Addressing the Maternal Health Crisis: The Biden-Harris Administration's Blueprint

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According to a new report from the Centers for Disease Control and Prevention, from 2017–2019, roughly 84 percent of pregnancy-related deaths in the U.S. were preventable.[1] Black and Indigenous women and Black and Indigenous birthing people continue to die at exponentially higher rates than their white counterparts.[2] Equitable, whole-of-government, and systemic solutions are urgently needed.[3]

Fortunately, the Biden-Harris Administration (Administration) has demonstrated a key interest in efforts to improve maternal health and addressing racial inequities in maternal health outcomes. In April 2021, President Biden issued the first-ever presidential proclamation for Black Maternal Health Week, In December 2021, Vice President Harris hosted the first-ever federal White House Maternal Health Day of Action, which underscored the need to end the crisis. In April 2022, during the second annual Black Maternal Health Week, Vice President Harris convened the first-ever meeting with cabinet secretaries and agency leaders to discuss the Administration's whole-of-government approach to fighting the maternal mortality crisis.[4] At that meeting, they stressed the importance of treating women and people capable of pregnancy as "whole human beings" by addressing the full range of factors that shape maternal health outcomes.[5]

On June 24, 2022—the same day that the Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*—the Administration released its *White House Blueprint for Addressing the Maternal Health Crisis* (*Blueprint*).[6] Through the *Blueprint*, the Administration articulates a vision for "a future where every person in this country can have a safe, dignified pregnancy and birth and where equitable access to health care before, during, and after pregnancy is assured."[7] It recognizes that achieving this vision will only be possible if we counter systemic racism in our health care system, laws and public policies, and public and private institutions. It will also require "bold, unprecedented action through a whole-of-government strategy, including coordinated efforts from multiple federal agencies."[8]

Consistent with this vision, the *Blueprint* lays out five goals and corresponding actions to address the maternal health crisis:

1. Increasing access to and coverage of comprehensive high-quality maternal health services, including behavioral health services;
2. Ensuring those giving birth are heard and are decisionmakers in accountable systems of care;
3. Advancing data collection, standardization, harmonization, transparency, and research;
4. Expanding and diversifying the perinatal workforce; and
5. Strengthening economic and social supports for people before, during, and after pregnancy.

On the whole, the *Blueprint* operates as a comprehensive guide to the Administration's prior and forthcoming actions to address the U.S. maternal health crisis.[9] It is a valuable tool for health advocates who wish to understand the Administration's maternal health policy strategy. In this issue brief, we offer some major takeaways.

Goal 1: Increase Access to and Coverage of Comprehensive High-Quality Maternal Health Services, Including Behavioral Health Services

The Administration's first goal is to close coverage gaps, improve access to high-quality care, and address geographical barriers to access.[10] Among other priorities, Goal 1 includes actions to help ensure that people have "comprehensive, continuous health coverage during pregnancy, and for no less than 12 months following the end of pregnancy."[11]

Under federal law, state Medicaid programs are required to provide at least pregnancy-related coverage to people with the higher of 133 percent of the federal poverty level or the state's Medicaid income limit for pregnancy-related coverage.[12] Pregnancy-related Medicaid and Children's Health Insurance Program (CHIP) coverage runs until the last of the month in which the 60th day after the end of a pregnancy falls.[13] Because many causes of pregnancy-related morbidity or mortality occur up to a year after delivery, many people with low incomes lose coverage long before significant health needs or dangers arise.[14] Nearly a quarter of pregnancy-related deaths occur after 41 days postpartum.[15]

The American Rescue Plan Act, enacted March 2021, sought to address this gap by creating a new state plan amendment option to extend Medicaid and CHIP postpartum coverage to one year.[16] As of October 27, 2022, 26 states and Washington, D.C. have adopted this lifesaving option, granting roughly 418,000 people a full 12 months of postpartum coverage.[17] Under the *Blueprint*'s first goal, the Administration articulates that it will continue to encourage states to

leverage this option.[18] It also urges Congress to make 12 months of postpartum Medicaid and CHIP coverage mandatory, rather than a state plan amendment option, nationwide and close the Medicaid coverage gap.

The *Blueprint* also recognizes that solely extending pregnancy-related Medicaid coverage would leave in place harmful coverage gaps that undermine maternal health equity. Twelve states refuse to expand Medicaid, and with it, affordable and continuous health coverage, forcing millions of people with low incomes into the Medicaid coverage gap.[19] This includes over 800,000 women of reproductive age, two-thirds of whom are women of color, exacerbating Black maternal health inequities.[20] Rates of preconception and postpartum Medicaid coverage are significantly lower in nonexpansion states compared to expansion states.[21] People with low incomes who lack health insurance before pregnancy lack the means to identify and address health risks, and can also experience delays in Medicaid enrollment after pregnancy that can delay prenatal care.[22] The *Blueprint* reiterates the Administration's calls on Congress to act and close the Medicaid coverage gap.[23]

Under the Families First Coronavirus Response Act of 2020, state Medicaid programs received enhanced federal funding in exchange for providing continuous coverage through the end of the month in which the public health emergency (PHE) ends.[24] Many people who qualified based on pregnancy have been able to retain health coverage throughout the COVID-19 pandemic, and will do so until the last day of the month in which the related PHE ends.[25] Yet when this requirement expires (likely early in 2023), states will need to redetermine eligibility for approximately 1.7 million people enrolled in a Medicaid or CHIP pregnancy eligibility group.[26] Many will lose coverage, underscoring the urgent need for states to extend pregnancy-related coverage under the American Rescue Plan Act's option and expand Medicaid if they have yet to do so.[27]

Goal 2: Ensure Those Giving Birth are Heard and are Decisionmakers in Accountable Systems of Care

The *Blueprint*'s second goal includes actions on a range of issues. It summarizes the steps the Administration will continue to take to advance the Centers for Medicare & Medicaid Services's (CMS) new "Birthing-Friendly" hospital designation, which will indicate a hospital's participation in maternity care quality activities.[28] It commits to increasing community participation in state maternal mortality review committees, training providers on culturally and linguistically appropriate care, and protecting consumers from unexpected medical bills.[29] It also describes the Administration's actions to help reproductive health care providers make their practices more accessible to people with disabilities and older adults.[30] The *Blueprint* also reflects President Biden's request of $25 million in the Fiscal Year 2023 Budget for Pregnancy Medical

Home demonstration projects.[31] The projects will aim to reduce adverse maternal health outcomes through a new team-based physical, behavioral, and social service care coordination model.

As the *Blueprint* notes, at the time of its publication, the Department of Health and Human Services (HHS) Office for Civil Rights was working on a proposed rule to strengthen implementation of Section 1557, the Affordable Care Act's nondiscrimination provision. HHS unveiled its proposed rule in August.[32] The proposed rule seeks to define sex discrimination to include "pregnancy or related conditions" and recognizes that abortion-related discrimination is sex discrimination. It also aims to restore regulations that clarify Section 1557's application to health services and health plans issued by covered entities that receive federal funds. HHS's proposed changes to Section 1557 regulations are extremely important in the fight to end systemic discrimination in maternal health care. As the National Health Law Program (NHeLP) recently addressed in our comments on the proposed rule, the agency can further strengthen the rule by clarifying specific forms of prohibited sex discrimination related to pregnancy or related conditions.[33]

Goal 3: Advance Data Collection, Standardization, Harmonization, Transparency, and Research

The *Blueprint* addresses the need for robust data collection on maternal health risks, services, and outcomes, and engaging in a systematic review of risk factors for poor pregnancy outcomes.[34] It details actions to improve the collection of maternal health data, including demographic data.[35] Of note, while the *Blueprint* calls for standardized, transparent, and regular data collection of maternal health risks, services, and outcomes, when it comes time to address specific actions, it addresses demographic data in a limited way. It commits to working with Federal Employees Health Benefits (FEHB) plan issuers to improve their collection of critical race and ethnicity data, but does not include disability, variations in sex characteristics, gender identity, sexual orientation, or primary language. Standardized demographic data collection across these dimensions is also critical to understand the scale of related maternal health inequities, as well as the role of ableism, xenophobia, and cisheteropatriarchy in outcomes. Moreover, standardizing demographic data collection beyond the FEHB program, and particularly in Medicaid, is vital. Beyond demographic data, the *Blueprint* reflects CMS's commitment to require state Medicaid and CHIP programs to report all measures from the Child Core Set, including perinatal measures included on the Maternity Core Set (*e.g.*, low birth weight, live births, timeliness of prenatal care) and all behavioral

health measures effective in 2024.[36] CMS also included some of the Maternity Core set measures in the public-facing Medicaid & CHIP Scorecard, which aims to increase public transparency about the program's administration and outcomes.[37]

The *Blueprint* also includes actions to better understand the health care and social conditions that harm maternal health outcomes.[38] These range from the clinical (*e.g.*, demonstration projects to implement and evaluate evidence-based interventions to comprehensively address inequities in diagnosis and treatment for endometriosis, fibroids, and polycystic ovarian syndrome) to the social (*e.g.,* research on how housing instability and environmental stressors harm maternal health). This research could bolster the evidence base that health and broader social policy reformers need to craft meaningful policy solutions to amenable maternal health inequities.

Goal 4: Expand and Diversify the Perinatal Workforce

Under Goal 4 of the *Blueprint*, the Administration outlines actions such as directly investing in a more diverse workforce, increasing the numbers of community health workers in underserved areas, and expanding access to doulas, midwives, and freestanding birth centers.[39] The *Blueprint* particularly underscores the need for states to expand coverage of doula care. Doula care is associated with lower maternal and infant health complication, preterm birth and low birth weight infant, and cesarean section rates, yet barriers to access abound.[40] This is particularly true for people with low incomes, including Medicaid enrollees. Citing to research from NHeLP's doula Medicaid project, the *Blueprint* recognizes that while several states are exploring options to advance access, only four states Medicaid programs currently provide coverage (as of the publication of this report, the number is now eight states and Washington D.C.).[41] Moreover, inadequate reimbursement rates and complex billing and credentialing requirements can impede access even where coverage is provided.[42] The *Blueprint* describes several actions to further doula Medicaid coverage and access.[43] It references CMS's December 2021 guidance to states on options for Medicaid doula coverage and best practices for extending postpartum Medicaid coverage.[44] It notes that HHS will continue to work with and provide learning opportunities for states who wish to provide or expand access. It references President Biden's $20 million request in his Fiscal Year (FY) 2023 budget for growing and diversifying the doula workforce. It also notes that the Department of Justice Bureau of Prisons will launch a program to provide pregnant inmates the option of doula care and create pathways for people who are incarcerated to volunteer to train and become certified as doulas.

Goal 5: Strengthen Economic and Social Supports for People Before, During, and After Pregnancy.

The *Blueprint* recognizes that the U.S. health care system is not solely responsible for the maternal health crisis; social and structural determinants of health greatly shape outcomes and inequities.[45] Accordingly, Goal 5 includes actions such as streamlining cross enrollment in federal public benefit programs (*e.g.*, Medicaid and SNAP), increasing awareness of workplace protections and accommodations for new parents, piloting a program to train providers on intimate partner violence against pregnant and postpartum people, and bringing awareness to the adverse impacts on maternal health posed by climate change.

ENDNOTES

[1] Susanna Trost et al., Ctrs. for Disease Ctrl. & Prevention (CDC), *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S. States, 2017–2019,* 4(2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCs-2017-2019-H.pdf.
[2] CDC, Pregnancy Mortality Surveillance System, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#trends (last visited October 20, 2022) (showing that from 2016–2018, the pregnancy-related mortality ratio was three times as higher for non-Hispanic Black people and nearly two times as higher for non-Hispanic American Indian or Alaska Native people compared to non-Hispanic white people).
[3] DCAF—Geneva Centre for Security Sector Governance, *Whole-of-Government Approach* (last visited Oct. 20, 2022), https://issat.dcaf.ch/Learn/Resource-Library/SSR-Glossary/Whole-of-Government-Approach-WGA (defining a whole-of-government approach as one which "integrates the collaborative efforts of the departments and agencies of a government to achieve unity of effort towards a shared goal").
[4] White House, Vice President Kamala Harris Announces Call to Action to Reduce Maternal Mortality and Morbidity (Dec. 7, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/12/07/fact-sheet-vice-president-kamala-harris-announces-call-to-action-to-reduce-maternal-mortality-and-morbidity/.
[5] White House, Remarks by Vice President Harris on the Administration's Commitment to Improve Maternal Health (Apr. 21, 2022), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/04/21/remarks-by-vice-president-harris-on-the-administrations-commitment-to-improve-maternal-health/.

[6] White House, *White House Blueprint for Addressing the Maternal Health Crisis* (June 2022), https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf (*hereinafter Blueprint*).
[7] *Id*. at 7.
[8] *Id.* at 3.
[9] Of note, on July 26, 2022, CMS published a new *Maternity Care Action Plan*, which tracks the *Blueprint*'s five goals and provides a high-level overview of CMS's steps to address gaps in maternity care. CMS, *Cross-Cutting Initiative: CMS Maternity Care Action Plan*, Jul. 26, 2022, https://www.cms.gov/newsroom/press-releases/cms-releases-maternity-care-action-plan-implement-biden-harris-maternal-health-blueprint-launches.
[10] *Blueprint*, *supra* note 6, at 4, 9–10.
[11] *Id.* at 9.
[12] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(1)(A), 1396a(l)(2)(A)(i-ii, iv); Amy Chen, Nat'l Health Law Prog. *Pregnancy-Related Medicaid and Minimum Essential Coverage* 1 (Jan. 2017), https://healthlaw.org/resource/issue-brief-pregnancy-related-medicaid-and-minimum-essential-coverage/.
[13] 42 U.S.C. § 1396a(e)(6).
[14] Eugene Declercq & Laurie Zephyrin, The Commonwealth Fund, *Maternal Mortality in the United States: A Primer* 8 (Dec. 15, 2020), https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer.
[15] *Id*.
[16] American Rescue Plan Act § 9812, 42 U.S.C. 1396a(e)(16) (2021).
[17] CMS, *Biden-Harris Administration Announces More than Half of All States Have Expanded Access to 12 Months of Medicaid and CHIP Postpartum Coverage*, Oct. 27, 2022, https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-more-half-all-states-have-expanded-access-12-months-medicaid.
[18] *Blueprint*, *supra* note 6, at 9.
[19] Madeline T. Morcelle, Nat'l Health Law Prog., *Closing the Medicaid Coverage Gap: Preventing a Separate and Unequal Result* 1 (Jun. 2021), https://healthlaw.org/resource/closing-the-medicaid-coverage-gap-preventing-a-separate-and-unequal-result/.
[20] Beyond cisgender women, many transgender, nonbinary, gender nonconforming, and intersex people can get pregnant, and people of all sexual orientations and gender identities need access to reproductive and sexual health care. While currently available coverage data often focus on antiquated binary cisgender sex disaggregation, gender-inclusive Medicaid data collection is needed. Madeline T. Morcelle, Nat'l Health Law Prog.: Health Advocate Blog, Fostering Maternal Health Equity Through Budget Reconciliation (Apr. 2022), https://healthlaw.org/fostering-maternal-health-equity-through-budget-reconciliation/.

[21] *See, e.g.*, March Clapp et al., *Preconception Coverage Before and After the Affordable Care Act Medicaid Expansions*, 132(6) OBSTETRICS & GYNECOLOGY 1394 (Dec. 2018); Emily M. Johnston, Post-ACA, More Than One-Third of Women with Prenatal Medicaid Remained Uninsured Before or After Pregnancy, 40(4) HEALTH AFFAIRS 572 (Apr. 2021).
[22] *Id*.
[23] *Blueprint*, *supra* note 6, at 3, 9, 18,
[24] Families First Coronavirus Response Act § 6008, 42 U.S.C. 1396d note (2020).
[25] CMS, *Medicaid and CHIP and the COVID-19 Public Health Emergency* 44 (Jan. 31, 2022), https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-01312022.pdf.
[26] Manatt Health & State Health & Value Strategies, *Protecting Coverage for Postpartum Individuals at the End of the Public Health Emergency* (Sept. 2023), https://www.shvs.org/wp-content/uploads/2022/09/Protecting-Coverage-for-Postpartum-Individuals-at-the-End-of-the-PHE.pdfl
[27] While many will lose coverage, some individuals may be eligible to retain their coverage or qualify for limited-scope coverage. For example, some people who live in states with expanded eligibility for coverage of family planning services, are currently covered under pregnancy-related Medicaid, and have exhausted the applicable duration of pregnancy-related coverage in their state (*e.g.*, roughly 60 days after the end of their pregnancy) by the time that the PHE ends may qualify for limited-scope family planning coverage upon redetermination. Likewise, in states that expanded Medicaid expansion during the PHE, some individuals eligible for coverage based on pregnancy may be newly eligible for full-scope benefits as a result.
[28] *Blueprint*, *supra* note 6, at 30; CMS, *FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Final Rule—CMS-1771-F Maternal Health*, Aug. 1, 2022, https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps-1**.**
[29] *Blueprint*, *supra* note 6, at 30–32; Mara Youdelman, Nat'l Health Law Prog., *Summary of State Law Requirements Addressing Language Needs in Health Care* (Apr. 29, 2019), https://healthlaw.org/resource/summary-of-state-law-requirements-addressing-language-needs-in-health-care-2/.
[30] *Blueprint*, *supra* note 6, at 33.
[31] *Blueprint*, *supra* note 6, at 11, 18, 31.
[32] U.S. Dep't of Health & Human Servs., *Nondiscrimination in Health Programs and Activities*, 87 Fed. Reg. 47824 (Aug. 4, 2022); Mara Youdelman et al., Nat'l Health Law Prog., *Questions and Answers on the 2022 Proposed Rule Addressing Nondiscrimination Protections under the ACA's Section 1557* (Aug. 15, 2022), https://healthlaw.org/resource/questions-and-answers-on-the-2022-proposed-rule-addressing-nondiscrimination-protections-under-the-acas-section-1557/.
[33] Madeline T. Morcelle, Nat'l Health Law Prog.: Health Advocate Blog, How Proposed Changes to Section 1557 Strengthen Protections Related to Pregnancy or Related Conditions, Including

Abortion, Sep. 27, 2022, https://healthlaw.org/how-proposed-changes-to-section-1557-strengthen-protections-related-to-pregnancy-or-related-conditions-including-abortion/.
[34] *Id*. at 3, 5, 36–42.
[35] *Id*. at 6.
[36] CMS, Child Core Set Reporting Resources, https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html (last visited Oct. 31, 2022).
[37] CMS, Medicaid & CHIP Scorecard, https://www.medicaid.gov/state-overviews/scorecard/index.html, last visited Oct. 31, 2022.
[38] *Blueprint*, *supra* note 6, at 12, 41.
[39] *Id*. at 6, 12–13, 43–48.
[40] *Blueprint*, *supra* note 6, at 45.
[41] *Id*.; Amy Chen & Alexis Robles-Fradet, Nat'l Health Law Prog., Doula Medicaid Project, https://healthlaw.org/doulamedicaidproject/ (last visited Oct. 31, 2022); *see also* Amy Chen, Nat'l Health Law Prog., Current State of Doula Medicaid Implementation Efforts in November 2022 (Nov. 14, 2022), https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/.
[42] Amy Chen and Allison Berquist, Nat'l Health Law Prog., Medi-Cal Coverage for Doula Care Requires Sustainable and Equitable Reimbursement to be Successful (May 20, 2022) https://healthlaw.org/medi-cal-coverage-for-doula-care-requires-sustainable-and-equitable-reimbursement-to-be-successful/.
[43] *Id*. at 47.
[44] *See* CMS, Dear State Health Official (Dec. 7, 2021) (SMD # 21-007) (guidance on options and best practices for expanding Medicaid doula coverage and extending postpartum Medicaid coverage), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.
[45] *Id*. at 49–44.