Maternal and Infant Mortality: What Does the Data Tell Us and What Can We do?

hosted by the Co-chairs of the Black Maternal Health Caucus, Congresswomen Lauren Underwood and Alma S. Adams, Ph.D.

Tuesday, November 19, 2019
10:15 – 11:15 am
121 Cannon House Office Building
A MATERNAL AND INFANT HEALTH CRISIS

• The health of moms and babies are interconnected.
• Rates of preterm birth, maternal death, and severe pregnancy complications are increasing.
• Significant racial disparities exist in maternal and infant health outcomes.
TRENDS IN MATERNAL MORTALITY

Pregnancy-related death has more than doubled over the past 25 years.

700 women die due to pregnancy-related complications each year. More than half of these deaths is preventable.

Black women are three times more likely to die as a result of pregnancy than white women.

50,000 women have life-threatening complications from labor and delivery.

The U.S. has the highest maternal mortality rate of any industrialized country, and it continues to rise.
SIGNIFICANT DISPARITIES EXIST IN PRETERM BIRTH RATES BETWEEN DIFFERENT RACIAL/ETHNIC GROUPS

In the U.S., the preterm birth rate among Black women is 49% higher than the rate among all other women.
WHAT CAN WE DO TO BEST PROTECT MOMS AND BABIES?

• Our speakers will talk about some of the actions being taken and debated at the federal, state, and community levels to best support moms and babies.

• Many of these include ensuring comprehensive health care coverage pre- and post-partum for women and babies through Medicaid, CHIP, and private coverage.

  - 55% of moms who were insured by Medicaid for their delivery were uninsured 6 months after giving birth.
  - The decline of infant mortality rates is 50% greater in Medicaid expansion states v. non-expansion states, includes a significant reduction in racial disparities.
  - The uninsured rate for women of childbearing age is nearly two times higher in Medicaid expansion states v. non-expansion states.
Maternal and Infant Mortality:  
What Does the Data Tell Us and What Can We do? 

hosted by the Co-chairs of the Black Maternal Health Caucus,  
CONGRESSWOMEN LAUREN UNDERWOOD AND ALMA S. ADAMS, PH.D. 

Panelists: 

Rachel Hardeman, PhD, MPH, Assistant Professor, Division of Health Policy and Management, University of Minnesota School of Public Health  
Charleta Guillory, M.D., M.P.H., F.A.A.P., Baylor College of Medicine, Texas Children’s Hospital  
Usha Ranji, M.S., Associate Director, Women’s Health Policy, Kaiser Family Foundation  
Kelsie Landers, LMSW, Policy and Advocacy Director, EverThrive Illinois
Maternal and Infant Health Inequities: Getting at the Root Cause

Rachel R. Hardeman PhD, MPH
Assistant Professor, Division of Health Policy & Management
400 Years of Inequality

The first documented Africans in Virginia arrived here in Aug. 1619 on the White Lion, an English privateer based in the Netherlands. Colonial officials traded food for these “20 and odd” Africans, who had been captured from a Portuguese slave ship. Among present-day Hampton’s earliest African residents were Anthony and Isabella. Their son, William, was the first child of African ancestry known to have been born in Virginia (ca. 1624). Many of the earliest Africans were held as slaves, but some individuals became free. A legal framework for hereditary lifelong slavery in Virginia evolved during the 1600s. The United States abolished slavery in 1865.
White supremacy shaped America

![Timeline of White Supremacy](image)

**Black Enslavement, About 60% of This Country's History**

![Timeline of Black Enslavement](image)

**Jim Crow, About 22% of Our History**

Feagin, 2019
A History of Racist Ideas
**Infant Mortality**

**Maternal Mortality**

**FIGURE 1**

Maternal mortality rates in select countries and the United States

- Total maternal deaths per 100,000 live births
  - All U.S. mothers: 14
  - U.S. non-Hispanic white mothers: 12.7
  - U.S. African American mothers: 43.5
  - Mothers in high-income countries: 10
  - Mothers in upper-middle-income countries: 44


**FIGURE 2**

Infant mortality rates in select countries and the United States

- Total infant deaths per 1,000 live births
  - All U.S. mothers: 6
  - U.S. non-Hispanic white mothers: 4.8
  - U.S. African American mothers: 11.7
  - Mothers in high-income countries: 5
  - Mothers in upper-middle-income countries: 12

Implicit Bias

Structural Racism

- Voting rights
- FHA Loans
- Residential segregation
- Access to education, green space, resources, safety, healthcare, etc.
- Jobs, hiring, & advancement

This is NOT about one man. This is about STRUCTURAL Racism in a country built on BLACK SLAVERY.
Manifestations of Structural Racism

“Social Determinants of Health”

Structural Racism

- Education Access & Quality
- Access to Quality Healthcare
- Housing Affordability & Options
- Work & Economic Opportunities
- Neighborhood Context & Factors
- Social Interactions & Relationships

Inequitable Health Outcomes by ‘race’
(Health Disparities)
VOGUE

"THE EMOTIONS ARE INSANE"

Serena
OPENS UP ON MOTHERHOOD, MARRIAGE & MAKING HER COMEBACK

Love All
MODERN FAMILIES WITH A CAUSE
IN THE TRENCHES A CLASSIC COAT BREAKS OUT

@RRHDR
Thank You.

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Maternal and Infant Mortality: What Does the Data Tell Us and What Can We Do?

Congressional Briefing
November 19, 2019

Charleta Guillory, MD, MPH, FAAP
Associate Professor of Pediatrics
Baylor College of Medicine
Director of Neonatal-Perinatal Public Health Program
Texas Children’s Hospital
Robert Wood Johnson Health Policy Fellow
Infant Mortality Rates by State, 2017

Death Rates

United States 5.8
3.7 - 4.6
4.6 - 5.7
5.7 - 6.1
6.2 - 7.1
7.1 - 8.6
Infant Mortality Rate in Texas and the US, 2008-2017

*2016 and 2017 data are provisional

Source: 2008-2017 Texas Birth and Death Files, National Center for Health Statistics
Prepared by: Texas Department of State Health Services, Maternal & Child Health Epidemiology Unit, October 2018
Infant Mortality Rate in Texas by Race/Ethnicity, 2008-2016

*2016 data are provisional

Source: 2008-2016 Death and Birth Files Prepared by: Texas Department of State Health Services, Maternal & Child Health Epidemiology Unit, October 2018
Leading Causes of Infant Death, 2008-2016

*2016 data are provisional  NOC: Not otherwise Classified

Source: 2008-2016 Death and Birth Files Prepared by: Texas Department of State Health Services, Maternal & Child Health Epidemiology Unit, October 2018
Texas Infant Mortality By Zip Codes

Black Infant Mortality Rate By Zip Codes -Houston, TX

Maternal Mortality – Trickle Down Theory

• Pregnancy related complications are closely tied to infant deaths.

• Maternal mortality increased the risk of delivering a premature infant.

• When a women experiences a maternal death, her infant is more likely to have a trajectory far worse compared to those who survived.
Medicaid Costs-Children’s Coverage in Texas

- 39% Medicaid and CHIP
- 44% Employer-sponsored insurance
- 2% Other, including Medicare, Tricare, VA
- 5% Direct purchase, including Marketplace
- 11% Uninsured
Medicaid Costs

• In 2017, the number of uninsured children increased for the first time in a decade, 276,000 more US children became uninsured, including 83,000 in Texas

• In 2018, the number of children enrolled in Medicaid and CHIP fell by about 840,000 nationwide, including 145,781 in Texas.
Medicaid Costs

• ~54% of all Texas births (204,000) paid by Medicaid

• $3.5 billion per year in birth and delivery-related services for moms and infants through first year
  - >67% of Medicaid costs for hospitalized newborns tied to billing codes for prematurity

• Newborn costs (1st year)
  - Preterm infant: $100,000
  - Term infant: $572
# Texas Solutions

<table>
<thead>
<tr>
<th>Healthy Women</th>
<th>Healthy Mothers</th>
<th>Healthy Babies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual and Public Awareness and Knowledge</strong></td>
<td><strong>Professional Education</strong></td>
<td><strong>Community Empowerment</strong></td>
</tr>
<tr>
<td>Increase Knowledge to Change Attitudes and Behaviors for Improved Maternal and Infant Health Outcomes</td>
<td>Strengthen Competencies and Prepare Professionals to Optimize Clinical Outcomes</td>
<td>Engage Community Partners to Strengthen Networks for Collaboration, Innovation, and Collective Impact</td>
</tr>
<tr>
<td><strong>DSHS Maternal and Child Health Knowledge, Leadership, and Partners</strong></td>
<td><strong>Community Improvement</strong></td>
<td><strong>Perinatal Quality Improvement Network</strong></td>
</tr>
<tr>
<td></td>
<td>Foster Development of Environments that Reduce Barriers, Promote Healthy Lifestyle Choices, and Optimize Maternal and Infant Health Outcomes</td>
<td>Drive System Changes to Support Adoption and Diffusion of Quality Improvements for Maternal and Infant Health and Safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DSHS Maternal and Child Health Epidemiology, Surveillance, Research, and Analytics</strong></th>
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<tbody>
<tr>
<td>Someday Starts Now Peer Education Program Peer Dads Program One Key Question Support from Day One Information for Parents of Newborn Children</td>
</tr>
<tr>
<td>Online Provider Education HTMB Life Course Conferences DSHS Grand Rounds Lactation Management Trainings and Skills</td>
</tr>
<tr>
<td>HTMB Community Coalitions Collaborative Improvement and Innovation Networks State and National Networks Community Forums</td>
</tr>
<tr>
<td>Texas Mother-Friendly Worksites Program Child Care Health Care Public Spaces</td>
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</tbody>
</table>

**Source:** Texas Health and Human Services and Texas Department of State Health Services
Individual Solutions

• **STOP**
  - Blaming the victim
  - Denying implicit bias regarding gender, socioeconomic status, and race

• **LOOK**
  - Patients in the eyes
  - For opportunities to empower
  - For evidence-based best practices

• **LISTEN**
  - Without judgement
  - With empathy
Thank You

As we challenge ourselves to improve the health of our nation

– standing with mothers and babies
Medicaid’s Role for Pregnancy-Related Care

Usha Ranji, M.S.
Associate Director, Women’s Health Policy, KFF

November 19, 2019
Maternal mortality has been in the spotlight

- Maternal Mortality Review Committees in most states - Data and documentation have been critical and improving.

- Clinical quality improvement efforts show promising results.

- Reproductive justice highlights needs to address complex, historic challenges, that include poverty, racism and bias, workforce diversity, access to care throughout lifespan.

- Improving maternal outcomes also means care BEFORE and AFTER pregnancy.

**Pregnancy-related maternal mortality ratio (per 100,000 live births)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>16.9</td>
</tr>
<tr>
<td>White</td>
<td>13</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.3</td>
</tr>
<tr>
<td>Black</td>
<td>42.4</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>14.1</td>
</tr>
<tr>
<td>American Indian / Alaska Native</td>
<td>30.4</td>
</tr>
</tbody>
</table>

Medicaid is the leading financier of maternity care in many states

- Medicaid covers 43% of births nationally.

- Minimum federal income threshold for Medicaid coverage of pregnant women is 138% FPL.

- Maternity services are mandatory under Medicaid, no cost-sharing is permitted.

- Coverage for women before, during, and after pregnancy, as well as access to primary, preconception, interconception, and preventive services are important for addressing maternal health.

- Post-partum coverage under traditional Medicaid ends at 60 days.

- Infants are covered for the first year of life.

Medicaid covers one in five reproductive age women and four in ten children.

**Health Insurance Coverage of Women Ages 15-49**
- 59% Employer Sponsored
- 20% Medicaid
- 12% Non-Group
- 2% Non-Employer
- 2% Other
- 5% Uninsured

**Health Insurance Coverage of Children, 0-18**
- 49% Employer Sponsored
- 39% Medicaid
- 2% Non-Group
- 5% Other
- 2% Uninsured

Significant differences in coverage by race/ethnicity

Health Insurance Coverage Among Women of Reproductive Age, by Race/Ethnicity, 2017

NOTES: Data reflect coverage in 2017 among women 15-49. “Other” includes those covered under the military or Veterans Administration as well as nonelderly Medicare enrollees.

On in ten children in Texas, Alaska, and Wyoming are Uninsured

Kaiser Family Foundation estimates based on the Census Bureau’s American Community Survey, 2018.
Total monthly enrollment in Medicaid and CHIP dropped for both programs between December 2017 and December 2018

In expansion states, most postpartum mothers can continue on Medicaid or qualify for subsidies.

Medicaid eligibility thresholds for pregnant women in expansion states, 2019

Eligible for Federal ACA Subsidies up to 400% FPL

Eligible for Medicaid post partum up to 138% FPL

NOTES: For pregnant women, reflects highest eligibility limit for pregnant women under Medicaid, CHIP, or the unborn child option. In 2019, the federal poverty level (FPL) was $21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.

SOURCE: Based on national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
In most non-expansion states, poor postpartum women fall in the coverage gap: Ineligible for ACA subsides or Medicaid

Medicaid eligibility thresholds for pregnant women and parents (family of three, 2019)

NOTE: For pregnant women, reflects highest eligibility limit for pregnant women under Medicaid, CHIP, or the unborn child option. For “Parents,” eligibility limits calculated as a percent of the Federal Poverty Level (FPL) & are calculated based on a family of three for parents. In 2019, the FPL was $21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.

SOURCE: Based on national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Medicaid expansion results in fewer uninsured women pre and post pregnancy

Themes from current maternal health efforts in Congress and states

• **Congressional interest in strengthening maternity care**
  - House: H.R. 4996, MOMS Act (Rep. Kelly) - Creates State option to extend continuous coverage, with full benefits from 60-days postpartum to 12 months; requires greater research on potential coverage and impact of doulas under Medicaid (currently covered in OR, MN, NY)
  - H.R. 4995 (Rep. Engel) – focus on grant funding for strengthening rural maternity services
  - Senate: Rural MOMS Act (Sens. Smith, Murkowski, Jones, Capito) - rebuilding maternity services and expanding and diversifying maternity workforce in rural areas

• **State efforts to extend postpartum coverage beyond 60 days**
  - Illinois - Expansion state with Medicaid eligibility for new moms up to 12 months
  - Tennessee – Recent three-year pilot proposed
  - Missouri - Waiver pending to “extend” coverage to postpartum women with substance misuse disorders
  - California – Extend Medicaid to 1 year for women with maternal mental health condition
  - Wisconsin – parental eligibility threshold 100% FPL
Thank you.
Addressing Maternal Mortality and Morbidity in Illinois

Kelsie Landers, LMSW
klanders@everthriveil.org
November 19, 2019
OUR MISSION

EverThrive Illinois works to improve the health of women, children and families over the lifespan.

OUR VISION

EverThrive Illinois envisions a society in which all Illinoisans are able to live their healthiest life.

OUR VALUES

- Strong Partnerships
- Diverse Voices
- Health Equity
Addressing Maternal Mortality and Morbidity

- **IDPH 2018 Report**

Key findings:
- In IL, an average of 73 women die each year of a pregnancy-related cause
- In IL, non-Hispanic Black women are six times as likely to die of a pregnancy-related condition than non-Hispanic White women
- In IL, 72% of the pregnancy-related deaths and 93% of violent pregnant-associated deaths were deemed preventable by review committees
IDPH Policy Recommendations

• Illinois should expand Medicaid eligibility for the postpartum period from 60 days to one year after delivery and health insurance plans should cover case management and outreach for high-risk postpartum women for up to one year after delivery.

• The General Assembly should pass legislation to adopt the American College of Obstetricians and Gynecologists’ recommended maternal levels of care within the state’s regional perinatal system.

• The State should create or expand home visiting programs to target high-risk mothers, such as doula programs, in Illinois during pregnancy and the postpartum period. The State should also expand efforts to provide universal home visiting to all mothers within three weeks of giving birth.
IDPH Policy Recommendations

• Illinois should **increase access to substance use and mental health services** statewide for pregnant and postpartum women.

• Hospitals should have **clear policies for emergency departments** to identify pregnant and postpartum women, and to consult with an obstetrical provider for all women with specific triggers indicative of pregnancy or postpartum complications.

• Health insurance plans should **separate payment for visits in the postpartum period from labor and delivery** (unbundle postpartum visit services from labor and delivery).
Legislation

• SB 1909, Senator Cristina Castro’s Maternal Mortality Omnibus – did not pass

- Expand Medicaid to 12-months postpartum
- Doula Medicaid reimbursement
- Family Planning SPA, 200% FPL
- Uncap substance use and mental health services in the 12-mo period (private insurance)
Policy Changes- In Process

• Illinois expanded Medicaid 12-mo pp through budget implementation
  • Unappropriated
  • Status of 1115

• Advocating for family planning SPA
• Assessing what other states have done re: doula reimbursement
EverThrive IL

Maternal and Child Health Advocacy

• Cover all postpartum people in the 12-mo expansion
• Advocate for other policy recommendations to address maternal mortality and morbidity
• Convene the IL WIC Coalition
• Plan a large-scale Chicago Collaborative for Maternal Health outreach project
2018 Coalition Report with:
- The Greater Chicago Food Depository
- Shriver Center on Poverty Law
- Ounce of Prevention Fund

State and Federal Recommendations
- Child Nutrition Reauthorization Act
  - Encourage flexible food substitutions
- Increase funding for breastfeeding peer counselors
- Encourage pilot programs that bring BPCs to homes and hospitals
- Fund outreach
Chicago Collaborative for Maternal Health

The Chicago Collaborative for Maternal Health will leverage these strengths to build awareness, foster collaboration, and drive quality of care to accomplish one goal: combat the maternal mortality crisis in Chicago and help women thrive.

Aim 1: Quality
Lead a quality improvement collaborative to improve health care quality for women receiving care in the outpatient clinics

Aim 2: Community
Implement a community engagement effort to improve awareness about maternal mortality and morbidity prevention and empower women

Aim 3: Policy
Advocate for policy and systems change to sustain improvements in health and health care and social service providers

This program is supported by funding from Merck, through Merck for Mothers, the company’s $300 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

Alliance Chicago
Ever Thrive Illinois
Questions?