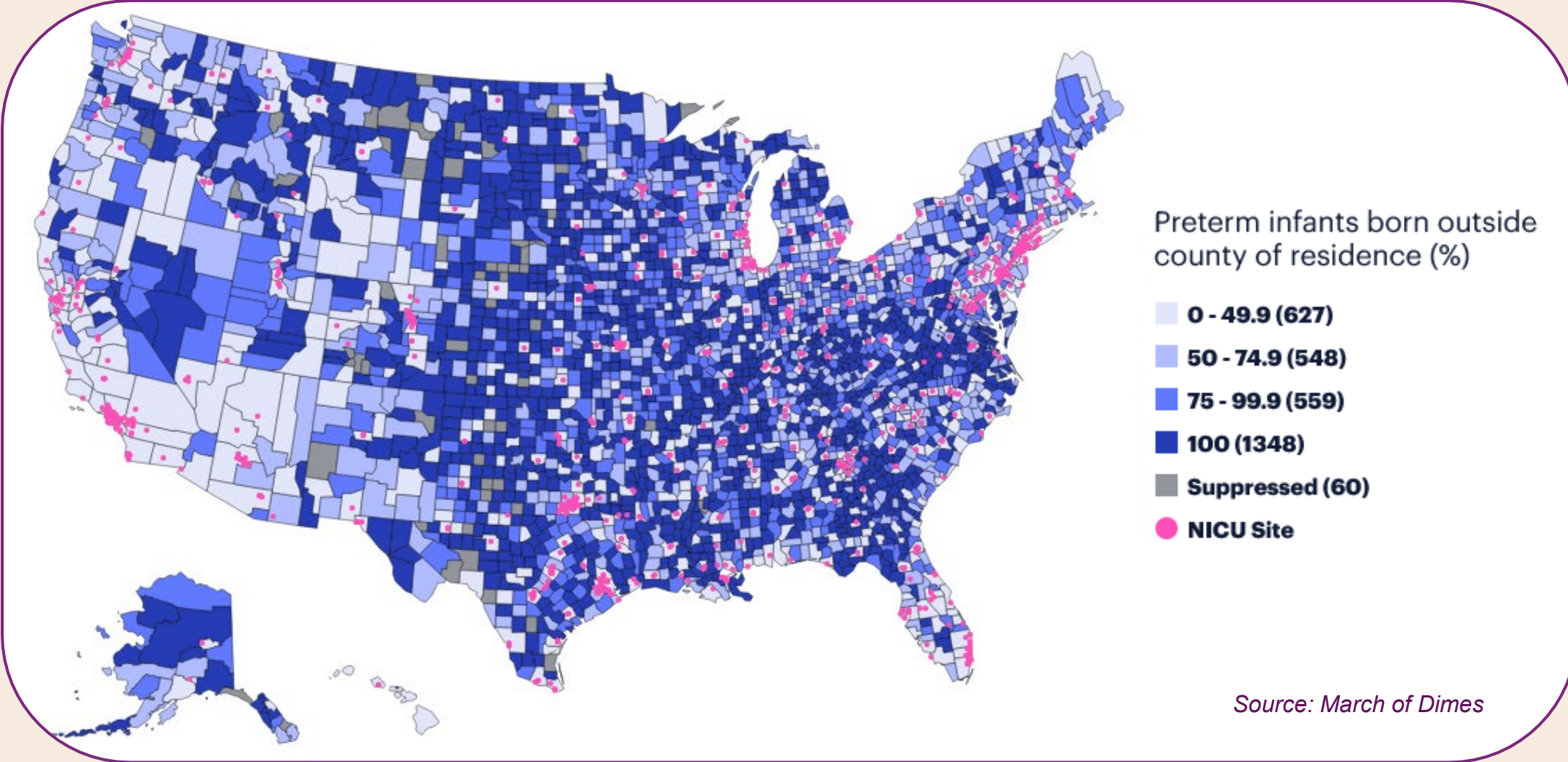
# Driver: Hospital/Birth Centers with L&D, 2019



# Impact: Preterm Births



# Impact: Percent of preterm infants born outside their county + NICUs



Source: March of Dimes

# Black and Indigenous mothers bear the brunt of the crisis

## American Indian and Alaska Native women (compared to white women):

- ◆ 2.3 times more likely to die
- ◆ roughly twice as likely to experience severe maternal morbidity.

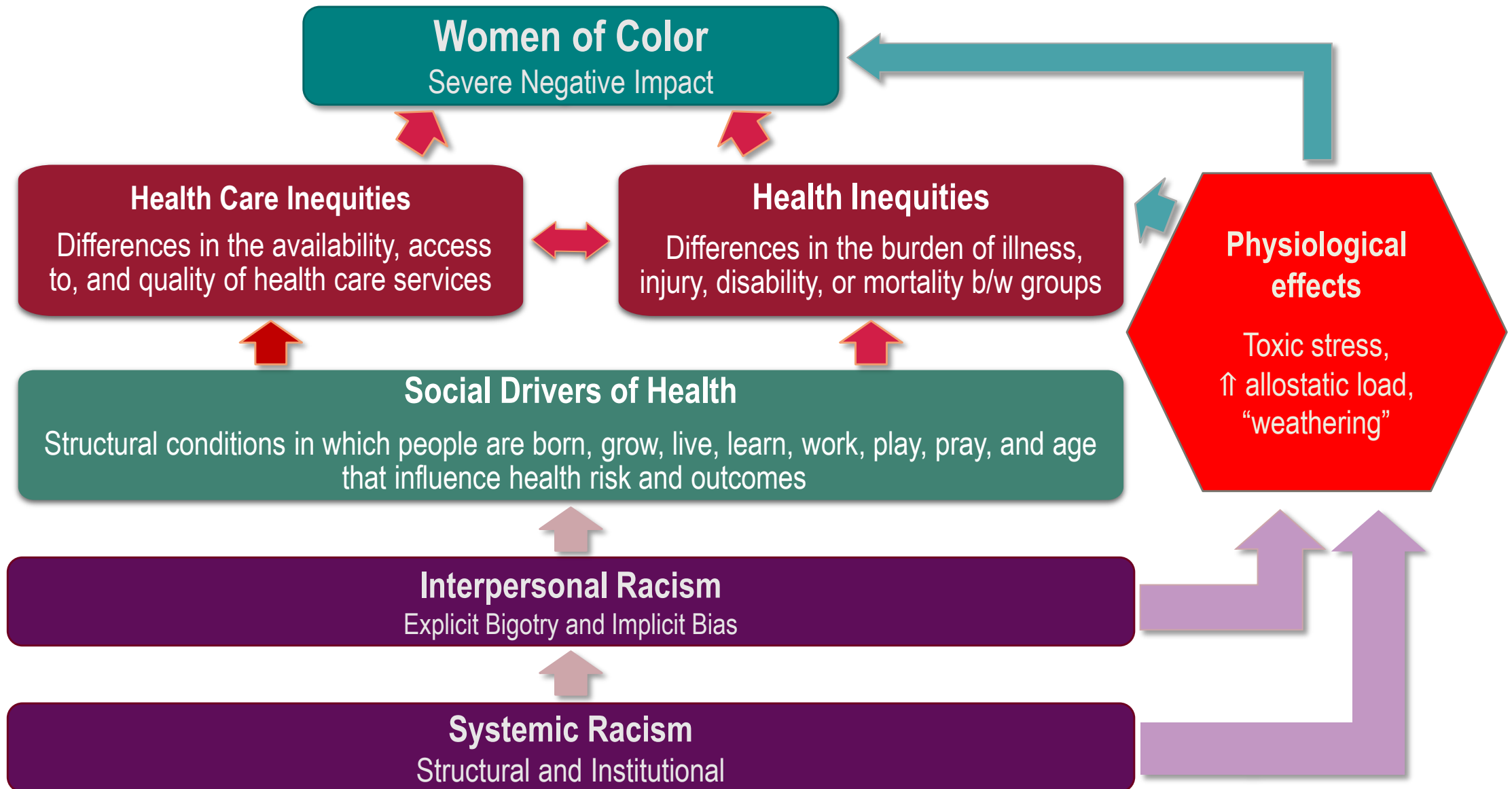
## Black women (compared to white women):

- ◆ 3 x more likely to die
  - Irrespective of education and income
  - Black college graduates were roughly 60% more likely to die than white women without a HS diploma

## Post pandemic maternal mortality “recovery” benefited women unequally

- ◆ white women’s 9% lower than pre-pandemic
- ◆ Black women still 15% worse,
- ◆ Hispanic, 19% worse

# Racism, Health and Women of Color



## TOPIC: RACISM

# RACISM IS HAZARDOUS TO THE HEALTH OF PREGNANT PEOPLE & THEIR INFANTS

Living in a body that is the target of racism not only takes a psychological toll but directly damages a person's physiology, including their DNA. The physiological impact of racism on Black and brown bodies is especially evident in the health of pregnant people and their infants.

- Nine of 13 U.S.-based studies found a negative effect of interpersonal discrimination on **preterm birth** or **gestational age at birth**.
- Ten of 13 U.S.-based studies found a negative effect of interpersonal discrimination on **birth weight**.
- Black birthing people exposed to racism in the year prior to giving birth were more likely to have an **infant with low or very low birth weight**.



# How did we get here?

- ◆ **Healthcare system was not designed to serve women**
  - let alone **birthing people**
  - never mind birthing people **of color**
- ◆ **Long history (and current practice) of minimizing women's health concerns and dismissing women's reported symptoms, pain, decisions**
- ◆ **Long history (and current practice) of healthcare institutions abusing women—especially women of color**
  - Abusive gynecological experimentation on enslaved Black women
  - Forced sterilization
  - Reproductive coercion
- ◆ **Pernicious role of racism**



# Where do we go from here?

## Achieving Optimal Maternal Health

The **physical, mental, and social well-being** of a birthing person and infant before, during and after childbearing, encompassing:

- ◆ Reproductive justice
- ◆ Personal agency
- ◆ Bodily autonomy
- ◆ Freedom from bias, racism and other forms of discrimination

### It must be

- ◆ Rooted in good health status before pregnancy
- ◆ Anchored in healthy communities and healthy families,
- ◆ Enabled by health-supporting structures, policies, programs, and practices

# How?

Pay for what we know **works**,  
and what women and families  
**want and need.**

# What works?

## ◆ Broaden and grow the workforce

- Midwives
- Doulas
- Lactation consultants
- Community Health Workers
- Peer support workers

## ◆ Address unmet social needs

- Require screening
- Build on community assets

## ◆ Enable & support telehealth

- Regulatory
- Broadband infrastructure & affordability

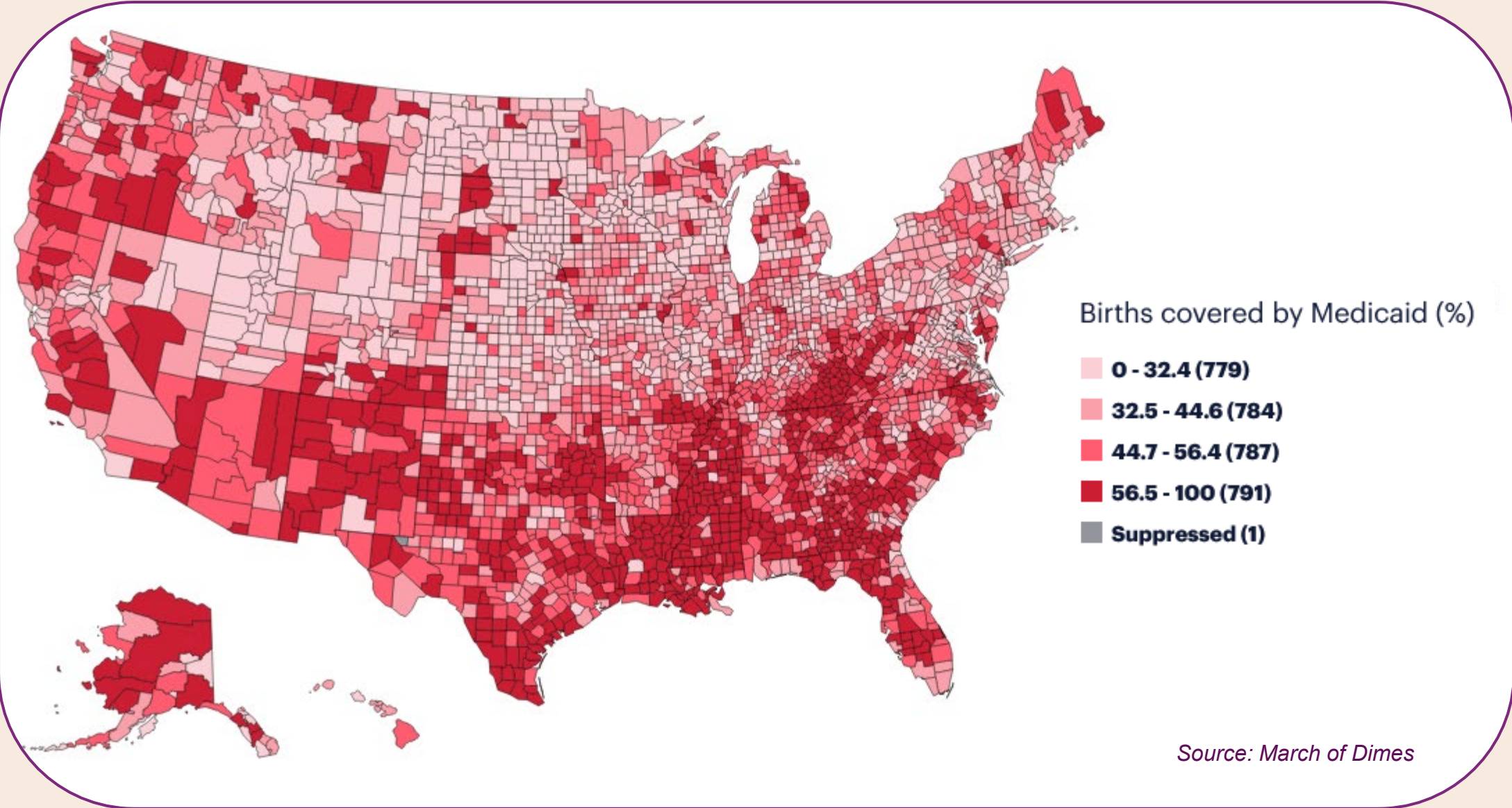


# Diversify the workforce

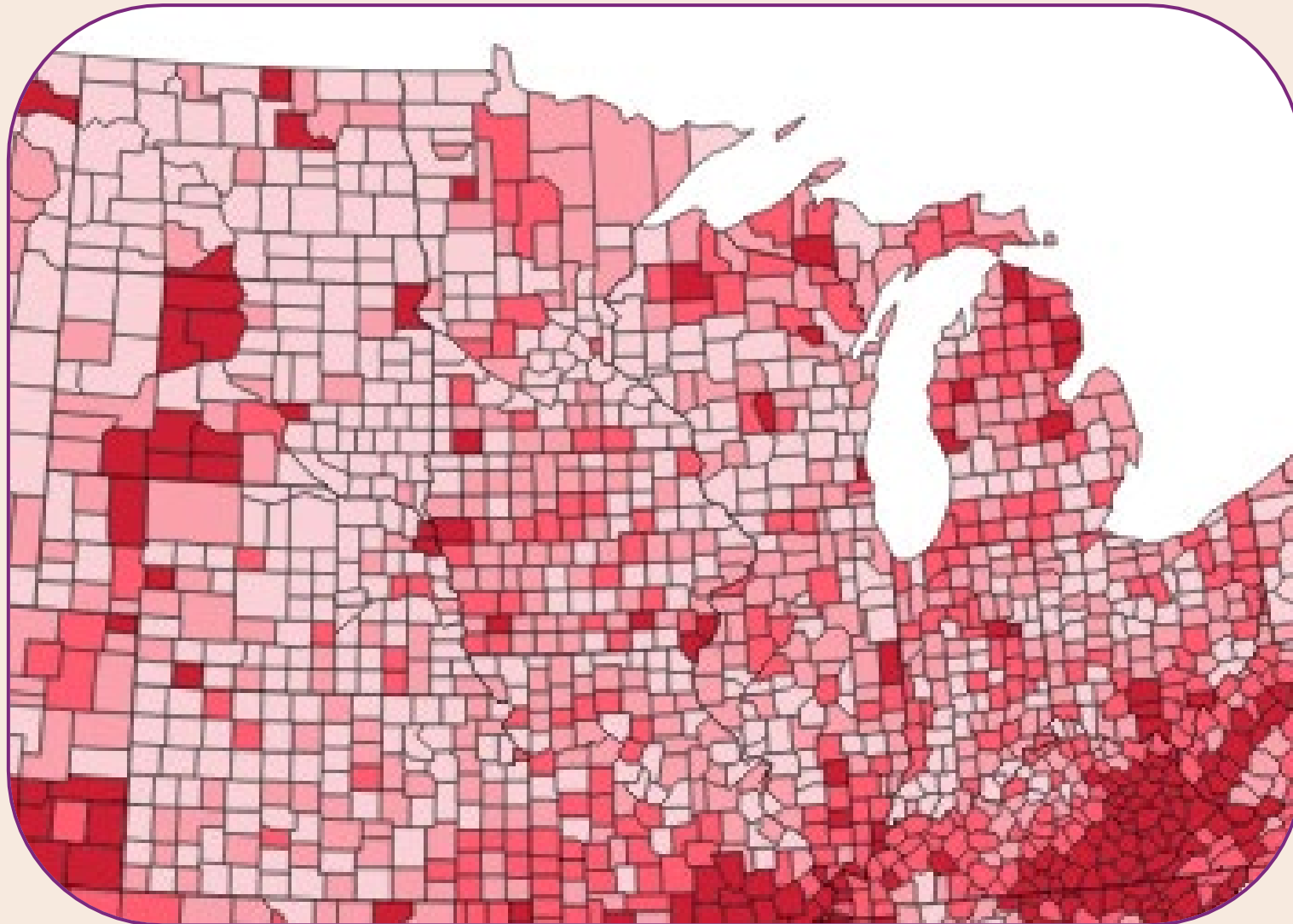


- ◆ **Nearly half the babies** in the US are born to mothers who are Black, Indigenous, Latinas, Asian American, or Pacific Islander
- ◆ **Racial concordance** between Black newborns and their physicians **halved infant mortality rates**
- ◆ **Nursing workforce diversity** reduced childbirth **severe maternal outcomes**
- ◆ **The value of racial and cultural concordance** has been shown in
  - Maternity nursing
  - Midwifery care
  - Doula and lactation support

# Your Lever: Medicaid



# Your Lever: Medicaid



Births covered by Medicaid (%)

0 - 32.4 (779)

32.5 - 44.6 (784)

44.7 - 56.4 (787)

56.5 - 100 (791)

Suppressed (1)

Source: March of Dimes

# Emerging state policies & federal opportunities

# Case in Point: Transforming Maternal Health (TMaH)

## New 10-year CMS Medicaid Initiative

- ◆ Current opportunity
  - Statewide or regional
  - Funding (up to \$17M) + Significant Technical Assistance
  - Encourage your State Medicaid Agency to apply
  - Letters of Intent due August 8, Applications due September 20
- ◆ Blueprint for how to transform maternity care
  - Helpful framework and strategy
  - Useful inventory of tactics



# TMaH: Ten-year program

## Pre-Implementation

**Years 1 - 3**

*1/25 - 12/27*

**Technical assistance and financial support to SMAs to work with partners to prepare to implement**

- ◆ Identify and plan with partners & stakeholders to work with (MCOs, maternal health providers and supports, CBOs)
- ◆ Shore up maternity care infrastructure: SPAs, waivers, legislation, regulations.

## Implementation

**Years 4 - 10**

*1/28 - 12/34*

**SMAs work with partners and stakeholders to implement model to achieve key interventions, key payment reforms, and improve outcomes**

- ◆ In year 4, providers receive incentive payments for reaching select quality and patient safety benchmarks
- ◆ In year 5, implement value-based alternative payment model

# TMaH: Three Pillars & Required Elements

## Access, Infrastructure, & Workforce

- ◆ Increase access to midwives & birth centers
- ◆ Increase access to doulas
- ◆ Improve data infrastructure (collection, exchange & linkages)
- ◆ Develop payment model

## Quality Improvement & Safety

- ◆ Implement AIM patient safety bundles
- ◆ Promote “Birthing Friendly” hospital designation

## Whole-Person Care Delivery

- ◆ Home monitoring & telehealth for diabetes, hypertension
- ◆ Routine screening, referral, follow-up for mental health, substance use, unmet social needs
- ◆ Develop health equity plan

# TMaH: Three Pillars & Optional Elements

## Access, Infrastructure, & Workforce

- ◆ Cover Certified Midwives and Certified Professional Midwives
- ◆ Cover perinatal community health workers
- ◆ Create regional rural partnerships
- ◆ Expand eligibility to 12 months postpartum

## Quality Improvement & Safety

- ◆ Promote shared decision-making
- ◆ Expand group prenatal care

## Whole-Person Care Delivery

- ◆ Expand oral healthcare
- ◆ Increase mobile clinics, home visiting, & telehealth



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