The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

June 16, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Calder Lynch
Deputy Administrator and Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Dear Administrator Verma and Deputy Administrator Lynch:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing over 60,000 physicians and partners dedicated to advancing women's health, thank you for your work to date to address our nation's unacceptable maternal health crisis. In addition to this crisis, the United States is also confronting the COVID-19 pandemic and the effects of systemic and persistent bias and racism. As physicians dedicated to providing quality care to women, ACOG is concerned that the challenges our country is facing will further exacerbate the maternal mortality crisis and deepen racial inequities in access to care and health outcomes. **To help address this concern, we urge the Centers for Medicare and Medicaid Services (CMS) to prioritize the review and approval of Section 1115 waiver applications that seek to extend Medicaid coverage for pregnant women beyond 60 days postpartum as you begin to resume regular activity across the agency.**

Continuous access to Medicaid is crucial to addressing our nation's rising rate of maternal mortality. Medicaid paid for 43 percent of U.S. births in 2018, including 50 percent of births in rural areas, 60 percent of births to Latina women, and 66 percent of births to Black women.[1] Under current law, women who are eligible for Medicaid based on the fact that they are pregnant become ineligible for coverage 60 days after the end of pregnancy.[2] While some women are able to successfully transition to other sources of coverage at this time, many are left in the untenable position of being uninsured shortly after a major medical event.[3,4]

The Centers for Disease Control and Prevention (CDC) considers insurance coverage disruptions to be one of many contributing factors to high rates of maternal mortality among the Medicaid-eligible population.[5] Importantly, half of all uninsured new mothers report losing Medicaid after pregnancy as the reason they became uninsured.[6] These coverage disruptions also disproportionately affect women of color; nearly half of all non-Hispanic Black women had discontinuous insurance from pre-pregnancy to postpartum and half of Hispanic Spanish-speaking women became uninsured in the postpartum period.[7] Moreover, we know that women with Medicaid coverage during their pregnancy are at increased risk for poor maternal health outcomes compared to their privately insured counterparts.[8]

As CMS is aware, there are major risks to becoming uninsured shortly after experiencing pregnancy. Nearly 70 percent of women report experiencing at least one physical problem during the 12-month postpartum period.[9] One in seven women experience symptoms of postpartum depression in the year after giving birth, and evidence suggests women with substance use disorder are more likely to experience relapse and overdose 7-12 months postpartum.[10,11] According to new research from the Urban Institute examining access and affordability challenges facing uninsured new mothers, almost one-third of women who lost Medicaid coverage and became uninsured in the postpartum period were obese before their pregnancy, and 18 percent reported either gestational diabetes or pregnancy-related hypertension – all conditions that require ongoing monitoring and treatment after giving birth.[12] In addition, about one-third of the women who lost coverage were recovering from a cesarean section and just over one-quarter reported being depressed sometimes, often, or always in the months after giving birth.[13]

Moreover, a recent report from the Health Care Cost Institute (HCCI) demonstrates that more than 70 percent of postpartum health care spending occurs more than 90 days and up to one year after the end of pregnancy.[14] While the HCCI data set is limited to women with employer-sponsored insurance (ESI), spending and utilization patterns of the ESI population can be useful for Medicaid policy. For example, this report demonstrates that women are utilizing health services – including surgeries, emergency and ambulatory care, and evaluation and management services – well beyond the pregnancy-related Medicaid coverage cutoff.[15] In fact, these low-frequency, high-cost services account for more than 40 percent of all postpartum spending.[16] The HCCI findings demonstrate the value of insurance in the full year after the end of pregnancy and that health care utilization does not meaningfully decrease after the first several weeks postpartum.

Many of these postpartum health risks could be mitigated if women were able to maintain coverage through the Medicaid program. Indeed, ACOG clinical guidance recommends that postpartum care be an ongoing process "with services and support tailored to each woman's individual needs."[17] This may include physical recovery from birth, an assessment of social and psychological well-being, chronic disease management, and initiation of contraception, among other services.[18] The time-limited nature of pregnancy-related Medicaid, however, makes it difficult for obstetrician-gynecologists and other health care professionals to provide the care that women need for the full 12-month postpartum period. Instead, pregnancy-related Medicaid's arbitrary 60-day cliff increases patient risk for poor health outcomes, including maternal mortality.

Approximately 30 percent of pregnancy-related deaths—not counting those that were caused by suicide or overdose—occur 43 to 365 days postpartum.[19] State analyses of maternal deaths, which include behavioral health-related causes, often find that 50 percent or more of deaths occur between 43 and 365 days after the end of pregnancy.[20] For example, 56 percent of all maternal deaths in Texas occurred after Medicaid's 60-day cliff.[21,22] In West Virginia, 62 percent of all maternal deaths occurred more than 60 days postpartum.[23] It is also important to note the stark racial disparities in maternal health; Black women experience maternal mortality at three times the rate of white women.[24]

These data have led multiple state maternal mortality review committees (MMRCs) to recommend extending Medicaid coverage beyond 60 days to 12 months postpartum. MMRCs see extending coverage as a way to reduce preventable maternal deaths, including those linked to cardiovascular disease, cardiomyopathy, and overdose and suicide. The Illinois MMRC, for example, recommends that Illinois "expand Medicaid eligibility for the postpartum period from 60 days to one year after delivery."[25]

Recent MMRC reports from Arizona, Georgia, Maryland, Texas, Utah, and Washington also call for extending Medicaid coverage to one year postpartum.[26,27,28,29,30,31]

While there is currently no definitive data on the long-term cost savings of improved maternal health outcomes from extending pregnancy-related Medicaid beyond 60 days postpartum, it is undeniable that the extension of postpartum coverage would result in cost savings for both the states and the federal government. According to one study, the average total per patient costs in 2013 for Medicaid-enrolled pregnant women with severe maternal morbidity was $10,134 compared to $6,894 for women without severe maternal morbidity, highlighting the potential savings associated with proper management of these conditions.[32] Reducing churn in the Medicaid program has also been found to lower monthly per capita spending and can help reduce administrative costs.[33] By providing 12 months of continuous coverage after the end of pregnancy, states can create administrative efficiencies and therefore cost savings by conducting a mother's redetermination at the same time as her infant's instead of doing two separate redeterminations at different times.[34]

Moreover, keeping women in the system enables patients and their obstetrician-gynecologists or other clinicians to address any ongoing health concerns, including those unrelated to pregnancy, before any subsequent pregnancies. This is especially important for women on Medicaid who are more likely to have had a prior preterm birth or low birthweight baby and experience certain chronic conditions, like substance use disorder, and maternal morbidity.[35,36] Addressing these concerns will help avoid long-term costs due to untreated conditions that may impact future pregnancies. Any potential savings from a postpartum coverage extension will be critical as our nation recovers from the economic toll of the COVID-19 pandemic.

Medicaid has a critical role to play in protecting our nation's mothers from adverse maternal health outcomes, including those linked to COVID-19. Given these two public health crises and their unique impact on pregnant and postpartum women, particularly women of color, ACOG urges CMS to act swiftly to review and approve Section 1115 waiver applications that seek to extend Medicaid coverage for pregnant women beyond 60 days postpartum. Granting states the flexibility they seek to extend postpartum coverage is more critical now than ever.

Thank you for your consideration of our comments as you continue your work to respond to the maternal health crisis and the COVID-19 pandemic. ACOG looks forward to our continued partnership on these critical issues. To discuss the above recommendations further, please contact Emily Eckert, Manager, Health Policy, at eeckert@acog.org.

Sincerely,

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Senior Director, Health Economics & Practice Management

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[15] Ibid.
[16] Ibid.
[17] Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;131:e140–50.
[18] Ibid.
[19] In 2018, a total of 658 women were identified as having died of maternal causes in the United States, and an additional 277 deaths were reported as having occurred more than 42 days but less than 1 year after delivery in 2018. These numbers are based on an updated method of coding (the "2018 method") maternal deaths based on the implementation of a revised U.S. Standard Certificate of Death. See Centers for Disease Control and Prevention, "Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018," available at: https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69_02-508.pdf.
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