

# Maternal and Child Health Update 2020



NATIONAL  
**GOVERNORS**  
ASSOCIATION

## Contents

- **Maternal and Child Health through a Governor's Lens**
  - Governors' Maternal and Child Health Priorities (Figure 1)
  - State and Territory Title V Priorities – Summary of Common Themes (Table 1)
  - State and Territory Executive and Legislative Action – Summary of Common Themes (Table 2)
- **Coverage and Payment**
  - Most Frequently Cited Medicaid/CHIP Payment or Delivery Reforms, by Type of Reform (Figure 2)
- **Health Equity and Disparities**
  - Strategies to Address Racial Disparities in Maternal and Child Health (Figure 3)
  - Policy Initiatives to Address Socioeconomic Disparities Among Mothers and Children (Figure 4)
- **Behavioral Health Care for Pregnant Women and New Mothers**
- **Maternal and Child Health Workforce**
  - Health Professional Shortages Impacting Maternal and Child Health (Figure 5)
- **Birth Outcomes and Early Childhood**
  - State and Territory Actions to Promote Healthy Birth Outcomes (Figure 6)
  - Groups Convened to Promote Healthy Birth Outcomes (Figure 7)
  - New or Innovative Breastfeeding Initiatives Planned in the Coming Year (Table 3)
  - Infant and Early Childhood Strategies (Figure 8)

## Maternal and Child Health through a Governor's Lens

The National Governors Association Center for Best Practices' (NGA Center) Maternal and Child Health Update (MCH Update) presents the results from a survey of senior state and territory health officials regarding MCH policy topics. Questions are modified from year to year to address new and emerging issues. The 2020 survey focused on Governors' MCH priorities, coverage and payment reforms, health equity, behavioral health, health workforce, and improving health outcomes. Individuals from multiple agencies with states and territories contributed to the survey, including MCH Directors, Medicaid Directors, and Governors' offices.

Forty-three states and territories participated in the survey, though response rates vary by question.\* Survey data were collected during the first half of 2020. Because the survey was designed before the COVID-19 pandemic, the NGA Center conducted a supplemental survey focused on COVID-19 related MCH considerations and **released** findings in August 2020.<sup>1</sup>

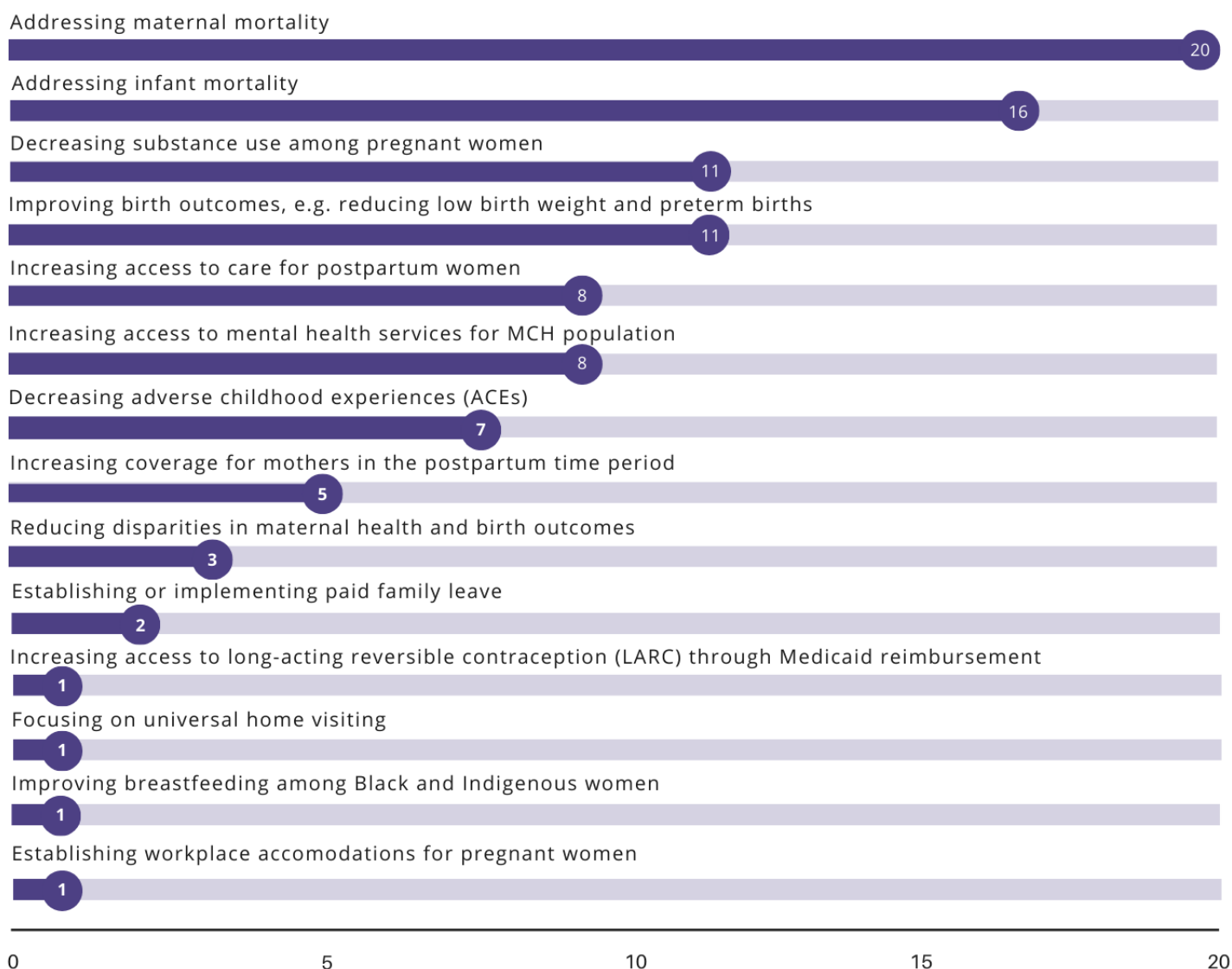
### Governors' Priorities for Maternal and Child Health

To understand priority MCH issue areas for Governors, the NGA Center asked Governors' staff to choose the top three priorities from a list of 13, with a write-in option. **Figure 1** depicts the responses. Thirty-four respondents completed this question, with more than half (20 respondents) indicating that addressing maternal mortality is a priority. Sixteen respondents specify infant mortality, followed by eleven respondents each identifying decreasing substance use among pregnant women<sup>+</sup> and improving birth outcomes as a priority.

\* Thirty-nine states and four territories responded to the survey.

<sup>+</sup> This survey was launched using the terms 'woman' and 'women'; therefore, the paper reflects use of these terms. Because of the evolving language used to describe individuals who are pregnant or postpartum, future writings will recognize appropriateness of revised terminology.



**Figure 1: Governors' Maternal and Child Health Priorities**

## State & Territory Title V Priorities

Every five years, states and territories conduct a needs assessment to identify areas for opportunity in their MCH programs. The most recent needs assessment was completed in September 2020. Through the needs assessment process, states and territories identify seven to ten priority needs and develop a five-year state action plan describing how they will use the federal allocation from the **Title V MCH Services Block Grant to States Program** distributed by the Health Resources and Services Administration and the Maternal and Child Health Bureau with state match. Based on the priorities, states and territories identify evidence-based or -informed strategies that address their needs across six domains: women/maternal health; perinatal/infant health; child health; children with special health care needs; adolescent health; and cross-cutting and systems building.<sup>2</sup> For



purposes of this survey, the NGA Center focuses only on strategies under women/maternal health, perinatal/infant health, and cross-cutting/systems building domains, excluding those focused on children, adolescents, and children with special health care needs.

Due to the timing of the survey, many respondents provided a list of their Title V priorities for both the 2016 – 2020 and 2021 – 2025 periods. **Table 1** includes a summary of the priorities. The most common theme identified (by 32 respondents) was providing quality, preventive care for infants, which includes practices such as early and continuous screenings and immunizations.

**Table 1: State and Territory Title V Priorities – Summary of Common Themes**

<b>Common Themes</b>	<b># of States and Territories</b>
Quality preventative care for infants	32
Oral health	21
Well woman visits and prenatal care	21
Safe and healthy environments and relationships	19
Physical activity and nutrition	18
Infant mortality	18
Breastfeeding initiation and duration	16
Behavioral and mental health	15
Improved birth outcomes	15
Access to health care services for MCH populations	14
Equity in MCH systems and programs	12
Safe sleep practices	12
Smoking/tobacco use	11
Intuitive, user-friendly systems for families	8
Maternal morbidity and mortality	7
Substance use	7
Data systems for MCH	4
Family planning and reproductive health services	4
Health and dental insurance coverage	4
MCH workforce shortages	4
Teenage pregnancy	4
Community-level resources to optimize health outcomes	3
Chronic health conditions in pregnant women	1



## **State & Territory Executive Action and Legislation to Address Maternal and Child Health**

Twenty-five respondents indicated that there had been executive or legislative action related to MCH in 2019. **Table 2** reflects measures highlighted by survey respondents, including actions focused on broad, systematic changes, birth outcomes, and those affecting the postpartum and infancy period. Eleven respondents had executive or legislative action focused on maternal mortality, including five that established or formalized a maternal mortality review committee or board through legislation or executive order. Six respondents indicated executive or legislative action addressing prematurity and infant mortality and five respondents provided information on executive or legislative action concerning Medicaid coverage and behavioral health services.

**Table 2: State and Territory Executive and Legislative Action – Summary of Common Themes**

Legislative and Executive Action Broadly Focused on MCH			
Five Respondents	Four Respondents	Two Respondents	
<ul style="list-style-type: none"><li>• Medicaid coverage for expanded services, including doulas and lactation consultants</li><li>• Behavioral health services, including mental health and substance use disorder</li></ul>	<ul style="list-style-type: none"><li>• Reproductive health measures</li></ul>	<ul style="list-style-type: none"><li>• Racial disparities</li><li>• MCH programming outlined in the state or territory budget</li><li>• Paid family leave</li></ul>	
Legislative and Executive Action to Improved Birth Outcomes			
Eleven Respondents	Six Respondents	Two Respondents	One Respondent
<ul style="list-style-type: none"><li>• Maternal mortality, including five that established a Maternal Mortality Review Committee/Board</li></ul>	<ul style="list-style-type: none"><li>• Prematurity and infant mortality</li></ul>	<ul style="list-style-type: none"><li>• Maternal and perinatal outcomes quality review committees</li></ul>	<ul style="list-style-type: none"><li>• Increase healthy behaviors for pregnant women and families</li></ul>
Legislative and Executive Action to Improve Post-Birth Outcomes			
Two Respondents			
<ul style="list-style-type: none"><li>• Breastfeeding, including setting break times and locations for state and territory employees to pump</li><li>• Developmental screening practices among babies</li><li>• Providing accessible locations to change diapers, specifically in low-income areas</li><li>• Home visitation</li></ul>			



## Coverage and Payment

Medicaid is the largest payer of maternity care in the country, financing 43 percent of all births in 2018.<sup>3</sup> Federal law requires all states to offer pregnancy-related Medicaid for women with incomes up to 138 percent of the federal poverty level (FPL). Most go beyond this minimum threshold, enabling women to receive Medicaid coverage for pregnancy (with eligibility thresholds ranging from 138 percent to 380 percent FPL depending on the state).<sup>4</sup>

Although the Centers for Disease Control and Prevention defines the postpartum period as 365 days following the end of pregnancy,<sup>5</sup> the federal Medicaid statute only requires coverage for pregnant women for 60 days postpartum.<sup>6</sup> If an woman qualifies for a different category of Medicaid, they may retain benefits longer than 60 days; however, more than half of pregnant women with Medicaid experience a gap or change in their health insurance coverage in the year following the end of the pregnancy.<sup>7</sup> The risk of a gap in coverage for women after the 60-day postpartum period is greater in states that have not expanded Medicaid.<sup>8</sup>

In addition to looking to opportunities to extend pregnancy-related Medicaid coverage past 60 days postpartum, states and territories are implementing payment reforms to improve health outcomes for mothers and babies. These initiatives are diverse in their design as states and territories reported a wide variety of initiatives to advance value-based care, disincentivize low-value care (such as early elective deliveries) and expand coverage for innovative models such as group prenatal care.

### Extending Medicaid Coverage Beyond 60 Days Postpartum

To address gaps in Medicaid coverage, several states and territories are interested in extending pregnancy-related eligibility for Medicaid after 60 days postpartum. However, to date, the Centers for Medicare & Medicaid Services has not approved any state requests for a waiver to enable pregnancy-related Medicaid coverage beyond the 60-day postpartum eligibility period.\*

Among 38 total respondents, 13 states have taken some policy action to extend the length of the postpartum Medicaid coverage duration, such as:

- Introducing legislation (six states)
- Preparing to submit an 1115 waiver application (three states)
- Enacting legislation (two states)
- Submitting an 1115 waiver application (one state)
- Using state/territorial revenue (one state)

---

\* At the time of publication, states and territories must provide continuous coverage for all current Medicaid enrollees and may not disenroll anyone currently receiving Medicaid, per requirements in the **Families First Coronavirus Response Act** and the **Coronavirus Aid, Relief, and Economic Security Act**. As a result, an individual covered under pregnancy-related Medicaid benefits will stay enrolled through at least one month following the end of the COVID-19 public health emergency.



Fifteen other states and territories noted interest in extending the postpartum coverage duration but have not yet taken any action. Eight states and territories reported they are not currently considering this type of coverage expansion for postpartum women.

## **Payment Reforms Addressing Care for Pregnant Women and Births**

States and territories reported adopting a variety of payment reforms via Medicaid and/or CHIP (the **Children's Health Insurance Program**) to improve MCH outcomes. The most frequently cited payment reforms among 36 respondents are summarized in **Figure 2**. In addition to the responses noted below, three states and territories reported that they had not implemented any relevant payment reforms for their MCH population.

### **A Guide to Payment Reforms for MCH**

***Unbundling Medicaid payments for long acting reversible contraception (LARC)*** is a strategy to encourage immediate postpartum use of contraception. By unbundling payments, a provider will have greater financial incentive to provide LARC after delivery and before discharge from the hospital, because the provider can be reimbursed separately for the LARC device, insertion procedure and the delivery.<sup>9</sup> Unbundling LARC payments has been shown to increase LARC utilization rates and reduce subsequent unwanted pregnancies, negative health outcomes and reliance on publicly funded programs.<sup>10</sup>

***Patient-centered medical homes*** are comprehensive, team-based primary care models that address the wellness, acute care and chronic care needs of patients.<sup>11</sup> Pregnancy medical homes are a similar approach to provide prenatal care.<sup>12</sup> Offering payment incentives or reimbursement enhancements for medical homes is a strategy to encourage providers to take a holistic approach to care for patients, including case management and care coordination.

***Maternity kick payments*** are supplemental payments available to birthing hospitals on a per-newborn basis, providing birthing hospitals with resources to cover the additional costs associated with caring for a preterm infant.

***Bundled payments for maternity clinical episodes*** combine payments for perinatal care into a single episode of care. This encourages members of the health care team to coordinate, holding providers accountable to provide care in accordance with clinical guidelines and promoting efficiency with shared savings for providers.<sup>13</sup>

***Risk-adjusted capitation*** offers providers a higher level of reimbursement for women who may utilize care at higher rates, or who may be at higher risk for negative outcomes.

***Pay-for-performance*** policies tie performance on key quality metrics to enhanced provider payments.

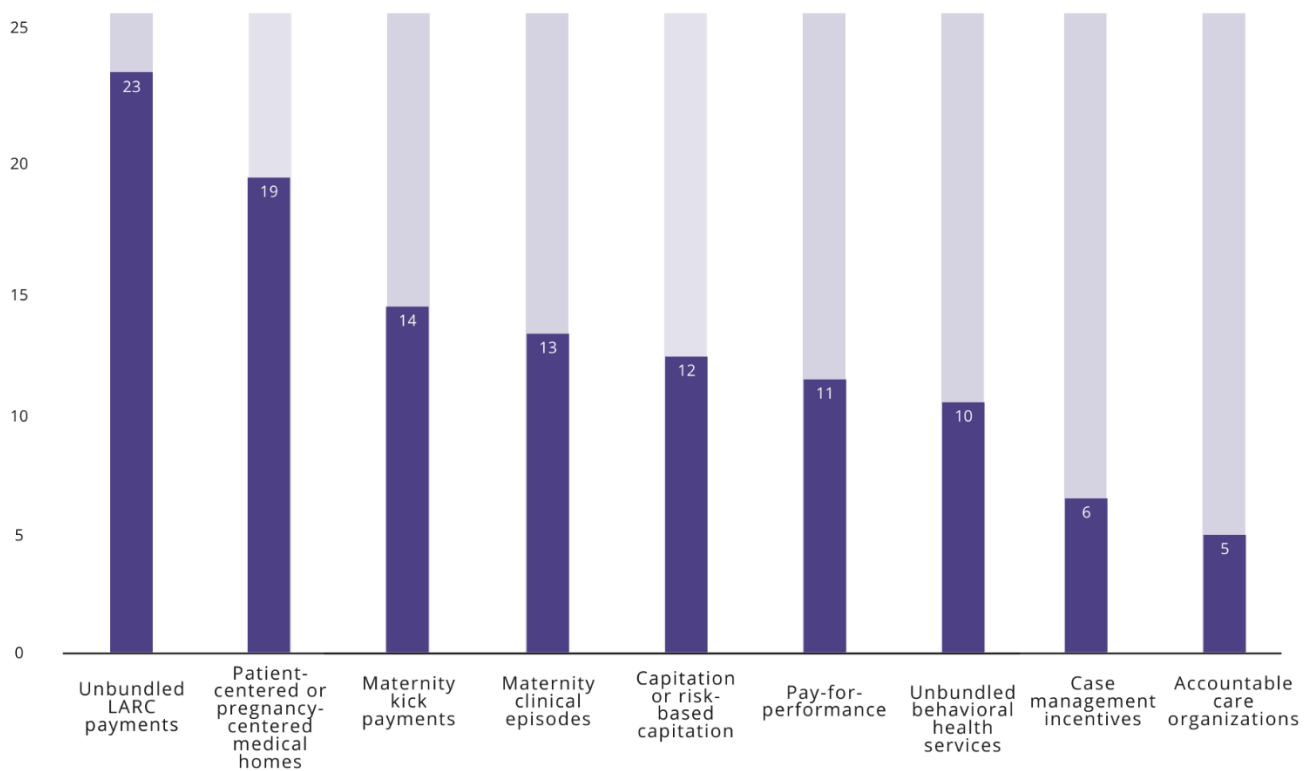


**Unbundled payments for mental health and substance use disorder treatment services** enables increased access to behavioral health services for pregnant women.

**Case management incentives for providers serving high-cost individuals** are typically calculated using a per member per month payment structure. These incentives encourage providers to provide case management services to women with complex health or social needs, strengthening the continuum of care.

**Accountable Care Organizations** are entities that hold providers financially accountable for the health of the patient population that they serve.<sup>14</sup>

**Figure 2: Most Frequently Cited Medicaid/CHIP Payment or Delivery Reforms, by Type of Reform**



## **Coverage Limits on Early Elective Deliveries**

Early elective deliveries are medically unnecessary C-sections or inductions scheduled prior to 39 weeks gestational age and are associated with both high costs and poor health outcomes.<sup>15</sup>

**Early Elective Delivery Tracking:** Among 38 states and territories that responded, 20 reported they currently have a mechanism in place to track early elective deliveries. An additional three states said they were in the planning phase to develop a tracking mechanism, and eight states said they were interested in developing a tracking system but have no current activity underway.



**Early Elective Delivery Coverage:** Among 37 states and territories that responded, 18 reported their Medicaid program covers early elective deliveries. However, three of these 18 respondents reported that Medicaid was expected to stop paying for them in the near future, and four of these 18 respondents reported that while their state covers these types of deliveries, it does so at a reduced rate to discourage their use. Meanwhile, 15 respondents reported their Medicaid program does not cover any early elective deliveries.

## **Medicaid Coverage for Group Prenatal Care**

Research indicates that group prenatal care models, such as **CenteringPregnancy**,<sup>\*</sup> are effective in improving health outcomes and reducing disparities in the preterm birth rate between Black and White women.<sup>16</sup> This model enables women to spend more time with health care providers and health educators, while building positive relationships for peer support during pregnancy.

Out of 37 respondents, 15 reported currently covering group prenatal visits through Medicaid. One respondent reported that coverage for group prenatal care is in the planning stages. Twelve respondents reported they are interested in covering these types of services via Medicaid but have not taken any action.

## **Medicaid Coverage for Midwife and Doula Services**

Certified nurse midwives are registered nurses with advanced degrees who specialize in prenatal, delivery and postpartum care.<sup>17</sup> Research indicates that low-risk patients who receive midwifery care are less likely to have C-sections or require interventions during labor and delivery.<sup>18</sup> Three respondents out of 31 said they were currently working to increase reimbursement rates for midwives in Medicaid.

Doulas are nonclinical professionals who provide one-to-one emotional support during labor, an approach recognized as a promising strategy to improve birth outcomes.<sup>19</sup> Some studies have found that doula care contributes to reductions in preterm births, better **Apgar Scores**,<sup>†</sup> and increased breastfeeding rates.<sup>20</sup> Out of 36 respondents, 20 indicated interest or some early action regarding expansion of Medicaid coverage for doula services. Specifically, two respondents reported they are in initial stages of expanding coverage for doulas and seven are in the planning stage for expansion. Eleven states reported that they are interested in expanding coverage for doulas but have not yet taken action.

---

<sup>\*</sup> CenteringPregnancy is a model of care that brings 8-10 women with similar due dates together for a 90 minute to two-hour prenatal visit. During the visit, the group participates in discussion and interactive activities with providers. Evidence shows this model leads to better birth outcomes, including reduced racial disparities in preterm birth.

<sup>†</sup> The Apgar score is a quantitative measure to quickly assess the health of a newborn infant based on color, heart rate, reflexes, muscle tone, and respiration.

## Health Equity and Disparities

There are significant racial, ethnic and socioeconomic disparities in health outcomes for women and infants in the United States. Maternal mortality rates are greatest among Black and Indigenous communities. According to recent data from the Centers for Disease Control and Prevention, non-Hispanic Black, Alaska Native and Native American women face about a three times greater risk of a pregnancy-related death than White women.<sup>21</sup>

There are also significant racial disparities in infant mortality within the United States, with non-Hispanic Black babies more than twice as likely to die in the first year of life compared to non-Hispanic White babies.<sup>22</sup> A major factor driving this disparity is short gestation and low birthweight, with Black infants nearly four times as likely to die from complications related to short gestation and low birthweight as compared to non-Hispanic White infants.<sup>23</sup>

A range of biological, social, environmental and physical factors influence maternal and child health. Discrimination, poverty, socioeconomic status and lack of community resources all significantly impact health outcomes.<sup>24</sup> When pregnant women and new mothers struggle to meet their basic needs for food, shelter and safety, mothers and children are more likely to experience negative outcomes. However, children raised in households with adequate resources are more likely to have better outcomes across the lifespan.<sup>25</sup>



## **Data Collection to Identify Disparities**

States and territories have taken steps to understand and address racial, ethnic and socioeconomic disparities in maternal and child health. Among 40 survey respondents, 37 collect data on health disparities, such as racial, ethnic and socioeconomic data at the community or population level. Thirty-six out of 38 respondents stratify data by race and ethnicity to better understand inequalities and trends specific to maternal health.

Twenty-eight of 35 state and territory respondents use data to target interventions related to maternal and child health. Survey respondents note that health disparities data:

- Informs Title V priorities<sup>26</sup> (20 responses);
- Identifies gaps in services and priority populations (10 responses);
- Helps focus programming on areas with high infant mortality rates (seven responses);
- Determines the effectiveness and progress of current programs (seven responses); and
- Enables data sharing with organizations, government officials and policymakers to improve knowledge regarding disparities (seven responses).

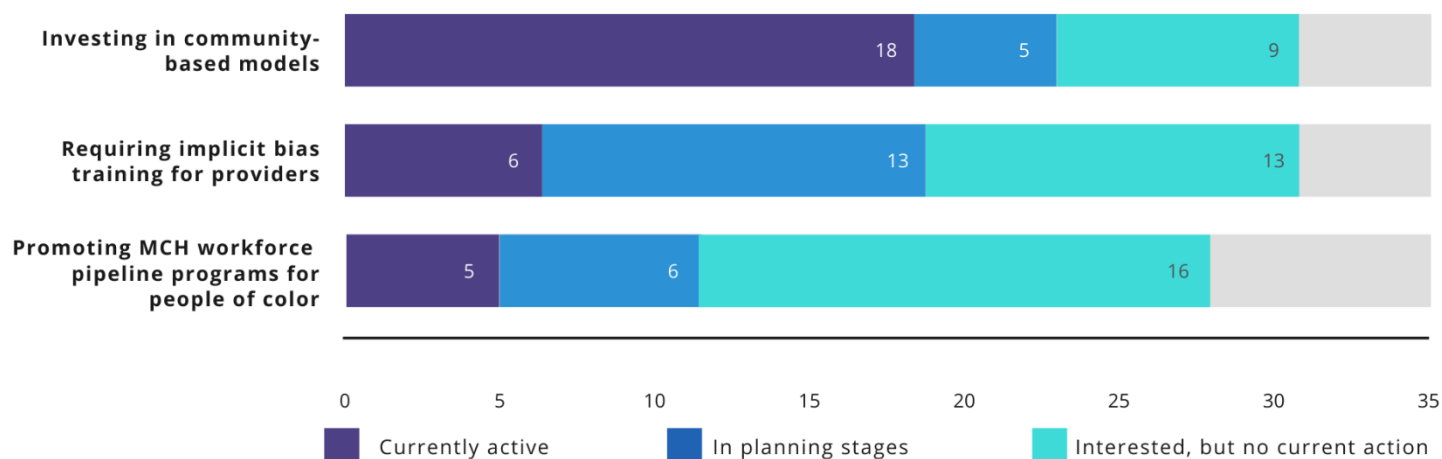
## **Strategies to Advance Racial Equity in Maternal and Child Health**

States and territories have invested in a variety of strategies and programs to address health disparities among maternal and infant populations. Eighteen out of 35 respondents report investing in community-based models to address racial disparities and five additional respondents report that they are in the planning phase to launch such initiatives.

Six out of 35 respondents have active initiatives to require implicit bias training for providers. An additional 13 respondents are in the planning stages for implicit bias training initiatives and 13 reported that they are interested in pursuing them but have not yet.

Five out of 33 respondents have active initiatives to promote MCH workforce pipeline programs for people of color. An additional six respondents are in the planning stages for such workforce initiatives and 16 reported that they are interested in pursuing them but have not acted yet.

Extending Medicaid coverage for doula services is also a state strategy to advance racial equity for women and children, as doula care is an evidence-based method to decrease factors that can lead to mortality, such as cesarean births, use of analgesics, and duration of labor.<sup>27</sup> Additional information on trends in Medicaid coverage for doulas can be found in **Coverage and Payment**.

**Figure 3: Strategies to Address Racial Disparities in Maternal and Child Health**

## Strategies to Address Social Determinants of Health

Many states and territories are working to improve integration of health care with social supports. For women with complex social needs, integrated screening and linkages to social services can improve health outcomes and address conditions of poverty. Twenty-three out of 38 states report that their Medicaid program currently covers services that address social determinants of health for mothers and children. An additional four respondents are in the planning stages to provide this type of coverage.

Among states that currently offer services financed via Medicaid to address social determinants of health, services offered for some women enrolled in Medicaid include the following (out of 23 responses total):

- ▶ Transportation services (21 responses)
- ▶ Services to support housing (15 responses)
- ▶ Services to address food insecurity (12 responses)
- ▶ Services to address employment (12 responses)

Additionally, 12 states report they offer other services via Medicaid to address social determinants of health.

States and territories have multiple policy mechanisms to cover services that address social determinants of health. In this survey, states reported they predominantly offer services to address social determinants of health under the authority of a State Plan Amendment (15 out of 22 respondents) or via Medicaid managed care contracts (12 out of 22 respondents).

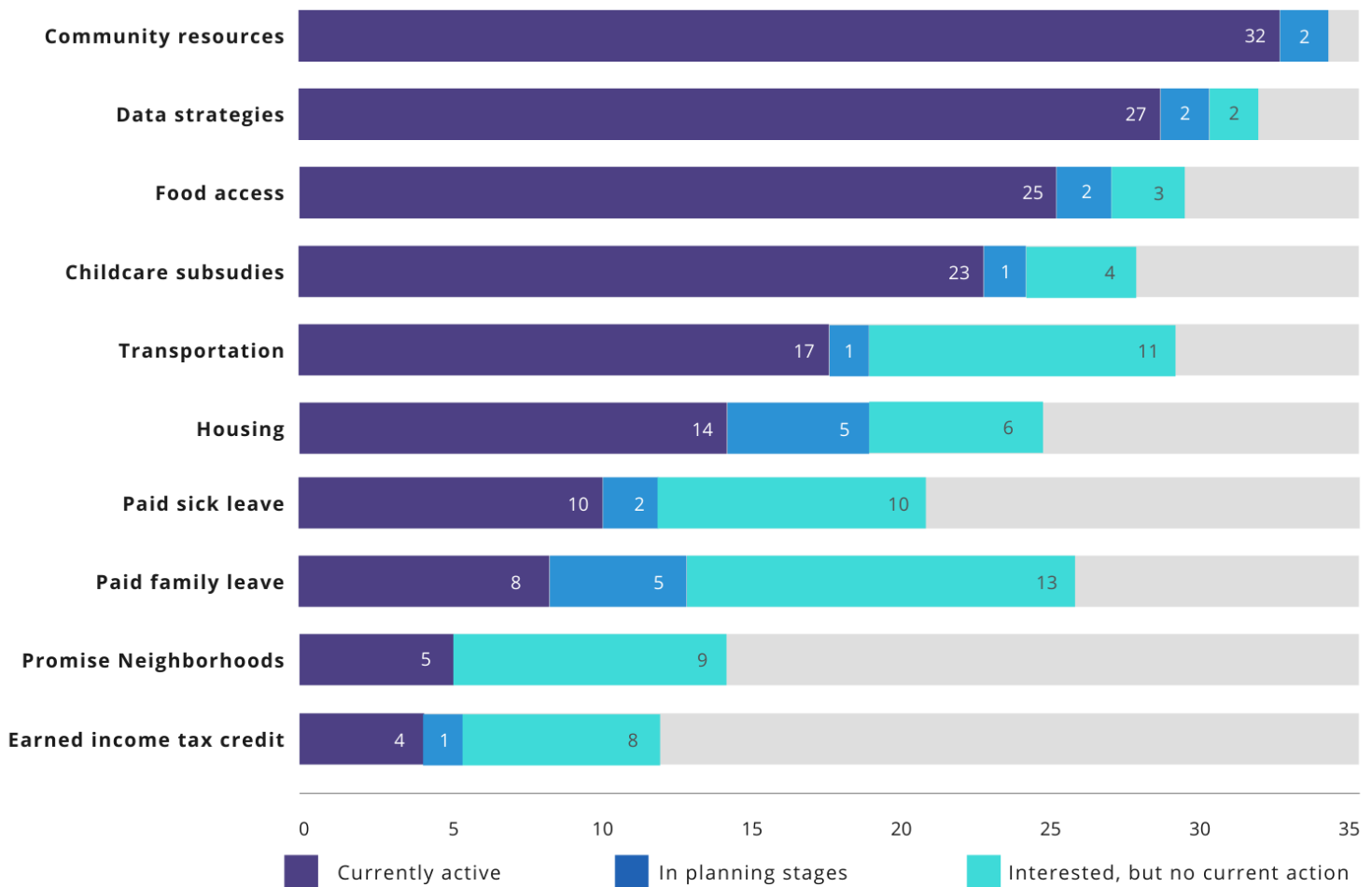
Through the Section 1115 demonstration waiver process, Medicaid funds can be used to provide housing services and reimburse expenses such as utility bills and childcare expenses, provided that

the state seeks approval from CMS.<sup>28</sup> Among 22 survey respondents, nine states report offering such services under the authority of Section 1115 Medicaid demonstration waivers.

States also offer services to address social determinants of health under the authority of Section 1915(c) Home- and Community-Based Services waivers (six responses). Four respondents use other mechanisms to provide services to address social factors that impact health, including relying on state-funded programs to enable service delivery.

In addition to services specifically focusing on women and children enrolled in Medicaid, states and territories are also undertaking broader policy initiatives to address socioeconomic disparities, as described in **Figure 4**.

**Figure 4: Policy Initiatives to Address Socioeconomic Disparities Among Mothers and Children**



## Behavioral Health Care for Pregnant Women and New Mothers

States and territories have prioritized policies to promote maternal behavioral health, including mental health, substance use disorders and wellbeing. As noted in the [Maternal and Child Health through a Governor's Lens](#) section above, policies focusing on maternal behavioral health are among Governors' top priorities. Specifically, survey responses indicate that Governors have prioritized efforts to decrease substance use among pregnant women (11 out of 34 respondents) and increase access to maternal mental health care (eight out of 34 respondents).

State and territory Title V priorities also reflect the importance of maternal behavioral health, with states and territories working to increase connections to supports for women and children (15 out of 41 respondents); reduce smoking among pregnant women and/or exposure to secondhand smoke for young children (11 out of 41 respondents); and address substance use among pregnant women (seven out of 41 responses). For additional information, see [Maternal and Child Health through a Governor's Lens](#).

Some of the most pressing concerns in this area include:

- ▶ **Maternal Depression:** Maternal depression is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women.<sup>29</sup> This condition can interfere with the development of healthy parent-child bonds, negatively impacting child development.<sup>30</sup> Women living in poverty are both more likely to experience depression and less likely to receive mental health treatment as compared to those with higher incomes.<sup>31 32</sup> Eleven states and territories specifically mentioned increasing access to mental health for pregnant and postpartum women.
- ▶ **Substance Use Disorder and Neonatal Abstinence Syndrome:** Substance use disorder during the perinatal period contributes to poor outcomes for newborns, drug-related deaths, and maternal mortality.<sup>33 34 35</sup> Neonatal Abstinence Syndrome is a serious condition that occurs when infants experience withdrawal from substances used by the mother during pregnancy, most often opioids.<sup>36</sup> The majority of states and territories surveyed (32 out of 37 respondents) track this syndrome among infants. Among these, hospital and health system data are used most frequently to track trends (25 responses). Eleven states have established a uniform clinical definition for Neonatal Abstinence Syndrome to enable more consistent reporting.
- ▶ **Smoking and Vaping:** Both traditional cigarettes and electronic vaping products pose risks to fetal development.<sup>37</sup> Although the Centers for Disease Control and Prevention recommends against the use of any nicotine products during pregnancy, some pregnant women continue to smoke, or turn to vaping in an attempt to quit or reduce smoking during pregnancy.<sup>38</sup> Twenty states and territories out of 35 respondents report they currently collect data on electronic vaping product use among pregnant women. In addition, two states said they are in planning stages to collect such data. Twelve states and territories indicated they are interested in collecting data on vaping during pregnancy but have not yet taken action.







## **Funding Best Practice Models for Mothers with Substance Use Disorder and Babies with Neonatal Abstinence Syndrome**

To address the unique needs of mothers with substance use disorder and their babies, states and territories have implemented policies and programs that incorporate best practice models of **mother-baby dyad care**<sup>\*</sup>. For instance, evidence suggests that hospital-based rooming-in models, where mothers with substance use disorders remain with their babies, may reduce the length of hospital stays for babies with Neonatal Abstinence Syndrome as well as the need for medication.<sup>39</sup>

Out of 36 respondents, 17 states and territories currently fund programs to encourage best practice models of mother-baby dyad care. An additional three respondents are in the planning stages to launch such initiatives. Multiple respondents specifically referred to implementation of the evidence-based **Eat, Sleep, Console**<sup>†</sup> model as a cornerstone of their approach.

---

<sup>\*</sup> Mother-baby dyad care is an evidence-based practice that acknowledges the physiology, physical safety and emotional well-being of the mother and infant after birth. The model emphasizes that the appropriate care of one must address the needs of the other. A common practice in dyad care is providing skin-to-skin contact between the mother and infant, as it is associated with – among other things – increased breastfeeding duration and cardio-respiratory stability in late preterm infants.

<sup>†</sup> Eat, Sleep, Console is an evidence-based model designed for parents to care for their infants who may be suffering from Neonatal Abstinence Syndrome while promoting family-centered care. Parents are instructed to use this model before seeking pharmacological options to differentiate between withdrawal symptoms and normal newborn behavior.

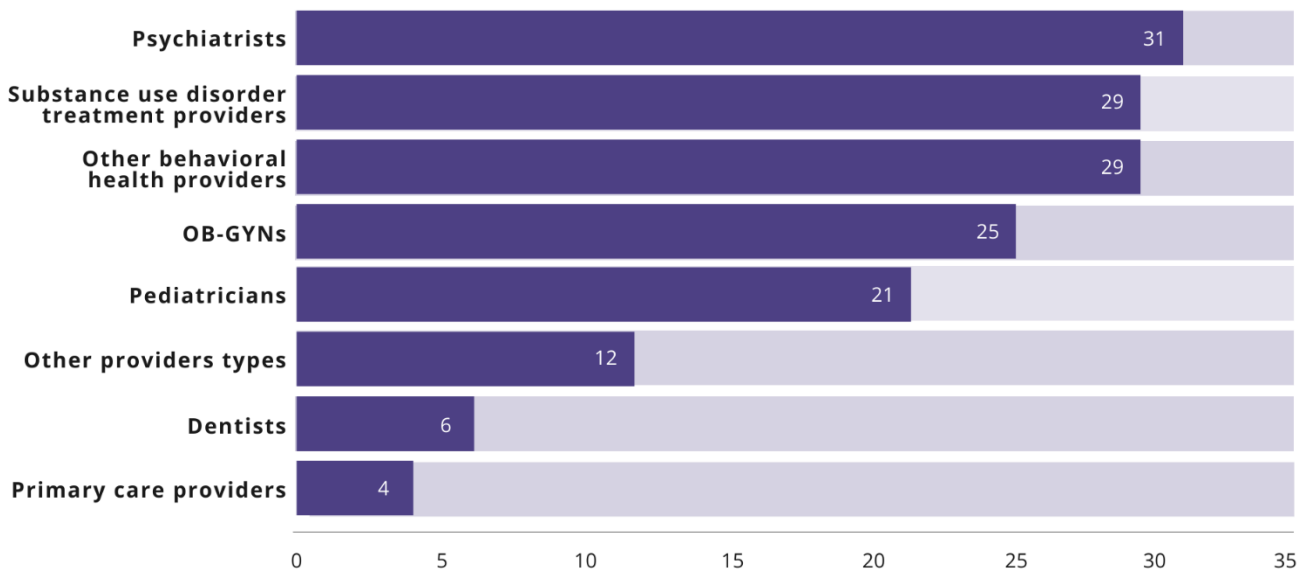
## Maternal and Child Health Workforce

States and territories are experiencing provider shortages that impact the health of pregnant women and infants. Twenty-nine out of 37 respondents said their state or territory experienced closures of hospital labor and delivery departments since 2016. Twenty-three states and territories provided figures for the number of closures during this time; among these, the average number of hospital labor and delivery department closures was four, with closures-per-state ranging from one to 13.

### Health Workforce Shortages

In addition to labor and delivery department closures, provider shortages impact the health of mothers and infants in other settings as well. Survey results indicated that many states and territories are facing provider shortages across a wide variety of provider types. Thirty-five respondents provided information on health professional shortages. The most frequently cited shortages focused on behavioral health care providers. States and territories most frequently report shortages of psychiatrists (31 respondents), substance use disorder treatment providers (29 respondents), and other behavioral health care providers (29 respondents). In addition, states and territories noted shortages of OB-GYNs (25 respondents) and pediatricians (21 respondents) as well as other provider types (12 respondents), dentists (six respondents) and primary care providers (four respondents).

**Figure 5: Health Professional Shortages Impacting Maternal and Child Health**

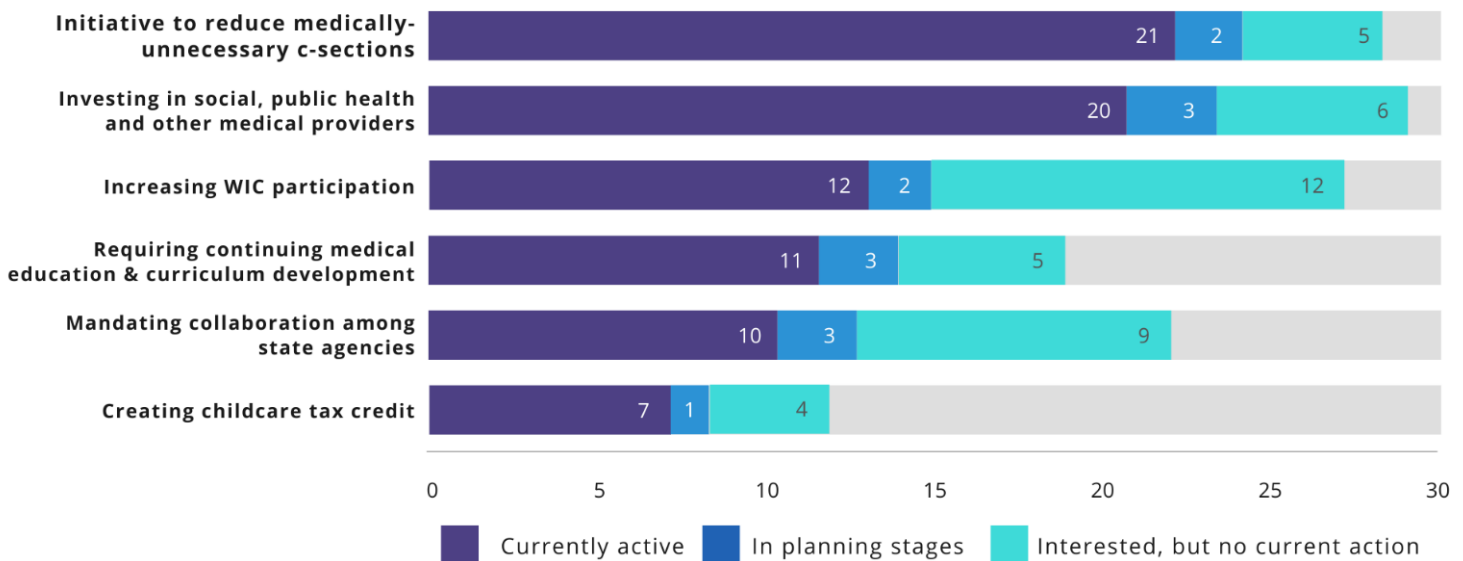


## Birth Outcomes and Early Childhood

States and territories are pursuing and considering a variety of actions to improve birth outcomes. Survey respondents reported implementing or working towards several new initiatives, using a variety of mechanisms such as enacting laws, regulations, executive orders, appropriation and/or allocation of state funding.

**Figure 6** summarizes state and territory actions that have been taken to improve birth outcomes. States report active initiatives to reduce elective C-sections (21 responses), promote Women, Infants and Children (WIC) program participation (12 responses), require continuing medical education and curriculum development (11 responses), and mandate collaboration among state agencies that serve maternal and infant populations (ten responses). Additionally, 20 states and territories have currently active programs to create a continuum of care across social, public health and medical providers. Seven respondents report active initiatives to offer a childcare tax credit at the state level.

**Figure 6: State and Territory Actions to Promote Healthy Birth Outcomes**



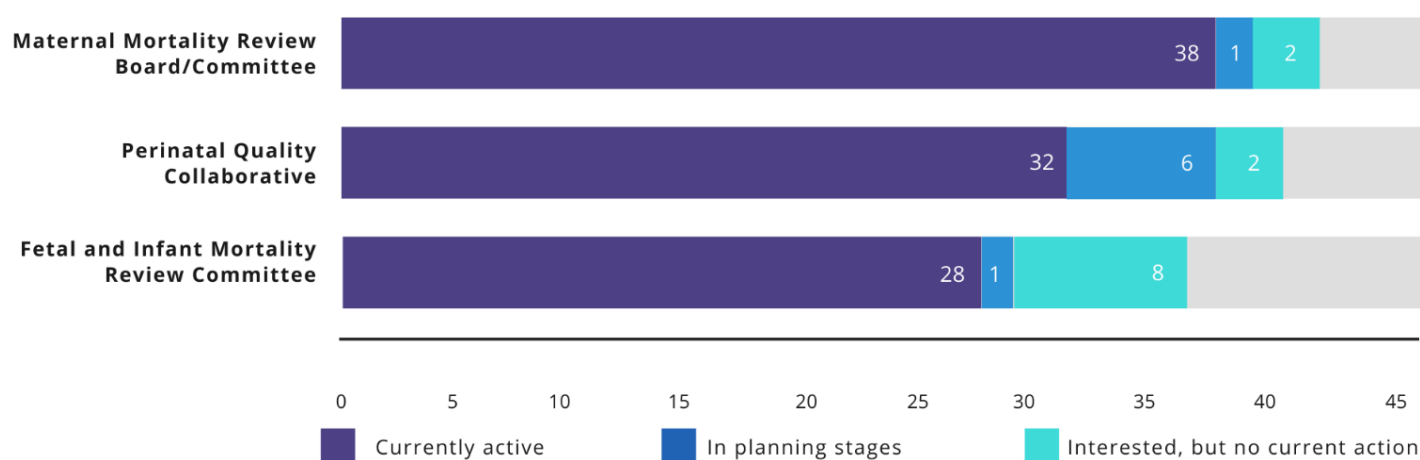
## Maternal and Infant Mortality Review Committees

States and territories have created different groups, boards and committees to improve maternal and infant birth outcomes. These interdisciplinary groups examine data from a variety of sources to understand the circumstances around maternal and infant deaths and make recommendations on how to reduce maternal and infant mortality and morbidity.<sup>40</sup> Maternal and infant mortality review committees often work in partnership with perinatal quality collaboratives, which promote actionable quality improvement initiatives that are clinically focused (e.g., creating, vetting and issuing clinical care guidelines). Twenty-four states and territories reported that these groups were established either via legislation (ten respondents), through the Fetal Infant Mortality Review

Program (seven respondents) or as a Title V initiative (five respondents). States and territories reported a broad range of dates of establishment, with founding years ranging from 1989 to 2020.

**Figure 7** describes state and territory efforts to convene committees and review boards focusing on maternal and infant mortality and morbidity.

**Figure 7: Groups Convened to Promote Healthy Birth Outcomes**



Mortality review committees are typically interdisciplinary bodies made up of professionals from a variety of backgrounds. Thirty-six respondents shared information on the composition of their maternal mortality review committees.

The most frequently cited organizations that participate in maternal mortality review committees include:

- State public health agency (32 responses)
- State Title V program (30 responses)
- Academic institutions (29 responses)
- Hospitals/Hospital associations (29 responses)
- Behavioral health agencies (25 responses)
- State chapters of professional associations (23 responses)
- State Medicaid agency (21 responses)

These groups examine data from a variety of sources to understand the circumstances around maternal and infant deaths and make recommendations on how to reduce mortality and morbidity. Among 38 respondents, 35 reported that they determine the maternal mortality rate in their state or territory by analyzing a combination of maternal death certificates and matching fetal death or birth certificates. Twenty-three states and territories examine hospital and health facility data, and 21 respondents look at maternal death certificates only.

Twenty-four respondents indicated funding sources for infant mortality review committees typically include Title V Block Grant funding (14 responses) or a combination of Title V Block Grant funding with other sources of funding, such as Medicaid or state funds (eight responses). Four respondents reported that they do not use Federal Title V funding to support mortality review board/committee activities, relying solely on state funding or other sources.

## **Breastfeeding**

Breastfeeding offers health benefits for both mothers and infants.<sup>41</sup> The vast majority of states and territories surveyed reported current initiatives to promote and support breastfeeding. Out of 38 respondents, 36 reported supporting efforts to provide access to professional and peer supports for breastfeeding. Thirty-two respondents reported they currently support breastfeeding initiatives in birthing facilities, and 26 respondents stated they consistently allocate funding to WIC breastfeeding programs.<sup>42</sup> Nineteen respondents said that they have current laws at the state/territory level to encourage breastfeeding.

Thirty-three states and territories reported that they planned to take new or innovative action to support breastfeeding in the coming year as described in **Table 3**, many of which are Title V-led initiatives.

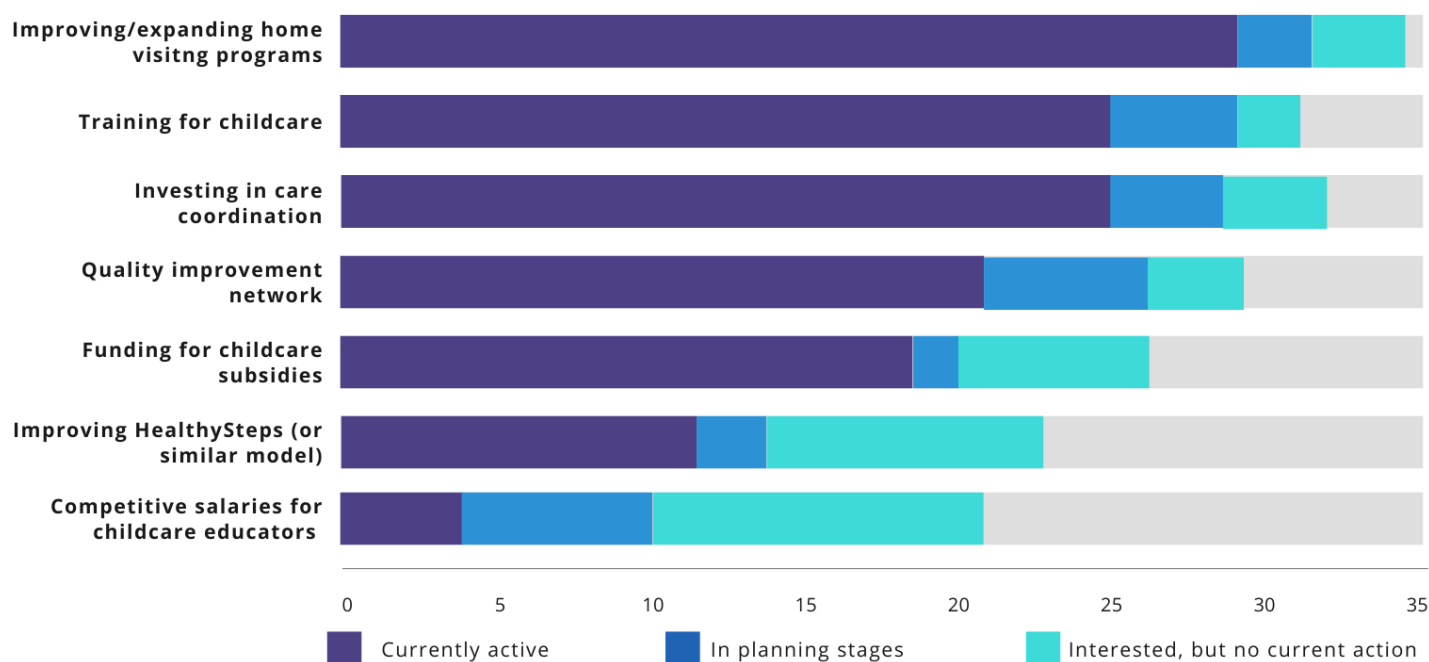
**Table 3: New or Innovative Breastfeeding Initiatives Planned in the Coming Year**

<b>Common Themes</b>	<b># of States and Territories</b>
Collaborating with WIC programs in the state	11
Evidence-based breastfeeding classes	6
Breastfeeding-friendly hospital initiative	6
Training public health professionals to better engage families in promoting breastfeeding	5
Launching initiatives to address racial, ethnic and geographic disparities in breastfeeding rates	5
Collaborating with community organizations to promote breastfeeding	4
Other types of breastfeeding initiatives	4
Promoting breastfeeding-friendly worksites	3
Collaborating to combine funding and other resources	3
Offering Medicaid coverage for breastfeeding equipment, lactation support services and pasteurized donated breastmilk	2
Increased funding for WIC breastfeeding peer counselor program	2
Enhanced media/online campaigns for breastfeeding	2

## Infant and Early Childhood Initiatives

Infancy and early childhood are recognized as critical periods for brain development, laying the foundation for educational success and health across the lifespan.<sup>43</sup> **Figure 8** describes initiatives states are pursuing to advance early childhood health and development during the 0-3 years.

**Figure 8: Infant and Early Childhood Strategies**



Home visiting is a well-established strategy to support healthy development in early childhood, with 29 out of 34 respondents reporting they have currently active initiatives to expand or improve home visiting programs. These programs bring specially trained women, such as nurses, social workers, community health workers and others, into the homes of families with young children to provide parenting education and complementary services that promote positive health and developmental outcomes.<sup>44</sup>

Twenty-six respondents have active initiatives to promote education and training for childcare providers. Eighteen respondents reported they currently fund childcare subsidies for low-income families to ensure they can access childcare services. Four respondents have active efforts to promote competitive salaries for early childhood educators.

States and territories also implemented quality improvement networks to support providers in delivering high-quality services (21 out of 30 respondents). Twenty-five respondents also reported having active initiatives investing in care coordination for infant and early childhood populations.



Eleven states reported they have an active **HealthySteps program**<sup>\*</sup> or a similar program that provides parenting education, screening and referrals within the context of a pediatric well child visit.<sup>45</sup>

## **Oral Health**

Many women with low incomes face barriers to accessing and receiving quality, affordable oral health care during pregnancy and the postpartum period. Although pregnant women enrolled in Medicaid are entitled to pregnancy-related services, oral health care is not explicitly included in that category.<sup>46</sup> In 2019, 48 states and the District of Columbia offered some type of oral health coverage to pregnant women receiving Medicaid.<sup>47</sup> The range and type of oral health services varies significantly from state to state according to the Association of State and Territorial Dental Directors, with 22 of the 48 states offering extensive dental benefits to pregnant women receiving Medicaid.<sup>48</sup>

Survey respondents shared information on a variety of initiatives related to oral health for pregnant women. Out of 36 respondents, 25 reported initiatives to increase primary care and dental care integration. Fourteen respondents have implemented strategies to expand participation in dental care provider networks accepting Medicaid, and 14 respondents reimburse for telemedicine services via Medicaid as a strategy to improve oral health among pregnant women.

Six respondents reported education and outreach initiatives around dental and oral health. Some specifically noted education conducted via home visiting, community health worker or doula programs.

Ten respondents reported that they have expanded dental hygienist scope of practice and six use dental therapists to address provider shortages and increase access to oral health care services.

## **Conclusion**

Governors are actively working with state and territory leadership to address priority areas around maternal and infant mortality, substance use in pregnant and postpartum women and improved birth outcomes. Many states are using their Medicaid programs to provide innovative, evidence-based services and collect data to identify gaps in care. Additionally, many Governors have issued executive orders and signed legislation to improve practices, including forming mortality review committees and addressing gaps in behavioral health services for pregnant women. Overall, the 2020 survey results show that Governors and state/territory leaders are committed to improving birth outcomes and ensuring high-quality care for pregnant women, moms and babies.

---

<sup>\*</sup> The HealthySteps national network has more than 170 pediatric and family practice sites in more than 20 states and the District of Columbia. The pediatric primary care program is an evidence-based, team-based model that promotes the health, well-being and school readiness of babies and toddlers.

## Acknowledgements

The NGA Center would like to thank the state officials and other experts who participated in the MCH Update survey and provided feedback to inform the publication. The NGA Center would also like to thank the Health Resources and Services Administration in the U.S. Department of Health and Human Services for their generous support of this project.

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of HRSA or the U.S. Department of Health and Human Services.

This publication was developed by Lauren Block, Michelle LeBlanc and Caroline Picher at the National Governors Association Center for Best Practices in collaboration with consultant Ann Ritter.

Recommended citation: LeBlanc, M., Block, L., & Picher, C. (2021). National Governors Association Maternal-Child Health Update 2020. Washington, D.C.: National Governors Association Center for Best Practices.

<sup>1</sup> LeBlanc, Michelle and Lauren Block. *State and Territory Policy Strategies Supporting Maternal and Child Health During COVID-19* (Washington DC: National Governors Association Center for Best Practices, August 2020), <https://www.nga.org/memos/policy-strategies-maternal-child-health-covid19/>

<sup>2</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), *Title V Maternal and Child Health Services Block Grant to the States Program* (Rockville, MD: HRSA, n.d.), <https://mchb.tvisdata.hrsa.gov/uploadedfiles/TvisWebReports/Documents/blockgrantguidance.pdf>

<sup>3</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), *Medicaid's Role in Financing Maternity Care* (Washington DC: MACPAC, January 2020), <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>

<sup>4</sup> Ranji, Usha, Ivette Gomez, and Alina Salganicoff, *Expanding Postpartum Medicaid Coverage* (Washington DC: Kaiser Family Foundation, May 2019), <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/>

<sup>5</sup> Petersen, Emily E., Nicole L. Davis, David Goodman et al., "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017," *MMWR Morbidity and Mortality Weekly Report*, 68 (2019): 423–429, <http://dx.doi.org/10.15585/mmwr.mm6818e1>

<sup>6</sup> "Pregnant women," Medicaid and CHIP Payment and Access Commission (MACPAC), accessed October 18, 2020, <https://www.macpac.gov/subtopic/pregnant-women/>

<sup>7</sup> Kozhimannil, Katy Backes, Elaine Hernandez, Dara D. Mendez and Theresa Chapple-McGruder, "Beyond The Preventing Maternal Deaths Act: Implementation And Further Policy Change," *Health Affairs Blog*, February 4, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190130.914004/full/>

<sup>8</sup> Ranji, Usha, Ivette Gomez, and Alina Salganicoff, *Expanding Postpartum Medicaid Coverage* (Washington DC: Kaiser Family Foundation, May 2019), <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/>

<sup>9</sup> U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *CMCS Informational Bulletin: State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception* (Baltimore, MD: CMS, April 8, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf>

<sup>10</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), *Evidence Summary: Prevent Unintended Pregnancy* (Atlanta GA: CDC, December 2015), <https://www.cdc.gov/sixteen/docs/6-18-evidence-summary-pregnancy.pdf>

<sup>11</sup> "Defining the PCMH," U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), accessed October 18, 2020, <https://pcmh.ahrq.gov/page/defining-pcmh>

<sup>12</sup> McCoy, Carolyn, "Pregnancy Medical Homes," *Pulse* (Washington DC: Association of Maternal & Child Health Programs, November/December 2013), <http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Archive/2013/NovDec2013/Pages/Feature9.aspx>



- <sup>13</sup> Lally, Sarah, *Transforming Maternity Care: A Bundled Payment Approach* (Oakland CA: Integrated Healthcare Association, September 2013), <https://www.ihc.org/sites/default/files/resources/issue-brief-maternity-bundled-payment-2013.pdf>
- <sup>14</sup> Center for Health Care Strategies (CHCS), *Medicaid Accountable Care Organizations: State Update* (Hamilton NJ: CHCS, February 2018), <https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf>
- <sup>15</sup> Fowler, Tara Trudnak, et al., "Early Elective Deliveries Accounted For Nearly 9 Percent Of Births Paid For By Medicaid," *Health Affairs* 33, no. 12 (December 2014): 2170-2178, <https://doi.org/10.1377/hlthaff.2014.0534>
- <sup>16</sup> Centering Healthcare Institute, *Issue Brief: How CenteringPregnancy Can Support Birth Equity* (Boston MA: Centering Healthcare Institute, October 2019), [https://www.centeringhealthcare.org/uploads/downloads/BirthEquity\\_IssueBrief\\_Oct9th2019.pdf](https://www.centeringhealthcare.org/uploads/downloads/BirthEquity_IssueBrief_Oct9th2019.pdf)
- <sup>17</sup> Costa, Jessica, "Nurse Midwife vs. Doula: What's the Difference, and Which One Do I Need?," *Cleveland Clinic Blog*, December 31, 2018, <https://health.clevelandclinic.org/nurse-midwife-vs-doula-whats-the-difference-and-which-one-do-i-need/>
- <sup>18</sup> Souter, Vivienne, et al., "Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births," *Obstetrics & Gynecology* 134, no. 5 (November 2019): 1056-1065, <https://doi.org/10.1097/AOG.0000000000003521>
- <sup>19</sup> American College of Obstetricians and Gynecologists (ACOG), *Committee Opinion Number 766: Approaches to Limit Intervention During Labor and Birth*, (Washington DC: ACOG, February 2019), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth>
- <sup>20</sup> Gebel, Christina and Sarah Hoden, "Expanding Access to Doula Care: State of the Union," *Maternal Health Task Force Blog*, January 8, 2020, <https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/>
- <sup>21</sup> Petersen, Emily E., Nicole L. Davis, David Goodman et al., "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017," *MMWR Morbidity and Mortality Weekly Report*, 68 (2019): 423–429, <http://dx.doi.org/10.15585/mmwr.mm6818e1>
- <sup>22</sup> "Infant Mortality in the United States, 2017: Data From the Period Linked Birth/Infant Death File," Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, August 1, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_10-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_10-508.pdf)
- <sup>23</sup> IBID
- <sup>24</sup> American Academy of Family Physicians (AAFP), *Addressing Social Determinants of Health in Primary Care* (Leawood KS: AAFP, 2018), [https://www.aafp.org/dam/AAFP/documents/patient\\_care/everyone\\_project/team-based-approach.pdf](https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf)
- <sup>25</sup> "Maternal, Infant, and Child Health Across the Life Stages," U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, accessed October 19, 2020, <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health/determinants>
- <sup>26</sup> "Title V Maternal and Child Health Services Block Grant Program," U.S. Department of Health and Human Services, HRSA, accessed October 19, 2020, <https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program>
- <sup>27</sup> Association of State and Territorial Health Officers (ASTHO), "State Policy Approaches to Incorporating Doula Services into Maternal Care," *ASTHOExperts Blog*, August 9, 2018, <https://www.astho.org/StatePublicHealth/State-Policy-Approaches-to-Incorporating-Doula-Services-into-Maternal-Care/08-09-18/>
- <sup>28</sup> Garg, Arvin, Charles J. Homer and Paul H. Dworkin, "Addressing Social Determinants of Health: Challenges and Opportunities in a Value-Based Model," *Pediatrics*, 143, no. 4 (April 2019): e20182355, <https://doi.org/10.1542/peds.2018-2355>
- <sup>29</sup> Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol* 2005;106:1071–83
- <sup>30</sup> Rogers, Alana, Shelley Obst, Samantha J. Teague et al. "Association Between Maternal Perinatal Depression and Anxiety and Child and Adolescent Development: A Meta-analysis," *JAMA Pediatrics*, published online September 14, 2020, <https://doi.org/10.1001/jamapediatrics.2020.2910>
- <sup>31</sup> Reeves, Richard V. and Eleanor Krause, *The Effects of Maternal Depression on Early Childhood Development and Implications for Economic Mobility* (Washington DC: Brookings, January 2019), [https://www.brookings.edu/wp-content/uploads/2019/01/ES\\_20190131\\_Reeves\\_Maternal\\_Depression2.pdf](https://www.brookings.edu/wp-content/uploads/2019/01/ES_20190131_Reeves_Maternal_Depression2.pdf)
- <sup>32</sup> McDaniel, Marla and Christopher Lowenstein, *Depression in Low-Income Mothers of Young Children: Are They Getting the Treatment They Need?* (Washington DC: Urban Institute, April 2013), <https://www.urban.org/sites/default/files/publication/23546/412804-Depression-in-Low-Income-Mothers-of-Young-Children-Are-They-Getting-the-Treatment-They-Need-.PDF>



- <sup>33</sup> Patrick, Stephen W., Judith Dudley, Peter R. Martin, et al., "Prescription Opioid Epidemic and Infant Outcomes," *Pediatrics*, 135, no. 5 (May 2015): 842-850, <https://doi.org/10.1542/peds.2014-3299>
- <sup>34</sup> American College of Obstetricians and Gynecologists (ACOG), *Committee Opinion Number 711: Opioid Use and Opioid Use Disorder in Pregnancy*, (Washington DC: ACOG, August 2017), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy>
- <sup>35</sup> "ACOG Statement on AMA Support for 12 Months of Postpartum Coverage Under Medicaid," American College of Obstetricians and Gynecologists (ACOG), June 12, 2019, <https://www.acog.org/news/news-releases/2019/06/acog-statement-on-ama-support-for-12-months-of-postpartum-coverage-under-medicaid>
- <sup>36</sup> "Neonatal Abstinence Syndrome (NAS)," March of Dimes, June 2019, [https://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-\(nas\).aspx](https://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-(nas).aspx)
- <sup>37</sup> "Tobacco, Alcohol, and Drugs During Pregnancy," American Academy of Family Physicians, *Familydoctor.org*, July 9, 2020, <https://familydoctor.org/tobacco-alcohol-drugs-pregnancy/>
- <sup>38</sup> "CDC Warns Against Peripartum Use of Vaping Products," American Academy of Family Physicians, March 11, 2019, <https://www.aafp.org/news/health-of-the-public/20190311vapepregnancy.html>
- <sup>39</sup> "A Mother-Centered Approach to Treating Neonatal Abstinence Syndrome," National Institute for Children's Healthcare Quality, accessed October 23, 2020, <https://www.nichq.org/insight/mother-centered-approach-treating-neonatal-abstinence-syndrome>
- <sup>40</sup> Davis, Nicole L., Ashley N. Smoots and David A. Goodman, U.S. Department of Health and Human Services, CDC, *Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017*, (Atlanta, GA: CDC, 2019), <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html>
- <sup>41</sup> "Understanding Breastfeeding Benefits," U.S. Department of Health and Human Services, HRSA, June 2019, <https://mchb.hrsa.gov/maternal-child-health-topics/understanding-breastfeeding-benefits>
- <sup>42</sup> "WIC Breastfeeding Support," U.S. Department of Agriculture, accessed October 23, 2020, <https://wicbreastfeeding.fns.usda.gov/>
- <sup>43</sup> Center on the Developing Child, *InBrief: The Science of Early Childhood Development*, (Boston, MA: Harvard University, 2007), <https://developingchild.harvard.edu/resources/inbrief-science-of-eecd/>
- <sup>44</sup> "Home Visiting," U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), March 2020, <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>
- <sup>45</sup> "HealthySteps: Transforming the promise of pediatric care," Zero to Three, accessed October 23, 2020, <https://www.healthysteps.org/>
- <sup>46</sup> Association of State and Territorial Dental Directors. 2020. Perinatal Oral Health Policy Statement. Reno, NV: Association of State and Territorial Dental Directors.
- <sup>47</sup> IBID
- <sup>48</sup> IBID