REPORT OF TMA PRESIDENT
Adopted on May 19, 2018

Subject: Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Presented by: Carlos J. Cardenas, MD, President

Referred to: Reference Committee on Socioeconomics

In September 2017, the Texas Medical Association and the Texas Department of State Health Services (DSHS) hosted a Maternal Health Forum. Based on the interest in and need for solutions to issues identified at this forum, TMA President Carlos J. Cardenas, MD, established the TMA Maternal Health Congress to develop and frame TMA's policy and advocacy on maternal health for the 86th legislative session. The congress consisted of members of TMA's Council on Science and Public Health, Council on Legislation, and Select Committee on Medicaid, CHIP, and the Uninsured, along with numerous statewide physician experts representing multiple specialties.

On March 24, 2018, the TMA Maternal Health Congress began with 2.75 hours of continuing medical education (CME) programming on maternal mortality and morbidity (MMM) in Texas. More than 80 state health care leaders and TMA physician leaders attended the congress. TMA has created a maternal health website with links to videos of each of the CME presentations at www.texmed.org/MHCongress/.

Presenters identified poor access to health care; limited availability of reproductive health services; and benefit limitations of Medicaid, the Children's Health Insurance Program-Perinatal (CHIP-P), Healthy Texas Women (HTW), and the Family Planning Program (FPP) as contributors to Texas having unacceptable levels of MMM. In addition to access barriers, speakers commented on potential inaccuracies in the reporting of maternal mortality in Texas' death registry system and the impact on MMM of chronic underlying health conditions including hypertension, obesity, diabetes, and substance use among women of reproductive age.

David Lakey, MD, chief medical officer of the UT System and chair of the TMA Council on Science and Public Health, led a panel discussion to consider 36 physician and health leader proposals for improving MMM rates that were submitted in response to TMA's request. The majority of proposals addressed factors identified as barriers to care for women while other proposals addressed quality improvement initiatives, prevention and treatment of behavioral health disorders, and improvements to state health programs for women of reproductive age. A full description of the proposals is on the maternal health webpage.

Texas Maternal Mortality and Morbidity and Health Coverage

Maternal mortality and maternal morbidity are key reflections of overall women's health and access to timely health services before, during, and after pregnancy. Even with the recent state corrections to inaccuracies in the maternal death data from 2012, Texas' data paints a troubling picture: Texas has a high rate of maternal mortality relative to many states and developed countries. Among African-American women, the data are even more alarming. A July 2016 report from Texas' Maternal Mortality and Morbidity Task Force described the most dramatic increase in MMM occurring among black women, who account for 28.8 percent of maternal deaths but only 11.4 percent of Texas births.

Texas' rate of maternal morbidity — severe complications following birth — also have increased dramatically. Nationally, while 700 to 900 maternal-related deaths occur each year, researchers conservatively estimate another 35,000-45,000 women will suffer from a severe maternal complication.

In Texas, most deaths occurred 42 days or more after delivery, the same timeframe in which low-income women lose pregnancy-related Medicaid or other coverage. Texas still leads the nation in the number of people who lack health insurance.

Many assume Texas Medicaid covers all low-income and poor women. In reality, to qualify for Medicaid, a woman must have limited income ***and*** qualify based on pregnancy, disability, or extremely limited resources. Working-age, healthy adult women who earn more than $250 per month do not qualify. Pregnancy-related Medicaid coverage ends 60 days postpartum regardless of post-delivery complications. As a result, low-income Texas women must maneuver through federal, state, and locally funded health programs. Preventive care — including annual exams and contraception— and basic primary care can be obtained via the state's women's preventive health programs, but access and availability varies considerably across the state. Moreover, the demand for services far exceeds capacity. For women needing specialty care, including treatment for substance use disorders (SUDs), the picture is even more dire. DSHS estimates only 9 percent of all Medicaid enrollees, including pregnant women, with a substance use disorder are able to obtain treatment. In 2015, the agency had funding to provide SUD treatment to fewer than 600 indigent pregnant women despite this being a priority population.

For low-income immigrant women, Medicaid is unavailable, except in emergency situations. If a low-income immigrant woman is pregnant, she can enroll in CHIP-P, which covers limited prenatal visits, delivery, and two postpartum visits. CHIP-P does not cover treatment of acute or chronic conditions unrelated to the delivery, including treatment for asthma, heart disease, and mental health and substance use disorders. CHIP-P covers care to support the fetus and not the mother. For those covered by CHIP-P, there is no automatic enrollment into Medicaid if income status or eligibility changes (for a detailed overview of women's health care programs, go to www.texmed.org/MHCongress/.

Adult women with an income between 100 percent and 400 percent of the federal poverty level qualify for federal subsidies for coverage purchased via the federal health care marketplace, though affordability of policies purchased there is an increasing concern.

Overview of Proposals and Testimony

Members of the Maternal Health Congress received testimony on each of the 36 proposals and organized them into five areas: (1) access to care, (2) behavioral health prevention and treatment, (3) access to long-acting reversible contraceptives, (4) quality improvement initiatives, and (5) public health programming.

(1) Access to care

Half of the 36 proposals urged TMA to ardently pursue reforms that increase health care coverage for women. Nineteen percent of adult Texas women lack health care coverage, three points higher than the overall statewide average. Rates are higher among women of color, low-income women, and immigrants. Uninsured women are less likely to receive preventive primary and specialty care they need to be healthy, foregoing everything from annual well-woman exams and high blood pressure screenings to behavioral health care and prescription medications.

The lack of regular medical care means uninsured (and underinsured) women tend to have poorer health outcomes, which is borne out in Texas by high rates of MMM. Late entry to prenatal care has been independently linked to increased rates of maternal mortality and severe maternal morbidity According to the Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report, July 2016, 60 percent of maternal deaths occur between six weeks post-delivery and one year following delivery. One important

barrier for postpartum care to low-income women is lack of Medicaid coverage. Fifty-three percent of Texas births are paid by Medicaid, but Medicaid coverage for these low-income pregnant women ends 60 days postpartum with no exception. When this happens, women no longer have access to comprehensive coverage to manage and treat pregnancy-related complications.

Federal law allows states to extend coverage to no-disabled, working-age adults earning less than 138 percent of poverty ($16,753 per year for an individual; $34,638 for a family of four), with 90 percent of the costs paid by the federal government. The law also gives states some flexibility to customize their programs to meet their own residents' needs, such as tailoring benefits or requiring copayments. The law does not allow states to narrow eligibility to include only certain populations. However, the current administration may be willing to accommodate a request to cover only low-income adult women or other subset populations.

Existing TMA policy 190.032 Medicaid Coverage and Reform, adopted in 2013, supports the use of federal funds to develop a Texas-designed program to provide health insurance to eligible low-income adults with incomes below 138 percent of poverty. To date, 33 states have done so, and several others have submitted proposals to the Centers for Medicare & Medicaid Service for review.

Participants in the congress readily acknowledge that Texas' legislative and budgetary environment in 2019 will make it challenging for TMA to make progress towards implementing existing policy for all low-income adults. But bipartisan support to address Texas' maternal health crisis might be an opportunity to at least improve coverage for women of reproductive age. There was widespread testimony in support of undertaking all available options to substantially reduce rates of MMM. Motherless households can present dire long-term consequences for children, families, and the state's economy. Several testifiers spoke to the detrimental impact of adverse childhood events — such as the loss or disability of a mother — to the long-term health of families and communities.

Extending coverage not only would improve women's health but also is fiscally sound policy because Texas uses general revenue dollars to pay for services that could be covered by federal dollars. As just one example, Texas could mitigate a significant portion of its Child Protective Services (CPS) costs by investing in appropriate substance use disorder treatment for pregnant and postpartum women. Estimates show that two-thirds of CPS interventions stem from SUDs among parents.

TMA will continue to promote legislative private-public solutions to achieve universal health care coverage consistent with existing TMA policy.

(2) Behavioral health

According to the most recent data compiled by the Texas Maternal Mortality and Morbidity Task Force, drug overdoses are the leading cause of maternal death during and after pregnancy, with most deaths occurring after the 60-day postpartum period. In the majority of cases, a combination of drugs was used, though opioids were detected in 58 percent of cases. For women enrolled in Medicaid, substance use disorder treatment is available as well as treatment for co-occurring mental health conditions. Because services are not uniformly available statewide and capacity at existing facilities is limited, few eligible women actually receive the services despite pregnant women being a priority population. When pregnancy-related Medicaid ends, adult enrollees are automatically enrolled in Healthy Texas Women, but HTW covers only basic depression treatment. Specialty care is not covered. Other services like counseling or therapy also are not included under HTW. The Family Planning Program does not provide mental health screening or treatment. Pregnant and postpartum women ineligible for Medicaid do have access to Texas' publicly funded SUD treatment, but there are limitations on what services are available and narrow eligibility criteria.

To prioritize access to SUD treatment for pregnant and postpartum women, reduce maternal mortality and morbidity from SUD, and enhance SUD treatment, testimony emphasized that treatment should cover all pregnant women and postpartum women regardless of their drug of choice or method of use, and include accommodations for mothers and babies to stay together. Addressing diagnosis and treatment of SUD without stigma and with the goal of maintaining the mother-baby dyad is imperative.

Mental health conditions such as maternal depression also affect health outcomes for pregnant and postpartum women. These women may experience a mental health condition alone or in addition to a SUD. Co-occurring disorders require proper diagnosis and treatment. The Texas Maternal Mortality and Morbidity Task Force reports that suicide is one of the top reasons for maternal death after seven days postpartum.

TMA will continue to advocate that pregnant and postpartum women be prioritized for treatment of a substance use disorder. Part of that advocacy effort is to ensure the availability of support services for children, eliminating any possibility that child care is a barrier to the mother's participation in treatment. In addition, TMA will explore and advance opportunities such as Project Echo and others that promote telemedicine and telehealth solutions to increase access to treatment for pregnant and postpartum women with substance use disorders.

TMA will encourage the American College of Obstetricians and Gynecologists (ACOG) to support physician screening of patients by identifying payment codes for screening and providing information on evidence-based approaches developed by the U.S. Substance Abuse and Mental Health Services Administration to identify and support patients with a substance use disorder.

(3) Long-acting reversible contraceptives

In Texas approximately half of pregnancies are unplanned. Increasing women's ability to plan and space their pregnancies leads to lower abortion rates, improved infant and maternal health, educational and economic opportunities for women and their families, and cost savings for the state. Women who plan pregnancies are more likely to get prenatal care early, have healthier pregnancies, and reduce their risk of having babies born too early or too small. Additionally, women whose pregnancies are unintended are more likely to have a short interval between pregnancies —18 months or less — significantly increasing health risks for both women and infants.

Besides the impact to women and families, unintended pregnancies increase Medicaid costs. The Texas Health and Human Services Commission (HHSC) reports that in 2015 Medicaid paid for 52 percent of all births in Texas, at a cost of $3.5 billion per year for pregnancy- and delivery-related services for moms and infants in the first year of life.

Continued reductions in the number of unplanned pregnancies must be a key component of Texas' efforts to improve maternal health. At the congress, physicians urged TMA to undertake advocacy and educational initiatives to increase women's access to long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices, which are 20 times more effective than other methods. While Texas Medicaid, Healthy Texas Women, and the Family Planning Program do cover LARCs as a benefit, physicians testified their usage among women who want LARCs still remains low, despite legislative guidance to HHSC to increase availability through policy and educational initiatives. Many physicians, hospitals, and clinics do not offer same-day availability of LARCs for women because of low payment, logistical hurdles, and insufficient training on how and when to use LARCs.

TMA's policy 260.075 Preventive Health Care for Texas Women promotes availability of long-acting reversible contraceptives to women. TMA will convene an expert panel of physicians, hospital

administrators, nurses, LARC manufacturers, and state agency officials to identify and resolve barriers preventing widespread availability of LARCs to low-income women.

(4) Quality improvement initiatives

Three proposals called for more consistency in implementing guidelines, standardized protocols, evidence, and other proven resources to reduce maternal mortality and morbidity. Several resources and tools were discussed, including ACOG and the national Alliance for Innovation on Maternal Health (AIM) Maternal Safety Bundles; the Association of Women's Health Obstetric and Neonatal Nurses safety bundles; and toolkits developed by the California Maternal Quality Care Collaborative, which provide important patient safety advances for the health of the mother and child.

Congress attendees discussed making use of the AIM bundles voluntary but readily available to hospital medical staff leaders. In particular, several testifiers said the AIM Maternal Safety Bundles for Obstetric Hemorrhage and for Severe Hypertension in Pregnancy should be prioritized. Women with cardiovascular risk in pregnancy and those who develop hypertension and preeclampsia with a targeted follow-up strategy also should be prioritized. There was widespread support for the development and implementation of quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery, and postpartum health outcomes.

(5) Public Health Interventions

Thirteen proposals submitted called for a range of public health activities to prevent or address maternal mortality and morbidity. These proposals addressed physician training and education, public awareness, improving current benefits and resources of state public health programs for women, and identifying chronic conditions associated with MMM.

State and local public health agencies have a key role in monitoring, and assessing public health and an important component of that role is the analysis of maternal health data. Maternal death records and other data must be accurate to enable the state to assess maternal health status and to identify populations at risk. These data are then used to inform the public on how to prevent adverse health events and to develop interventions to improve health status for women of reproductive age.

Discussion supported proposals that called for better surveillance of maternal mortality and improving physician access to the health records of women of reproductive age, especially those at higher risk of poor maternal health outcomes. They noted that physicians often do not have access to the patient's complete social or medical history. Not infrequently, physicians use an electronic health record, but health information exchange systems do not support interoperability, so physicians cannot access all of a woman's health records. Further, the state's limited health coverage prevents or complicates a physician's ability to provide optimal follow-up care. Several testifiers focused on the importance of quality and accuracy of death records. Suggestions for improving the records included partnering with DSHS to train physicians in their use and working with hospitals to ensure death summaries are captured accurately as part of the review of maternal deaths.

A member of the Texas Maternal Mortality and Morbidity Task Force proposed that TMA engage physicians in understanding the implicit racial bias that may influence care provided to some pregnant women, and black women in particular. TMA will work with others to convene a physician focus group to assess physician bias as a strategy to reduce health disparities. National models are not available, and this provides an opportunity for TMA to facilitate Texas' leadership in this area.

There also was testimony in support of TMA's role in promoting public awareness, such as through the Texas Medical Association Foundation providing seed grants to TMA members, residents, and medical students. These grants could support research and quality projects related to maternal mortality and

morbidity; implement best practice guidelines for perinatal and postpartum care; support local awareness activities such as a "march for mothers"; and increase the public's awareness of the importance of early entry into prenatal care, follow-up postpartum care, and the warning signs of postpartum mood disorders.

Physicians spoke in support improving provider networks and quality of current public women's health programs including Healthy Texas Women and the Family Planning Program; supporting payment for screening, brief intervention, and referral to treatment for substance use disorders; and ensuring HTW and FPP provide additional health benefits for women at greater health risk. Offering women who smoke access to counseling and education to support smoking cessation would be an example.

TMA must advocate for the enhancement of the state's public health programs for women of reproductive age and ensure these state programs address the prevention and management of chronic diseases that have an impact on maternal health. This includes a focus on evidence-based disease prevention services such as screening for substance use and smoking cessation programs, as well as appropriate support services such as transportation and support for models of maternal medical homes.

Conclusion

The TMA Maternal Health Congress provided a unique opportunity for TMA members and allied organizations to articulate a compelling case for Texas to invest much-needed resources towards substantially improving the health for women of childbearing age. Texas must do a much better job providing physicians, hospitals, and communities with accurate, timely, and reliable data on women's health — data that can be used to design effective policy and programmatic interventions.

Pregnancy is a brief period in most women's lives. To ensure healthy birth outcomes, Texas women must have access to appropriate preventive, primary, and specialty care across their reproductive lifespans if the state is going to reduce unacceptable levels of maternal mortality and morbidity. As one testifier said, the death — or grievous illness or injury — of any mother is one too many. Let's get to work.

Adopted 1: That the Texas Medical Association pursue legislation authorizing the Texas Health and Human Services Commission to: (a) submit a federal Medicaid 1115 demonstration waiver requesting approval to design and implement a tailored health benefits program for eligible uninsured women of childbearing age that provides 12 months' continuous coverage for preventive, primary, and specialty care coverage, including behavioral health services, to women before, during and after pregnancy; (b) ensure adolescents aging out of the Children's Health Insurance Program (CHIP) are seamlessly enrolled into Healthy Texas Women; (c) ensure women losing CHIP-Perinatal are seamlessly connected to the Family Planning Program to avoid gaps in preventive health care; and (d) implement initiatives that improve early-entry prenatal care, including a statewide campaign on the importance of prenatal care during the first trimester, expediting Medicaid eligibility and enrollment for pregnant women, promoting use of telemedicine for routine prenatal care, and reforming the Medicaid transportation program to ensure pregnant women with young children can travel with their children to obtain preventive services.

Adopted 2: That the Texas Medical Association develop a continuing medical education program for physicians that covers: (1) information on publicly funded support services for women with substance use disorders (SUDs); (2) guidelines for the prescribing of opioids and pain management; (3) efforts to better connect SUD treatment physicians and providers with women's health physicians and providers to ensure women undergoing treatment for these disorders are able to obtain preventive health care services, and (4) diagnosis and treatment of behavioral health issues such as anxiety and depression.

Adopted 3: That the Texas Medical Association develop legislation to: (1) allocate sufficient state resources to resolve red tape and payment barriers preventing widespread adoption of long-acting reversible contraceptives (LARCs), including ensuring the state pays physicians, hospitals, and clinics

their full LARC acquisition costs so women can obtain a LARC according to clinical best practice; (2) ensure availability of LARCs immediately following delivery to women enrolled in the Children's Health Insurance Program (CHIP)-Perinatal; and (3) remove roadblocks preventing teens from simultaneously enrolling in CHIP and Healthy Texas Women to obtain contraceptive services with parental consent.

Adopted 4: That the Texas Medical Association develop a continuing medical education program, in partnership with the American College of Obstetricians and Gynecologists District XI (Texas Chapter), Texas Association of Obstetricians and Gynecologists, and Texas Academy of Family Physicians, designed to increase patients' and physicians' awareness of long-acting reversible contraceptives as the most effective form of contraception.

Adopted 5: That the Texas Medical Association develop continuing medical education programs on: (1) quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery and postpartum health outcomes; and (2) implementation of hospital-based quality improvement initiatives that reduce maternal mortality and morbidity, based on best practice and standardized protocols.

Adopted 6: That the Texas Medical Association introduce legislation to improve the quality of health data records for women of reproductive age to support patient health, the quality of maternal death records, and the exchange of health information for women of reproductive age. The legislation should encompass: (a) support of comprehensive efforts to improve the state's surveillance of maternal mortality and ensuring Texas' maternal death records have accurate information on the factors associated with maternal deaths; (b) mandates to the Texas Department of State Health Services to develop training and educational materials for physicians and other medical certifiers to accurately report maternal deaths; and (c) mandates to electronic health record systems to improve the interoperability of health records, including resolution of barriers that are preventing the exchange of health information critical to providing quality maternal and postpartum care.

Adopted 7: That the Texas Medical Association develop a public campaign to increase awareness of the importance of early and timely maternal health care and promote existing community-based efforts.

Adopted 8: That the Texas Medical Association adopt as formal policy the goals of eliminating maternal mortality in Texas.

Sources:

1. Nearly Dying In Childbirth: Why Preventable Complications Are Growing In U.S., National Public Radio, Dec. 22, 2017.
2. Health Insurance Coverage and Health — What the Recent Evidence Tells Us, Benjamin D. Sommers, MD, PhD; Atul A. Gawande, MD, MPH; and Katherine Baicker, PhD, *New England Journal of Medicine*, August 2017.
3. Texas Maternal Mortality and Morbidity Task Force, 2016.
4. Texas HHSC, Medicaid and CHIP: An Overview, February 2017.