MARCH OF DIMES

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August 10, 2021

Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

Chairman Hilderbrand and Members of the Committee:

March of Dimes leads the fight for the health of all moms and babies. Ensuring that women, children and families have access to timely, affordable and high-quality health care is essential to achieving our goals. We appreciate this opportunity to discuss the current maternal health crisis in Kansas.

Women, children, and families in Kansas need us now more than ever. We are facing an urgent maternal and infant health crisis that has only intensified with the COVID-19 pandemic. Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When adjusting for factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

Prematurity (or delivery before 37 weeks of pregnancy) is the leading cause of newborn death and disability among infants, including developmental delays, chronic respiratory problems, and vision and hearing impairment. In addition to the health consequences of preterm birth, the emotional and economic impact of preterm birth on families is too high. Preterm birth in the state of Kansas has been rising for years, in a time when medical knowledge is presumably at its highest. According to the latest data from the Kansas Department of Health and Environment, 10.1% of all 2019 live births were preterm, as well as 11.9% of Medicaid births[1]. This is higher than the US Department of Health and Human Services Healthy People 2030 goal of 9.4% and the March of Dimes goal of 8.1%. Based on the 2016-2019 average from the March of Dimes PeriStats, there are 68 Kansas counties with preterm birth rates higher than the March of Dimes goal[2]. The worst rates by county are Cheyenne (15.6%), Wichita (14.9%), Chautauqua (14.2%), and Scott (13.0%). Our largest counties are also seeing poor outcomes: Wyandotte (10.8 %), Sedgewick (10.5%), Shawnee (9.7 %), and Douglas (9.3 %). Moreover, premature birth and its complications were the largest contributor to infant death in 2019, with our state infant mortality rate at 5.3 per 1,000 live births and 7.2 per 1,000 live births for families on Medicaid[1] in that same year In addition to the human toll, the societal cost of premature birth, last measured in 2016, was more than $193 million dollars in the state of Kansas, and approximately $56 thousand per preterm birth[3]. Premature birth has a major impact on society overall and on business in particular. Employers

[1] Kansas Department of Health and Environment. (2020). *Title V Outcome Measures and Performance Measures: Kansas Maternal and Child Health Services Block Grant.* Topeka: Kansas Department of Health and Environment

[2] National Center for Health Statistics. (2021). Preterm: Kansas, 2016-2019 Average. Retrieved from https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=20&top=3&stop=60&lev=1&slev=4&obj=18

[3] Waitzman, N. J., & Jalali, A. (2019). *Updating National Preterm Birth Costs to 2016 with Separate Estimates for Individual States.* March of Dimes. Retrieved from https://www.marchofdimes.org/peristats/documents/Cost_of_Prematurity_2019.pdf

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pay as much as 12 times more in health care costs for babies born premature and at low birthweight as compared to babies born without these complications.

Birth outcomes in Kansas are not equitable. In the 2020 March of Dimes Premature Birth Report Card based on a 2016-2018 average, the preterm birth rate for African American women in Kansas was 51% higher than the rate among all other women at 13.6%[4]. If you are born Black in the state of Kansas, you are more than twice as likely not to celebrate your first birthday[5]. According to the Kansas Maternal Mortality Report, 2016-2018, while African American women accounted for only 7.1% of births in Kansas, they accounted for 14.0% of pregnancy-associated deaths[6]. We must do more to achieve equitable outcomes and improved quality of care for all women

Access to quality maternity care is a critical component of maternal health and positive birth outcomes, especially considering the high rates of maternal mortality and severe maternal morbidity in the U.S. In Kansas, 102 of 105 counties have a primary healthcare provider shortage[7]. Kansas was ranked 41 out of 50 states for health care, with a quality of care ranking of 48, in addition to, 31st in access, and 35th in public health, based on US News and World Report Rankings[8]. Kansas has 45 counties classified as maternity care deserts, with 35,317 women 15 to 44 years old lacking those essential services, especially in rural communities[9]. Additionally, there are 24 counties with low access to maternity care, representing an additional 58,131 women[9]. I encourage you to review March of Dimes Peristats report card and our Nowhere to Go report on maternity care deserts.

Insurance access affects preterm birth rates by limiting access to preconception care (for chronic disease, mental health and family planning) and timely entry into prenatal care. In 2019, data from the U.S. Census Bureau's American Community Survey shows that 1 in 7 (13.9%) women of childbearing age (15-44) were uninsured in the state of Kansas[10]. According to the 2019 Kansas Pregnancy Risk

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[4] March of Dimes. (2020). *2020 March of Dimes Report Card.* March of Dimes Perinatal Data Center. Retrieved from https://www.marchofdimes.org/peristats/tools/reportcard.aspx

[5] National Center for Health Statistics. (2021). Infant mortality rates by race/ethnicity: Kansas, 2016-2018 Average. (M. o. Dimes, Compiler) Retrieved from https://www.marchofdimes.org/Peristats/ViewSubtopic.aspx?reg=20&top=6&stop=92&lev=1&slev=4&obj=1

[6] Kansas Maternal Mortality Review Committee. (2020). *Kansas Maternal Mortality Report 2016-2018.* Kansas Department of Health. Retrieved from https://kmmrc.org/wp-content/uploads/2021/02/KS-Maternal-Morbidity-Mortality-Report_Dec-2020_FINAL2-21.pdf

[7] Health Resources and Services Administration. (2021). Health Professional Shortage Areas: Primary Care, by County, 2021 - Kansas. (R. H. Hub, Compiler) Retrieved April 2021, from https://www.ruralhealthinfo.org/charts/5?state=KS

[8] US News and World Report. (2019). Public Health Rankings: Measuring the health of state populations. Retrieved from https://www.usnews.com/news/best-states/kansas#state-recommended-articles

[9] March of Dimes. (2020, September). *Nowhere to Go: Maternity Care Deserts across the U.S.* March of Dimes.

[10] American Community Survey. (2021, August 2). Uninsured women: Kansas, 2009-2019: Percent of women ages 15-44. (M. o. Dimes, Compiler) Retrieved from https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=20&top=11&stop=158&lev=1&slev=4&obj=1

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Assessment Monitoring System (PRAMS), 29.5% of women report having no healthcare visits in the 12 months prior to pregnancy[11].

Psychosocial factors like chronic stress, lack of social support and maternal mental health conditions increase risk of preterm birth. Perinatal Mood and Anxiety Disorders (PMADs) are the number one complication of pregnancy and childbirth, affecting 1 in 7 pregnant and postpartum women[12]. Nationally, 1 in 5 women will experience postpartum depression[13]. In Kansas, in 2019, 20.9% of mothers reported depression during pregnancy.[11] Moreover, suicide and overdose are the leading causes of death in the first year postpartum, with 100% of these deaths deemed preventable[12]. Kansas ranks 43rd in access to mental health providers[14], and those with training in perinatal mental health is lower, with even fewer providers accepting Medicaid. Despite available screening tools, perinatal mood and anxiety disorders often go undiagnosed and untreated. Of those diagnosed, only 50% of perinatal women with depression receive any treatment[12]. Women living in poverty and women of color are more likely to experience maternal mental health conditions and less likely to get help due to lack of access to healthcare, including culturally appropriate mental health care, cultural and racial biases in the healthcare system, more barriers to care, such as lack of transportation or childcare and fear that child protective services or immigration agencies will become involved[13]. Rates of perinatal depression of up to 50% have been documented in African American women[15]. The total estimated societal cost of untreated perinatal mood and anxiety disorders in the US is $14.2 billion for all births in 2017 when following the mother-child pair from pregnancy through five years postpartum, or an average of $32,000 for every mother-child pair affected, but not treated, with most of the costs borne by employers and health care payers[12].

We need to make a serious commitment to women and families in our state. Medicaid is the largest payer for maternity care in the United States, and as of 2019, covered about one-third (29.8%) of births in Kansas[16]. The program has an important role to play in improving maternal and perinatal health outcomes. Managed Care Organizations in Kansas need to take immediate and decisive action to

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[11] Kansas Department of Health and Environment Division of Public Health. (2021). *Kansas PRAMS 2019 Surveillance Report.* Topeka: Bureau of Epidemiology & Public Health Informatics. Retrieved from https://www.kdheks.gov/prams/downloads/Kansas_PRAMS_2019_Surveillance_Report.pdf

[12] Luca, D. L., Garlow, N., & Staatz, C. (2019). *Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States.* Cambridge: Mathematica Policy Research. Retrieved from https://mathematica.org/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states

[13] Maternal Mental Health Leadership Alliance. (2021). *Fact Sheet Maternal Mental Health.* Retrieved from https://www.mmhla.org/wp-content/uploads/2020/07/MMHLA-Main-Fact-Sheet.pdf

[14] Mental Health America. (2020). *Access To Care Ranking 2020.* Retrieved from https://mhanational.org/issues/2020/mental-health-america-access-care-data

[15] Recto, P., & Champion, J. D. (2017). Psychosocial Risk Factors for Perinatal Depression among Female Adolescents: A Systematic Review. *Issues Mental Health Nursing, 38*(8), 633-642.

[16] National Center for Health statistics, final natality data 2018. (2021, August 2). Medicaid coverage of births: Kansas, 2016-2019: Percentage of Live Births. (M. o. Dimes, Compiler) Retrieved from https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=20&top=11&stop=154&lev=1&slev=4&obj=1

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dismantle racism and address unequal treatment. We must address drivers of health caused by social, environmental and economic factors to reduce disparities and improve health equity. We need to expand the scope of research on social determinants of health as fundamental drivers for maternal and infant health. We must engage in health system reform, including educating providers on implicit racial bias to better serve the highest-risk populations; empowering communities through inclusion, education, social activism and advocacy; and advancing work to change social and economic conditions (poverty, unemployment, low wages, housing, education, etc.), as well as underlying health inequities. We also need to create paid family leave systems that make benefits available to all workers while distributing the responsibility for funding this system among employers.

Managed Care Organizations need to improve access to high-quality, high-value, and risk-appropriate integrated health care, which means we need to expand Medicaid. New research shows that expanding Medicaid can improve the health of women of childbearing age by increasing access to preventive care, reducing adverse health outcomes before, during and after pregnancies, and further reducing maternal mortality rates. Urgently, we need to extend postpartum Medicaid coverage to 12 months. Timely postpartum visits provide an opportunity to assess a woman's physical recovery from pregnancy and childbirth. The need for postpartum services exists well beyond the current limit in federal law of 60 days after the end of pregnancy.

Managed Care Organizations and Kansas legislature need to expand access to midwifery care and further integrate midwives and their model of care into maternity care in Kansas by improving reimbursement strategies and eliminating practice restrictions. This can help improve access to maternity care in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs and improve the health of mothers and babies.

Managed Care Organizations should be fully implementing and reimbursing maternal depression screening and intervention in obstetrics and pediatrics, in addition to adult preventive care visits, as recommended by the U.S. Preventive Services Task Force. We need to ensure that screening is consistent, both during pregnancy and in the postpartum period, and that positive screens are followed-up with timely and effective services. Mental health professionals should be co-located within the settings where screening is performed to provide immediate evaluation, diagnosis, and treatment of mothers with positive screening results. When mental health conditions are identified in obstetrical settings, providers and insurers should collaborate to ensure continuity of care postpartum both in pediatrics and adult health treatment, as these settings become more common points of contact after pregnancy ends. This builds on the American College of Obstetrics & Gynecology's recommendation on optimizing postpartum care[17]. Health care systems and insurers should offer evidence-based supports for parents. Integration of evidence-based parenting supports into obstetrics and pediatrics as well as

[17] The American College of Obstetrics and Gynocologists. (2016, June). Committee Opinion: Optimizing Postpartum Care. Retrieved from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

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coverage by insurance, can improve outcomes for families over the long-term and potentially reduce overall health care costs.

Managed Care Organizations should support evidenced-based efforts to increase access to high-quality, high-value, risk-appropriate, integrated healthcare. March of Dimes partnered with the Kansas Department of Health and Environment seven years ago to create the Kansas Perinatal Community Collaborative. Evidence of this program's successes demonstrate that true wrap-around services (i.e education, clinical care, language supports, maternity navigation, home visiting programs, community health workers, doulas, lactation support, and true integrated mental health screening, treatment, and referral) has demonstrated real quality improvement in our state. Wrap-around services should be covered in a way that makes care sustainable in pregnancy and postpartum care. These services have been proven to make a difference in maternal and infant health outcomes.

Managed Care Organizations should work with doulas, home visitors, and maternal community health workers throughout the state to make reimbursement attainable and sustainable. Increased access to doula care is one tool to help improve birth outcomes and reduce higher rates of maternal morbidity and mortality among women of color in the United States. In some states coverage of doula services is provided under the full range of private and public insurance programs, including Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and others. Payment levels should be sufficient to support the care provided. Efforts should be made to make the doula profession more accessible to people of diverse socioeconomic and cultural backgrounds.

We also need to implement perinatal regionalization, a strategy to improve both maternal and neonatal outcomes. Perinatal regionalization, supports risk-appropriate care provisions that assure women and infants receiving care in a facility staffed with personnel and equipment that matches their risk. The CDC LOCATe tool provides a standardized assessment of facility levels of care, which allows a facility to measure its capabilities in an unbiased way, supported by national guideline[18]. By coordinating a system of care within a geographic area, pregnant women would receive risk-appropriate care in a facility equipped with proper resources and health care providers.

For all moms and babies,

Elizabeth Lewis, MPA, MSN, WHNP-BC, BSN, RN

[18] Catalano, A., Bennett, A., Busacker, A., Carr, A., Goodman , D., Kroelinger, C., . . . Barfield, W. (2017, December). Implementing CDC's Level of Care Assessment Tool (LOCATe): A National Collaboration to Improve Maternal and Child Health. *Journal of Women'a Health, 26*(12), pp. 1265-1269. Retrieved from https://pubmed.ncbi.nlm.nih.gov/29240547/


HEALTHY
MOMS.
STRONG
BABIES.
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MATERNAL
HEALTH CARE
CRISIS IN KANSAS

2020 MARCH OF DIMES REPORT CARD

HEALTHY MOMS. STRONG BABIES.

2020 MARCH OF DIMES REPORT CARD

In the 2020 Report Card, we highlight the latest key indicators to describe and improve maternal and infant health in the United States (U.S.). Preterm birth and its complications are the second largest contributor to infant death in the U.S., and preterm birth rates have been increasing for five years. Prematurity grades are assigned by comparing the 2019 preterm birth grade to March of Dimes' goal of 8.1 percent by 2020.

Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

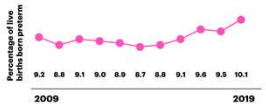
KANSAS

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.1%

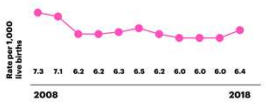


INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

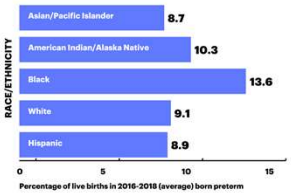
INFANT MORTALITY RATE

6.4



PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Kansas, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO:

1.17

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Wichita	C-	10.1%	Better

MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

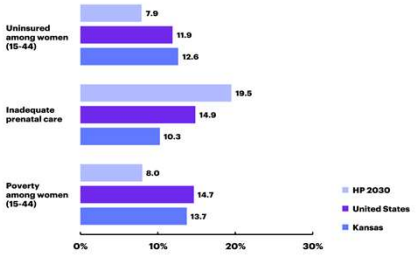
March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit Policy & Action. For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit www.marchofdimes.org.

Scan for details

KANSAS MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.



MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant health care.

Legend

- State has or is developing the indicated organization/policy
- State has the indicated organization and is CDC funded
- State does not have or is not developing the indicated organization/policy
- State is above estimated U.S. cost
- State is below estimated U.S. cost

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

Additional details on these future measures can be found **here.**

MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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Preterm birth and its complications are the second largest contributor to infant death in the U.S., and preterm birth rates have been increasing for five years.
Prematurity grades are assigned by comparing the 2019 preterm birth grade to March of Dimes' goal of 8.1 percent by 2020.

Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health,
availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby.
While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

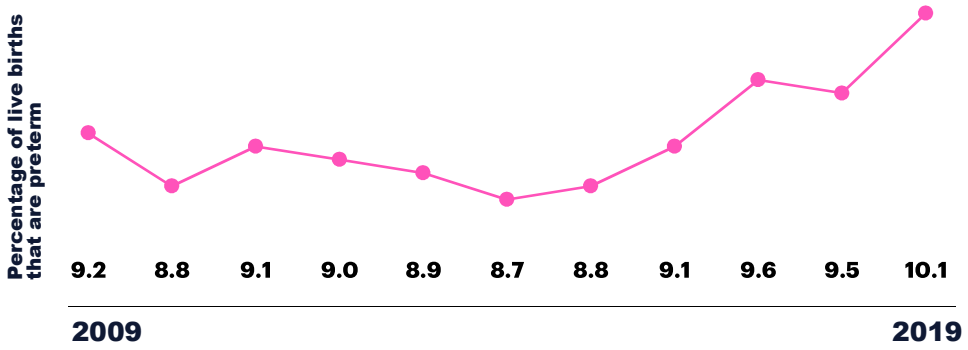
KANSAS

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.1%



Grade and Range

A	B+	B	B-	C+	C	C-	D+	D	D-	F
7.8 – 8.1	8.2 - 8.5	8.6 – 8.9	9.0 – 9.2	9.3 – 9.6	9.7 – 10.0	10.1 – 10.3	10.4 – 10.7	10.8 – 11.1	11.2 – 11.4	11.5 or greater

HEALTHY MOMS. STRONG BABIES.

Preterm is based on less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics: final natality data 2009-2019

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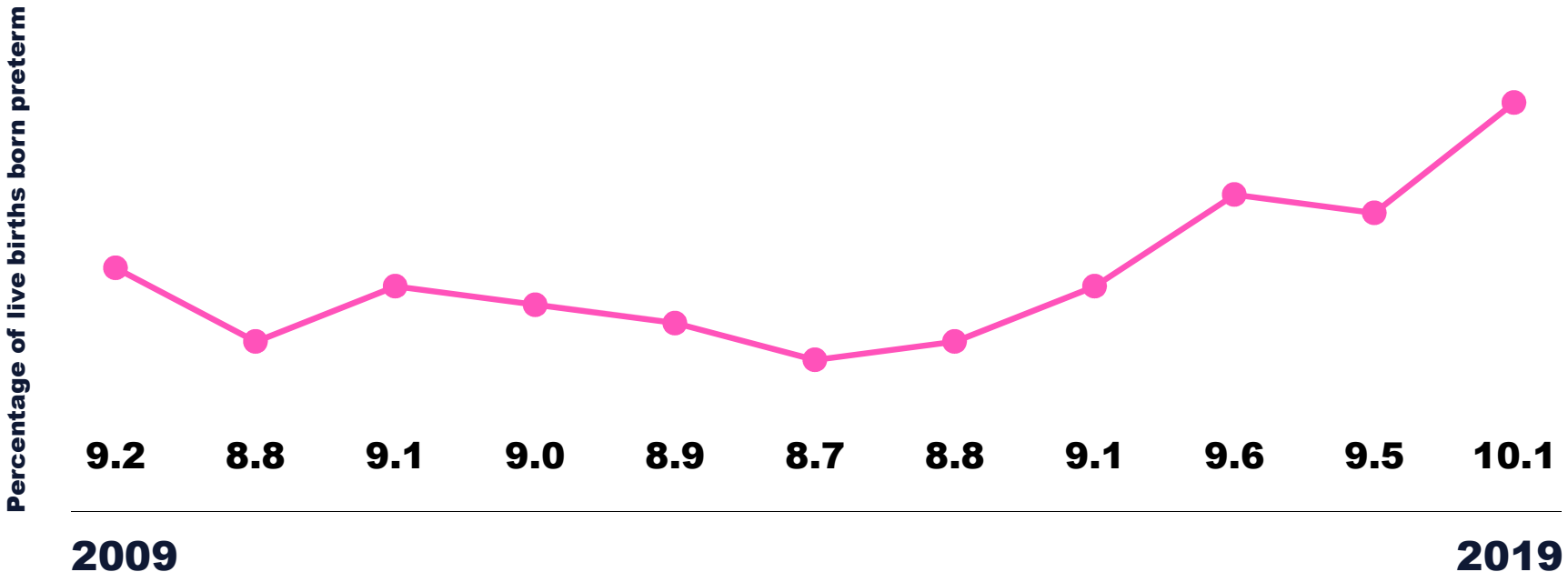
PRETERM BIRTH TREND IN KANSAS, 2009-2019



HEALTHY MOMS. STRONG BABIES.

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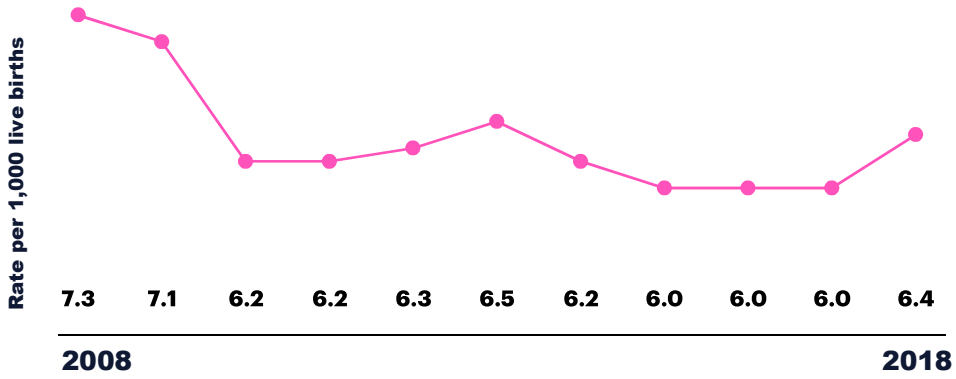
KANSAS

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

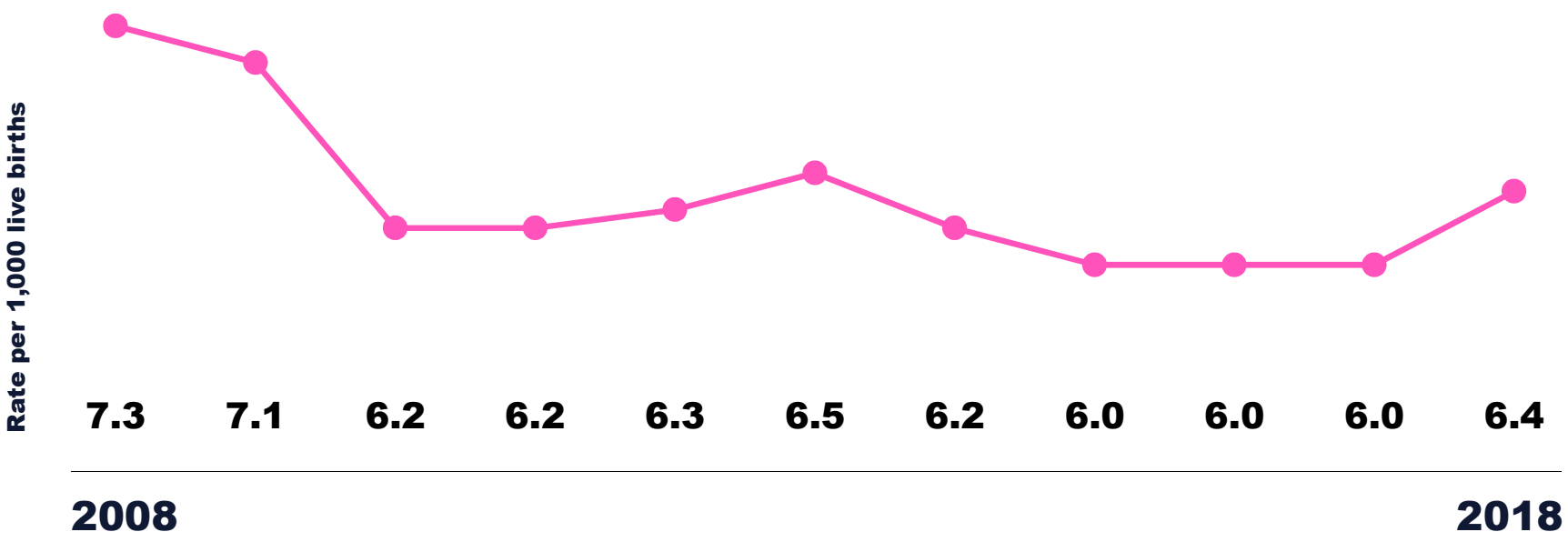
6.4



Source: National Center for Health statistics, period linked infant death/birth data 2008-2018.

2020 MARCH OF DIMES REPORT CARD

INFANT MORTALITY TREND IN KANSAS, 2008-2018



HEALTHY MOMS. STRONG BABIES.

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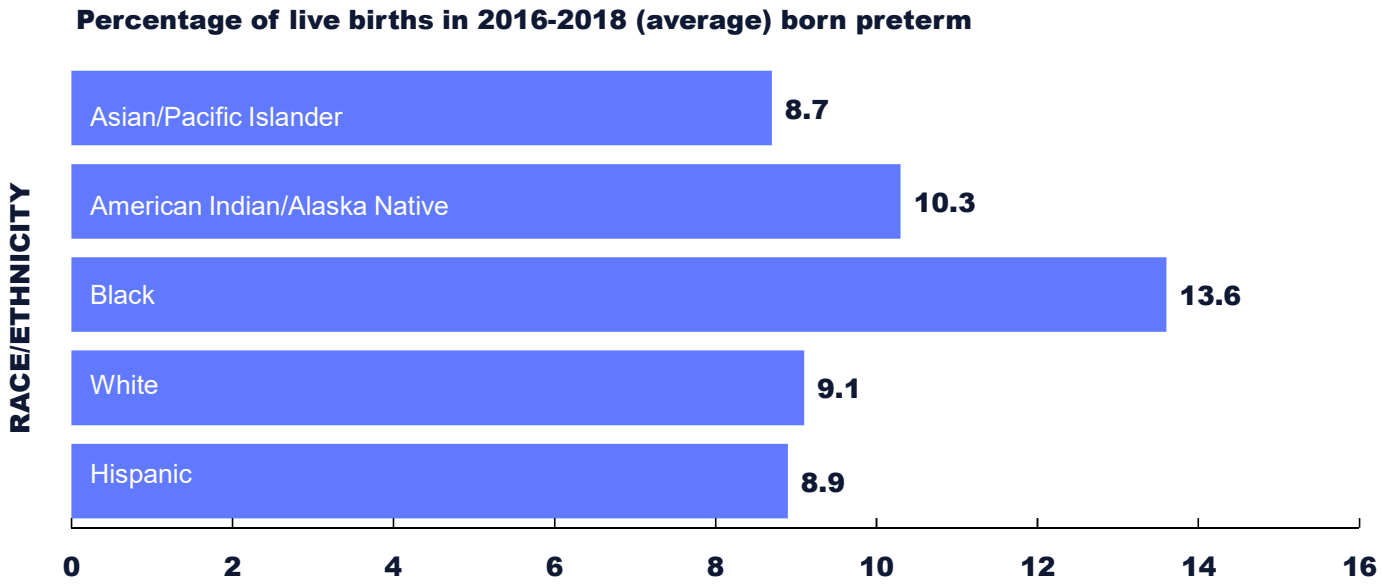
PRETERM BIRTH RATE BY RACE AND ETHNICITY



In Kansas, the preterm birth rate among Black women is 51% higher than the rate among all other women.

HEALTHY MOMS. STRONG BABIES.

Preterm is less than 37 weeks gestation based on obstetric estimate.
Race categories include only women of non-Hispanic ethnicity.
Source: National Center for Health Statistics, final natality data 2016-2018

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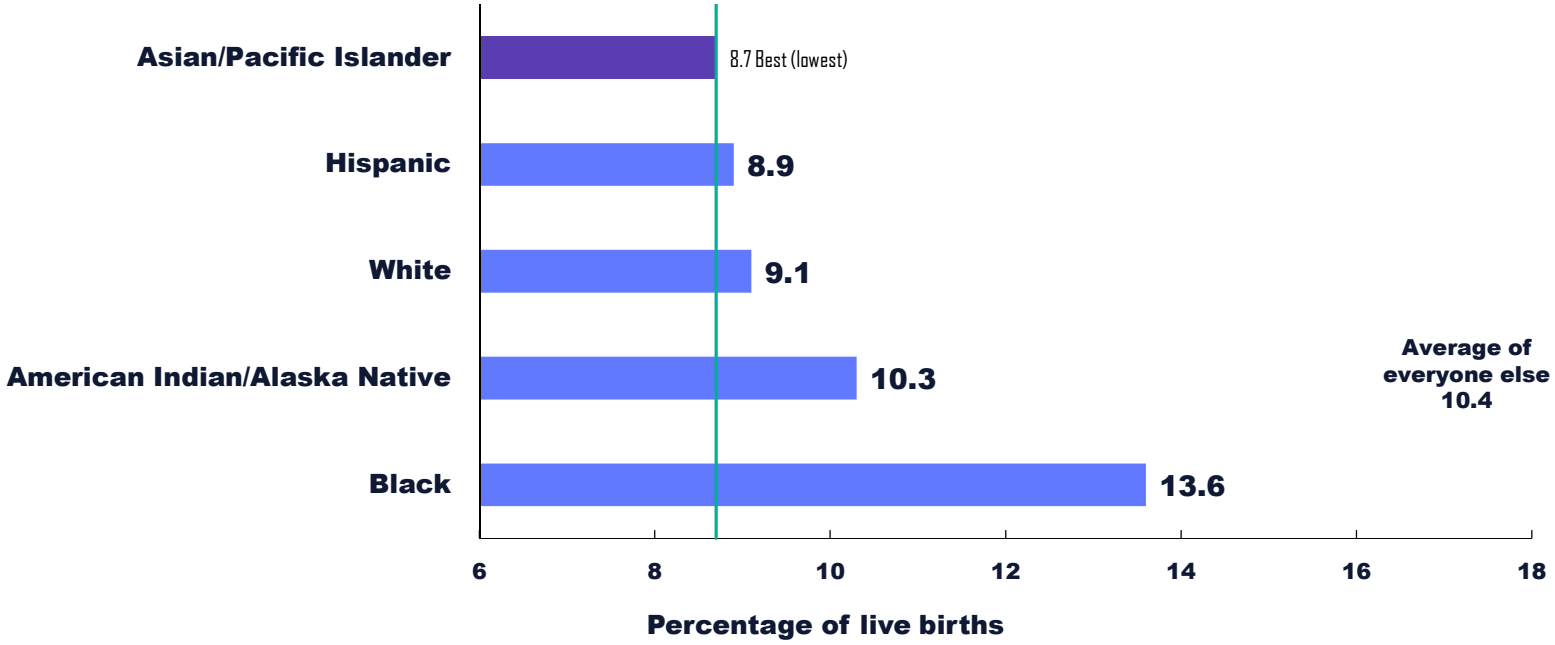

DISPARITY RATIO

1.17

CHANGE FROM BASELINE

No Improvement

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Source: National Center for Health Statistics, final natality data 2016-2018

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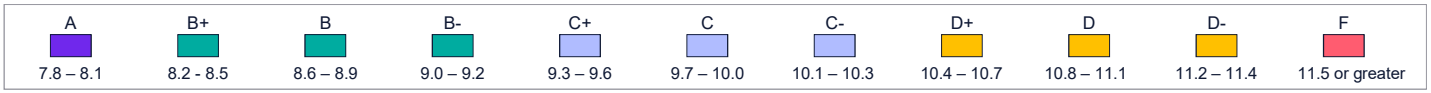
2020 MARCH OF DIMES REPORT CARD

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE FROM LAST YEAR
Douglas	C+	9.3%	Improved
Johnson	B+	8.5%	Improved
Leavenworth	B+	8.5%	Worsened
Sedgwick	C	10.0%	Improved
Shawnee	C-	10.2%	Improved
Wyandotte	D+	10.7%	No change

CITY	GRADE	PRETERM BIRTH RATE	CHANGE FROM LAST YEAR
Wichita	C-	10.1%	Better

Grade and Range

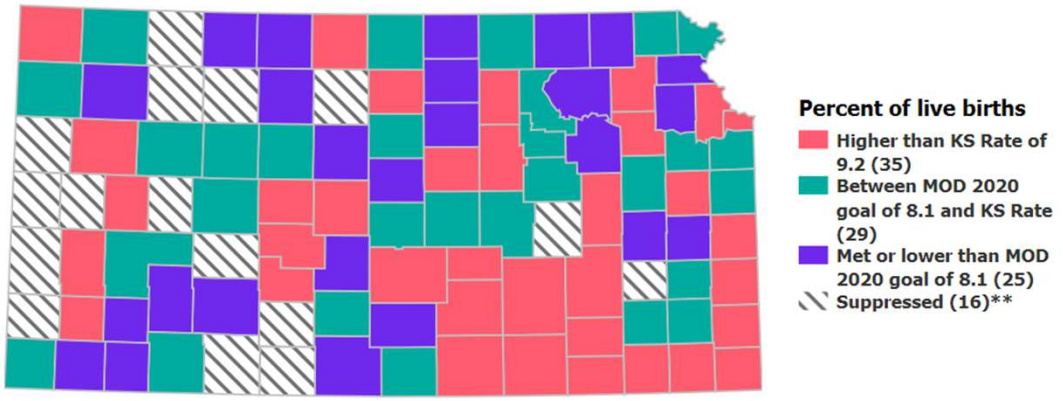


HEALTHY MOMS. STRONG BABIES.

Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statics, 2018 natality data.

PRETERM BIRTH

KANSAS, 2015-2018 AVERAGE



HEALTHY MOMS. STRONG BABIES.

Preterm is less than 37 weeks of pregnancy.

Source: National Center for Health Statistics, final natality data. Retrieved October 29, 2020, from www.marchofdimes.org/peristats.

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

2020 MATERNITY CARE DESERT STATE HIGHLIGHTS- KANSAS

INTRODUCTION

Maternity care encompasses health care services for women during pregnancy, delivery and postpartum.

- Access to quality maternity care is a critical component of maternal health and positive birth outcomes, especially considering the high rates of maternal mortality and severe maternal morbidity in the U.S.

WHAT IS A MATERNITY CARE DESERT?

Definitions	Maternity care deserts	Low access to maternity care	Moderate access to maternity care	Full access to Maternity Care
Hospitals and birth centers offering OB Care	zero	<2	<2	>2
OB Providers (OB/GYN, CNM) per 10,000 Births	zero	<60	<60	≥60
Proportion of women 18-64 without health insurance*	any	≥10%	<10%	any

Notes: OB/GYN = obstetrician/gynecologist; CNM = certified nurse midwives
*U.S. national average is 11% (Kasier, 2020)

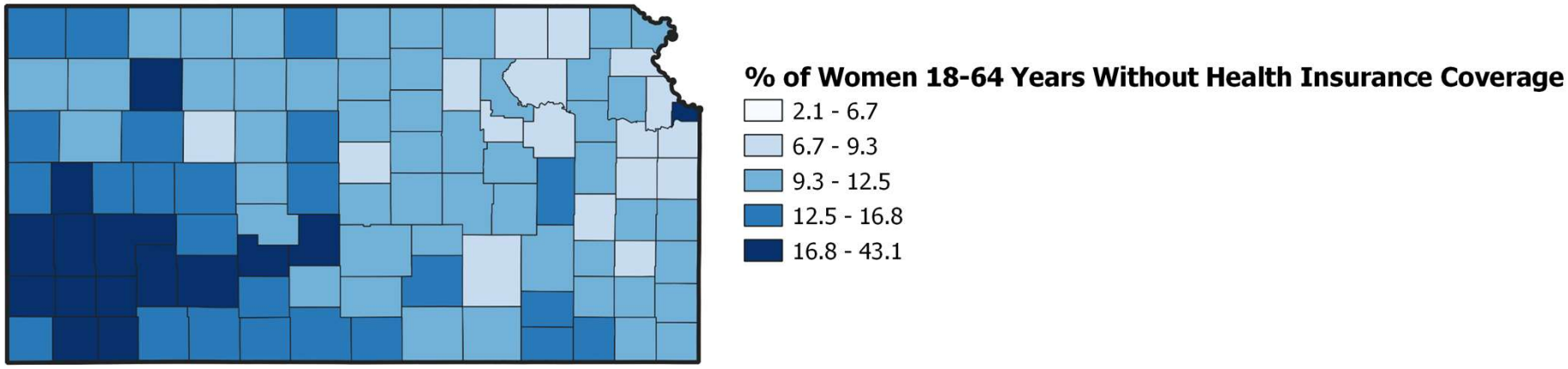
Full Report Link: https://www.marchofdimes.org/maternitycaredesertsreport

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

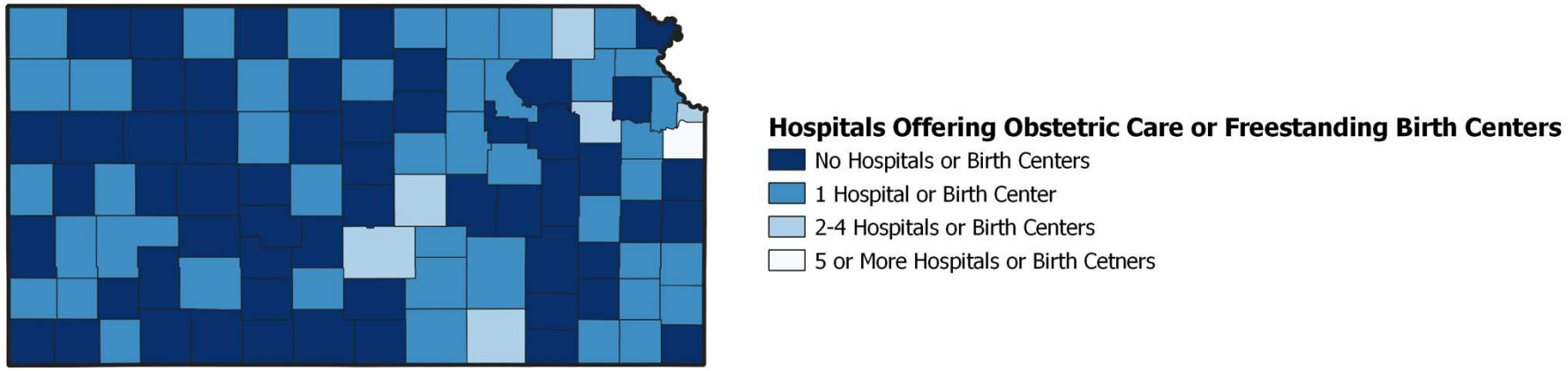
Source: March of Dimes. Nowhere to Go: Maternity Care Deserts across the U.S. September, 2020;
Kaiser Family Foundation. Women's Health Insurance Coverage. https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/ Published January 4, 2020. Accessed July 7, 2020.

WOMEN WITHOUT HEALTH INSURANCE



Source: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019

ACCESS TO HOSPITALS OR BIRTH CENTERS OFFERING OB CARE

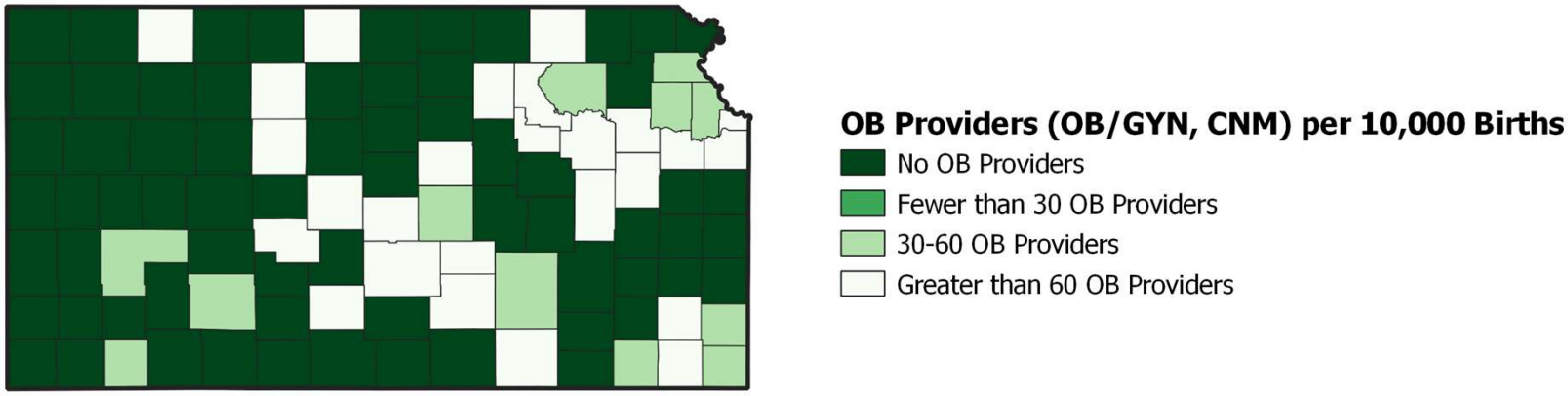


HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019; American Association of Birth Centers, 2020

DISTRIBUTION OF OBSTETRIC PROVIDERS



Source: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019

STATE STATS

Maternity Care Access	Counties (n)	Women 15-44 yrs old (n)	Births (n)	Women (18-64 yrs) Without Health Insurance (Mean, %)	Median Household Income (Mean, $)	Population Below Poverty (Mean, %)	Hospitals Providing OB Care (n)	OB Providers (n)	OB Providers per 10,000 births (n)
Maternity Care Desert	45	35,317	2,438	13.7	48,337	11.2	0	0	0.0
Low Access to Maternity Care	24	58,131	4,408	13.7	48,868	13.1	23	13	29.5
Moderate Access to Maternity Care	8	45,034	3,006	8.5	58,694	11.8	6	12	39.9
Full Access to Maternity Care	28	421,639	26,785	10.9	51,739	13.8	30	333	124.3

All data are from 2017, except number of women 15-44 years old (US. Census 2010)

Sources: Nowhere to Go: Maternity Care Deserts across the U.S. March of Dimes, September 2020., U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019; American Association of Birth Centers, 2020; U.S Census, 2010

POLICY AND ACTION

IMPROVE ACCESS TO QUALITY MATERNAL CARE

- **Reduce Disparities and improve health equity.** We must engage in health system reform, including educating providers on implicit racial bias to better serve the highest-risk populations; empowering communities through inclusion, education, social activism and advocacy; and advancing work to change social and economic conditions (poverty, unemployment, low wages, housing, education, etc.), as well as underlying health inequities.
- **Expand Medicaid** for individuals who fall at or below 138 percent of the Federal Poverty Level (FPL). New research shows states that expand Medicaid improve the health of women of childbearing age by increasing access to preventive care, reducing adverse health outcomes before, during and after pregnancies, and further reducing maternal mortality rates.
- **Extend the Medicaid postpartum coverage period** to 12 months. The need for postpartum services exists well beyond the current limit in federal law of 60 days after the end of pregnancy.
- **Expand access to midwifery care** and further integrate midwives and their model of care into maternity care in all states. This can help improve access to maternity care in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs, and improve the health of mothers and babies.

IMPROVE ACCESS TO QUALITY MATERNAL CARE

- **Reimbursement of meaningful assessment and meaningful referrals for perinatal mental health.** Mental health professionals should be co-located within the settings where screening is performed to provide immediate evaluation, diagnosis, and treatment of mothers with positive screening results. When mental health conditions are identified in obstetrical settings, providers and insurers should collaborate to ensure continuity of care postpartum both in pediatrics and adult health treatment, as these settings become more common points of contact after pregnancy ends.
- **Reimbursement for doula care.** Support increased access to doula care as one tool to help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States. In some states coverage of doula services is provided under the full range of private and public insurance programs, including Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and others. Payment levels should be sufficient to support the care provided. Efforts should be made to make the doula profession more accessible to people of diverse socio-economic and cultural backgrounds.
- **Provide coverage for evidence-based telehealth services for pregnant and postpartum women and support alignment of telehealth reimbursement approaches across payers.**
- **Implement perinatal regionalization**, a strategy to improve both maternal and neonatal outcomes. By coordinating a system of care within a geographic area, pregnant women would receive risk-appropriate care in a facility equipped with the proper resources and health care providers.

PREVENTION AND TREATMENT

- **Create paid family leave systems** that make benefits available to all workers while also distributing the responsibility for funding this system among employers.
- **Address determinants of health** caused by social, environmental, and economic factors to reduce disparities to improve health equity. Expanding the scope of research on social determinants of health as fundamental drivers for population maternal and infant health. Engage in health system reform, including educating providers on implicit racial bias better serve the highest risk populations; empower communities through inclusion, education, social activism and advocacy; and advance work to change social and economic conditions (poverty, employment, low wages, housing, education, etc.) as well as underlying health inequities.
- March of Dimes partnered with the Kansas Department of Health and Environment seven years ago to create the Kansas Perinatal Community Collaborative. Evidence of this program's successes demonstrate that true wrap-around services (i.e education, clinical care, language supports, maternity navigation, home visiting programs, community health workers, doulas, lactation support, and true integrated mental health screening, treatment, and referral) has demonstrated real quality improvement in our state

RESEARCH AND SURVEILLANCE

- Improve maternal mortality and morbidity data collection and surveillance and prioritize policy recommendations from Maternal Mortality Review Committees.