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January 30, 2024

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor of Virginia

The Honorable L. Louise Lucas
President Pro Tempore, Senate of Virginia

The Honorable Don Scott
Speaker of the House, House of Representatives

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: 2023 Report to the Governor and General Assembly Task Force on Maternal Health Data and Quality Measures

This report is submitted in compliance with the 2021 Virginia Acts of the Assembly – Chapter 215 An Act to establish the Task Force on Maternal Health Data and Quality Measures; report, which states:

> *The Task Force shall report its findings and conclusions to the Governor and General Assembly by December 1 of each year regarding its activities and shall conclude its work by December 1, 2023.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/AJ
Enclosure

Pc: The Honorable John Littel, Secretary of Health and Human Resources

TASK FORCE ON MATERNAL HEALTH DATA AND QUALITY MEASURES REPORT

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

2023

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

The State Health Commissioner presents the 2023 annual and final report of the Task Force on Maternal Health Data and Quality Measures (the Task Force). During the 2021 General Assembly Special Session I, the General Assembly enacted Chapter 215 [HB 2111], which tasked the State Health Commissioner with establishing the Task Force for the purpose of evaluating maternal health data collection processes to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The Task Force is required to report its findings to the Governor and General Assembly by December 1 of each year and conclude its work by December 1, 2023. This report contains summaries of 2022 and 2023 Task Force meetings and the final recommendations from the Task Force. This report will be available on December 1, 2023, to the General Assembly and the Governor. The Virginia Department of Health (VDH) provided staff support, meeting coordination, and assistance with writing this report to the Task Force.

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Virginia House of Delegates
Shelly Simonds, Delegate
Charniele Herring, Delegate
Candi Mundon King, Delegate
Kaye Kory, Delegate
Dawn Adams, Delegate

Virginia Senate
George Barker, Senator
Mamie Locke, Senator
*Jen Kiggans, Senator (through 2022)
Siobhan Dunnavant, Senator

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EXECUTIVE SUMMARY

In 2021, the General Assembly tasked the State Health Commissioner with establishing the Task Force on Maternal Health Data and Quality Measures (the Task Force) for the purpose of evaluating maternal health data collection processes to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The Task Force is required to report on its activities by December 1 each year and conclude its work by December 1, 2023. This final report contains the recommendations from the Task Force that are due by December 1, 2023, to the General Assembly and the Governor. The Task Force convened for ten meetings in 2022 and 2023 and developed 22 recommendations for the Governor and General Assembly. Ten of the recommendations impact Medicaid. The Task Force recommendations are listed below.

Recommendations

The Task Force's work concluded with preparing recommendations to address maternal health data collection, data capacity, data linkage, data warehousing, and data reporting throughout the Commonwealth of Virginia. These recommendations seek to fill gaps in the aforementioned areas and are detailed further in the "Recommendations" section of this report.

Recommendation 1: **Improve the Virginia All-Payer Claims Database (APCD)**

Recommendation 2: **Develop a Statewide Maternal Health Data Board**

Recommendation 3: **Ensure Behavioral Health Access for Pregnant and Postpartum Women by Studying and Reporting on Certain Metrics by 2024 (detailed metrics listed in the "Recommendations" section)**

Recommendation 4: **Enhance Maternal Mental Health Data**

Recommendation 5: **Expand Maternal Health Data Reporting**

Recommendation 6: **Continue to Fund Yearly Virginia Neonatal Perinatal Collaborative (VNPC) Report**

Recommendation 7: **Incorporate Evidence Based Home Visiting Program into the Model of Care**

Recommendation 8: **Expand Benefit Coverage to Include Presumptive Eligibility for Ambulatory Prenatal Care**

Recommendation 9: **Authorize Federally Qualified Health Centers (FQHCs) to Bill for Multiple Encounters**

Recommendation 10: **Authorize Medicaid to Cover and Reimburse FQHCs for Services Delivered by Doulas, Marriage & Family Therapists, Licensed Professional Counselors, and Community Health Workers (CHWs)**

Recommendation 11: **Expand Preventive Dental Services for Expectant Mothers**

Recommendation 12: **Implement Multi-Year Continuous Eligibility for Children up to Five Years of Age**

INTRODUCTION

WORKGROUP MANDATE

During the 2021 Special Session of the General Assembly, the General Assembly enacted Chapter 215, which directed the State Health Commissioner to establish the Task Force on Maternal Health Data and Quality Measures (the Task Force). Per Chapter 215, the purpose of the Task Force was to evaluate maternal health data collection to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. Chapter 215 also laid out seven specific charges for the Task Force related to this overall purpose:

1. Monitor progress and evaluate all data from state-level stakeholders, including third-party payers, and all available electronic claims data to examine quality of care with regard to race, ethnicity, and other demographic and clinical outcome data;
2. Monitor progress and evaluate all data from existing state-level sources mandated for maternal care, including new Healthcare Effectiveness Data and Information Set (HEDIS) measure updates to Prenatal and Postpartum Care and Postpartum Depression;
3. Examine the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers;
4. Examine current maternal health benefit requirements and determine the need for additional benefits to protect the health of birthing people;
5. Evaluate the impact of Social Determinants of Health (SDoH) screening on pregnant women and its impact on outcomes data;
6. Collect and analyze data one year after delivery; and
7. Develop recommendations for standard quality metrics on maternal care

– Chapter 215 of the 2021 Acts of Assembly, special session I

WORKGROUP ACTIVITIES

Throughout 2022 and 2023, the Task Force examined the components of each charge in Chapter 215 and assessed the existing data-related needs. Task Force members met and elected that this report, and more so the recommendations within it, highlight the solutions to understanding and fulfilling those data needs.

MARCH 22, 2022

VDH staff facilitated the meeting virtually, and the agenda included a welcome and introductions of all members and staff. Task Force members had received electronic copies of the draft bylaws prior to the meeting. VDH staff provided a detailed review of Chapter 215 and the draft bylaws. This review was followed by an open discussion among Task Force members regarding where and how best to start the work of the Task Force, as well as a timeline for discussions and actions. This timeline sought to ensure that the Task Force met the deadline for submitting recommendations to the General Assembly. Members agreed that an environmental scan was needed to establish the baseline of maternal health data that is currently collected and accessible in Virginia. Members volunteered to form a subgroup to perform that environmental scan.

MAY 24, 2022

This meeting was in a hybrid format, with those able to attend in person doing so in Glen Allen, Virginia, and the remaining members attending virtually. Following a roll call, the Task Force voted to accept the draft bylaws. With bylaws enacted, the Task Force nominated and elected Dr. Scott Sullivan of Inova Health and Delegate Shelly Simmonds for the roles of Chair and Vice Chair, respectively, which they accepted. John

Muraca of United Healthcare presented on third-party payer benefits data; Laura Boutwell of Virginia's Department of Medical Assistance Services presented on updated HEDIS measures; and Shannon Pursell of the Virginia Neonatal Perinatal Collaborative presented an example of best practices in collecting and using data collaboratively in Virginia. The presentations were followed by an open discussion about improving access to third-party payer data and the data collection and sharing tool Ms. Pursell had presented. The Task Force discussed and agreed upon a meeting cadence.

AUGUST 30, 2022

This meeting was in a hybrid format and Task Force Chair Dr. Scott Sullivan facilitated. The agenda included introductions and a presentation related to the fourth charge of the Task Force to examine current maternal health benefit requirements and recommend additional requirements. Shannon Pursell, Director of the Virginia Neonatal Perinatal Collaborative, presented the VHHA Maternal Health Dashboard (Dashboard) to the Task Force. Angela Lello, the East Region Policy Director at United Healthcare, presented the current maternal health benefit requirements for Virginia Medicaid. These presentations were followed by facilitated discussions to develop recommendations to add new benefits and expand current benefits to fit the needs of Virginia's pregnant women. The Task Force members agreed on five broad areas for recommendations to include in their final report on the Task Force's findings.

OCTOBER 25, 2022

The Task Force Vice Chair, Delegate Shelly Simonds, facilitated this hybrid meeting. The agenda included a presentation on the Maternal Mortality Review (MMR) process, a presentation on the SDoH data collected by the Pregnancy Risk Assessment Monitoring System (PRAMS), and a discussion to identify barriers to data collection in various healthcare settings. Dr. Melanie Rouse, VDH's Maternal Mortality Projects Manager, presented on the data collected through the MMR process and highlighted the data that the MMR team is currently missing which would better inform the review process. Dr. Kenesha Smith Barber, Virginia PRAMS Principal Investigator, presented the survey questions PRAMS uses to collect some SDoH indicators and discussed resources needed to expand the use of the data gathered. Kelly Cannon and Mary Brandenburg of Virginia Hospital and Healthcare Association led an open discussion on the barriers to collecting data in healthcare settings.

MARCH 21, 2023

The first meeting of 2023 for the Task Force was held in hybrid format. Shannon Pursell, Director of the Virginia Neonatal Perinatal Collaborative, discussed updated data metrics being captured in the Dashboard previously introduced at the August 2022 meeting. Updated metrics included severe maternal morbidity, COVID-19 indicators, and mental health diagnoses. Jacque Hale of Unite Virginia presented on the history, purpose, and current reach of Unite US, its data collection platform, and the trends in service needs seen in the data. The meeting concluded after a guided discussion which led to the formation of three recommendations that the Task Force finalized and approved by consensus vote.

MAY 2, 2023

Dr. Scott Sullivan, Task Force Chair, facilitated the hybrid meeting. Principal investigators of the Postpartum Assessment of Health Survey, a one-year follow-up survey for PRAMS respondents conducted in collaboration with seven states, including Virginia, discussed their surveillance efforts. The study team described what the survey consisted of, the purpose, and the results for Virginia. The Task Force then discussed the directive received from Senate Committee on Education and Health to review and discuss any evidence on the needs, frequency, and effectiveness of an implicit bias training for medical professionals licensed by the Board of Medicine as stated in SB1440. The Task Force created a plan to research implicit bias training best practices outside of the meetings, in order to make recommendations for an implicit bias training throughout the Commonwealth during the following two meetings. The Chair led discussion regarding recommendations

for maternal health data improvements, with a focus on evaluating the impact of SDoH screening on pregnant women and its impact on outcomes data; collecting and analyzing data one year after delivery; and developing recommendations for standard quality metrics on maternal care (charges five, six, and seven). Six recommendations were drafted, to be finalized and voted on at the next meeting.

JUNE 13, 2023

The Task Force convened in hybrid format. The meeting's agenda consisted of a general review of implicit bias training for healthcare providers, including examples of other states' approaches, and drafting recommendations to address charges. The Task Force's Chair, Dr. Scott Sullivan discussed his findings of implicit bias trainings for medical providers in other states. Task Force members discussed what further information was necessary to assess the need, benefit, and implementation of an implicit bias training for Virginian physicians. Task Force members developed and refined recommendation language for examining the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers; evaluating the impact of Social Determinants of Health (SDoH) screening on pregnant women and its impact on outcomes data; and collecting and analyzing data one year after delivery (charges three, five, and six). The meeting concluded with the drafting of four recommendations.

JULY 5, 2023

The Task Force meeting convened in a hybrid format. Dr. Shoba Mehta of Johns Hopkins University presented the differences in maternal mortality, pregnancy-related mortality, and pregnancy-associated mortality and the role of intimate partner violence as a factor contributing to pregnancy-associated homicides and suicides. Ksenia Primich, VDH's former Council of States and Territorial Epidemiologist Fellow, presented on implicit bias trainings in other states with attention to the foundational research from which the trainings were developed, length and frequency of trainings, and the manner by which the implicit bias trainings became mandated in those states. Mr. Arne Owens, Director of the Department of Health Professions, discussed DHP's experience with mandated continuing education (CE) requirements for provider licensure and the potential risks and benefits of mandating implicit bias training, including burdens to providers and limited capacity for CE auditing. The Task Force discussed and drafted recommendations for monitoring progress and evaluating all data from state-level stakeholders, including third-party payers, and all available electronic claims data to examine quality of care with regard to race, ethnicity, and other demographic and clinical outcome data; and examining current maternal health benefit requirements to determine the need for additional benefits to protect the health of birthing people (charges one and four).

AUGUST 2, 2023

The Task Force convened for its final in-person meeting. Members unanimously approved a revision to the bylaws to include language allowing a virtual meeting. Kyle Russell of Virginia Health Information (VHI) presented an overview of VHI's history and its current role in data collection related to maternal health. Mr. Russell highlighted VHI data systems relevant to the scope of the Task Force, along with the benefits and challenges of those data systems. He encouraged the Task Force to consider those challenges when creating recommendations to address maternal health data systems. The Task Force then discussed, finalized, and approved recommendations. The meeting concluded with scheduling the Task Force's final meeting.

AUGUST 28, 2023

The final Task Force meeting convened fully virtually via Zoom. This meeting was held solely to finalize and approve remaining recommendations to address all charges outlined in Chapter 215, along with recommendations regarding implicit bias training for providers licensed by the Board of Medicine. Dr. Scott Sullivan, Task Force Chair, directed the discussion to finalize and vote on the remaining proposed recommendations. The Task Force concluded by approving all 22 recommendations included in this report.

REPORT OUTLINE

The following report gives background on the status of maternal health and maternal mortality in the United States and the Commonwealth of Virginia. It also explains how the Task Force chose to examine and address each charge. Lastly, the report concludes with 22 recommendations that the Task Force developed to address the issues highlighted in each charge of Chapter 215.

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BACKGROUND

Maternal mortality, defined as death during pregnancy and up to 42 days postpartum due to direct obstetric causes, is often used to assess the status of maternal health in a given place and time (Declercq & Zephyrin, 2020). The United States ranks last among industrialized nations with an overall maternal mortality rate of 32.9 deaths per 100,000 births (Gunja et al., 2022). From 2020 to 2021, maternal mortality increased significantly for all racial and Hispanic origin ethnicity groups (Hoyert, 2023; Virginia Department of Health, 2022). However, disparities in maternal mortality persist. The maternal mortality rate for non-Hispanic Black women (69.9 per 100,000 live births) was significantly higher than rates for non-Hispanic White (26.6 per 100,000 live births) and Hispanic women (28.0 per 100,000 live births). Using this indicator to understand maternal health in the United States suggests the need for improvements to maternal healthcare access and quality through policies, systems, and environmental change (Declercq & Zephyrin, 2020).

Data from the Virginia Vital Statistics System showed that in Virginia, the rate of maternal mortality (as defined in the paragraph above) rose between 2020 and 2021 from 18.0 to 47.1 women per 100,000 live births (Virginia Department of Health, 2023). Virginia's non-Hispanic Black women (96.7 per 100,000 live births) were reported as dying at a rate more than two times that of non-Hispanic White women (39.6 per 100,000 live births) (Virginia Department of Health, 2023). The disparities that exist in the health outcomes of Virginia's pregnant women mirror the trends of the United States, and Virginia's efforts to eliminate those disparities mirror recent efforts of the federal government to do the same (Creveling, 2021). Improving maternal health data collection, access, and utilization to inform policy and programmatic change is one such effort aimed at improving maternal health outcomes across Virginia (Secretary of Health and Human Resources, 2021). Robust, high-quality data that is accessible and actionable helps facilitate informed decision-making by providers, policymakers, and stakeholders seeking to improve maternal health outcomes. Data that identifies the risk and protective factors and drivers of maternal health outcomes will support Virginia's efforts to address disparities and ensure that Virginia is the best place for all moms and babies (Department of Medical Assistance Services, 2022).

In recent years, Virginia has implemented significant policy measures to improve health outcomes for pregnant women in the Commonwealth. These include expanding Medicaid coverage for postpartum women to 12 months; creating a Medicaid benefit for state certified community doulas; appropriating funding for a perinatal quality collaborative; and codifying the Maternal Mortality Review Committee (March of Dimes, 2023). Policymakers have acknowledged the importance of data in driving decision-making by using legislation to create the Maternal Health Data and Quality Measures Task Force and request a report on the reestablishment of a Fetal Infant Mortality Review Team. Addressing the maternal health needs of pregnant women and the disparities that persist in Virginian communities is a public health issue that encompasses clinical, systemic, community, socioeconomic, and behavioral factors and requires a wide array of approaches, voices, and data to be impactful (Declercq & Zephyrin, 2020). The processes of gathering and analyzing data are more useful when that data are valued by the impacted populations and are disseminated in an understandable and actionable manner (CDC, 2022). The Task Force considered this when assessing levels of accessibility to relevant maternal health data, reports, and services.

CONCENTRATIONS

Chapter 215 outlined seven charges that relate to maternal health data. Members of the Task Force assessed the types of data, data systems, and availability of data related to the scope of the Task Force's charges. Presentations and discussions from subject matter experts (SMEs) on the Task Force, and external experts brought in by the Task Force, assisted with identifying gaps and needs. Each expert highlighted current data successes and remaining needs, and offered potential solutions to address each of the seven charges as follows:

1. Clinical outcome data
    a. The theme and recommendations for this charge focused on utilizing and enhancing access to existing data at Virginia Health Information and creating a body to evaluate and report on up-to-date data.
2. HEDIS data
    a. The theme and recommendations for this charge focused on having an independent third-party study the benefits of expanding coverage of maternal mental health services and collecting comprehensive maternal mental health data.
3. Barriers to data collection
    a. The theme and recommendations for this charge focused on improving maternal health related data reporting to various stakeholders, and producing an accessible multi-agency data report yearly.
4. Maternal health benefits
    a. The theme and recommendations for this charge followed a thorough examination of current maternal health benefits by members with significant input from United Healthcare (a Virginia Managed Care Organization) and focused on expanding coverage and/or reimbursement for the specific coverage benefits.
5. SDoH screen and impact on health
    a. The theme and recommendations for this charge highlighted the importance of CHWs in addressing social determinants of health beyond clinical care. The recommendations focused on incentivizing data collection and reporting on SDoH, referral to resources addressing SDoH, and reimbursement for the preceding.
6. Data one year after delivery
    a. The theme and recommendations for this charge focused on utilizing existing data methods, namely the Virginia PRAMS survey, and advocating for continued follow-up of postpartum maternal health.
7. Recommendations for quality metrics
    a. The themes for addressing this charge focused on understanding what quality metrics were in place, including experience of care and hospital levels of care. Task Force members were unable to formulate recommendations to address the many areas of quality metrics. The recommendation for this charge focused on the establishment of a FIMR team as recommended by the 2021 workgroup formed by Chapter 164 of the 2021 Acts of Assembly, Special Session I.

RECOMMENDATIONS

In order to produce informed recommendations to improve maternal health data and data quality, the Task Force worked with internal and external SMEs to highlight current successes and remaining needs related to each of the seven charges outlined in Chapter 215. The Task Force approved all recommendations included below by a majority vote. The recommendations the Task Force developed seek to address the identified needs by offering solutions to data and service gaps. The Task Force envisioned that for any recommendations where an entity is not distinctly expressed, the Governor and/or General Assembly will examine the content and context of that recommendation, and direct the best equipped organization, agency, and/or body to undertake the work within each charge.

The Task Force convened for ten meetings in 2022 and 2023 and developed 22 recommendations for the Governor and General Assembly. Ten of these recommendations impact Medicaid. The Task Force recommendations are listed below.

Charge I: Monitor progress and evaluate all data from state-level stakeholders, including third-party payers, and all available electronic claims data to examine quality of care with regard to race, ethnicity, and other demographic and clinical outcome data.

Recommendation 1: Improve the Virginia All-Payer Claims Database (APCD)

The Virginia All-Payer Claims Database (APCD) is a program under the authority of the Virginia Department of Health (VDH) that collects paid medical and pharmacy claims for roughly five to five and a half million Virginia residents with commercial, Medicaid, and Medicare coverage across all types of healthcare services. It is housed within Virginia Health Information (VHI). The data from the APCD is only available for claims paid between January 2011 and December 2021. The Task Force recommends to:

- Maintain an updated dataset – through most recently completed quarter of the current year, if possible
- Utilize the VHI and APCD as a centralized maternal health access point for the public, policymakers, providers, and payors alike
- Standardize a dataset specific to maternal health patients, including race/ethnicity, socioeconomic status, age, region, present/chronic health conditions, clinical interventions, and clinical outcomes
- Ensure that data can be disaggregated as appropriate, such as to reflect urban versus rural outcomes, and stratified by sociodemographic indicators to identify disparities
- Improve the captured data to include social determinants of health indicators, patient care plan adherence, and any missing information as listed in the two prior bullets (bullets three and four of this recommendation)

Recommendation 2: Develop a Statewide Maternal Health Data Board

Improving maternal health outcomes requires a comprehensive data strategy and intentional translation of data into policy. Regular review of the most up-to-date data and information on maternal mortality and morbidity in the Commonwealth will support effective development of policies to address risk factors occurring prior to pregnancy (preconception), prenatal, postpartum, and between pregnancies (inter-conception). The Task Force recommends:

- The General Assembly establish an oversight body – a statewide Maternal Health Data Advisory Board – which would meet quarterly, with the purpose of reviewing the most up-to-date quantitative and qualitative maternal mortality and morbidity health data, identifying gaps, analyzing trends, and evaluating the efficacy of policy recommendations

- The Advisory Board provide yearly recommendations to the Governor and General Assembly that include evidence-based statewide maternal health recommendations regarding data collection, analysis, visualization, and integration
- The Advisory Board have wide-reaching representation by those that work to improve maternal health, including, but not limited to, community organizations, community obstetric providers, community providers, community perinatal mental health providers, doulas, health systems, health insurance plans, state/local agencies, and consumers of maternity care

Charge II: Monitor progress and evaluate all data from existing state-level sources mandated for maternal care, including new Healthcare Effectiveness Data and Information Set (HEDIS) measure updates to Prenatal and Postpartum Care and Postpartum Depression

The Task Force recognizes that maternal mental health, including depression and anxiety, are major risk factors when it comes to the health and wellbeing of women. This recommendation is meant to improve the maternal mental health outcomes through increased insurance coverage for pregnant and postpartum women, and enhanced data from payer claims submitted to the APCD. The Task Force recommends:

Recommendation 3: Ensure Behavioral Health Access for Pregnant and Postpartum Women by Studying and Reporting on the following:

- Expanding insurance coverage for wraparound supports needed to access behavioral healthcare, including transportation and childcare
- Implementing widespread coverage for Perinatal Depression screenings
    - Remove billing barriers
    - Ensure a trauma-informed approach to billing practices
- Conducting a behavioral healthcare rate study to identify changes that would increase provider participation in Medicaid
- Expanding insurance coverage for nontraditional, alternative behavioral health therapies such as meditation or art therapy
- Expanding use of telehealth to improve maternal mental health outcomes
- Expanding insurance coverage for maternal mental health screenings conducted at pediatric visits
- Allowing providers to bill for multiple encounters on a single day, particularly for Federal Qualified Health Centers
- Establishing a scholarship fund for prescribers and therapists to become PMHC (perinatal mental health certification)

Recommendation 4: Enhance Maternal Mental Health Data

- Ensure all payers report on HEDIS measures for Prenatal and Postpartum Care and Postpartum Depression and make it publicly available in a centralized location.
- Collect data from Postpartum Support International on perinatal mental health certified prescribers and therapists in the Commonwealth of Virginia and whether those certified providers accept Medicaid
- Coordinate with the Department of Behavioral Health and Developmental Services and Right Help Right Now to determine if call centers are collecting data on pregnancy status and review data if available

Charge III: Examine the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers

Recommendation 5: Expand Maternal Health Data Reporting

- Include nationally recognized and validated quality measure sets for maternal health across a diverse group of care settings in VHI's maternal health-specific data sets
- Grant the Maternal Mortality Review Team (MMRT) access to medical records including, but not limited to, substance use disorder, mental health, oral health, etc., for incarcerated or recently incarcerated decedents
- Explore the addition of community-based organizations to the MMRT
- Improve bidirectional data sharing between VHI and relevant state agencies for the purpose of improved evaluation and analysis of maternal health outcomes

Recommendation 6: Continue to Fund Yearly VNPC Report

- Continue to provide funding to the Virginia Neonatal Perinatal Collaborative to conduct quality improvement initiatives to improve maternal and infant health outcomes
- VNPC should produce a public annual report on the state of maternal and infant health quality improvement initiatives and outcomes measures, tracking annual progress on outcomes metrics and identifying opportunities for targeted improvement methods based on current VNPC projects. This report should be made available publicly and widely disseminated to members of the General Assembly, state leaders, and all providers who treat pregnant women, women between pregnancies, and infants.

Charge IV: Examine current maternal health benefit requirements and determine the need for additional benefits to protect the health of pregnant women

Recommendation 7: Incorporate Evidence-Based Home Visiting Program into the Model of Care

The Task Force recommends that Medicaid incorporate a comprehensive home visiting program into its suite of covered benefits to ensure enhanced support for healthy pregnancies and postpartum care. The program should include a range of services and supports aimed at promoting maternal and child health, preventing child abuse and neglect, and enhancing child development and school readiness. The covered benefits should encompass assessment and screening, case management, skills building and education, health promotion and counseling, and referral to services, as well as monitoring and follow-up activities.

To implement this recommendation, Virginia should explore options for coverage through either a state plan amendment or waiver. Additionally, it is important to seek additional federal funding from sources such as the Health Resources & Services Administration (HRSA) Federal Home Visiting Program to support the implementation and sustainability of home visiting services for pregnant and parenting families in the Commonwealth.

Recommendation 8: Expand Benefit Coverage to Include Presumptive Eligibility for Ambulatory Prenatal Care

The Task Force recommends that qualified providers, as currently defined in statute, be granted the authority to determine presumptive eligibility for Medicaid for ambulatory prenatal care for pregnant individuals. This means that individuals would receive immediate, temporary Medicaid coverage while their full Medicaid eligibility is being determined. By implementing this coverage expansion, pregnant individuals would have access to crucial prenatal services for a period of up to 60 days, which would lead to improved maternal and birth outcomes.

Recommendation 9: Authorize Federally Qualified Health Centers to Bill for Multiple Encounters

The Task Force recommends the Commonwealth authorize Federally Qualified Health Centers (FQHCs) to bill for multiple encounters on a single day to enhance access to comprehensive care and reduce barriers for underserved populations. The policy change would streamline the delivery of medical, dental, and behavioral health care services, allowing for whole person care to be provided in a convenient and efficient manner. By addressing SDoH barriers such as transportation, childcare, and time off from work concerns, this approach would improve access to and quality of maternal health care, leading to better maternal and birth outcomes.

Recommendation 10: Authorize Medicaid to Cover and Reimburse FQHCs for Services Delivered by Doulas, Marriage & Family Therapists, Licensed Professional Counselors, and CHWs

The Task Force recommends authorizing Medicaid to cover and reimburse FQHCs for services delivered by doulas, marriage & family therapists, licensed professional counselors, lactation consultants, and community health workers (CHWs). This approach will enhance collaboration and improve access to culturally aligned services. Currently, access to these providers is limited due to state Medicaid policy decisions on coverage, state licensure, and FQHC reimbursement policies. Therefore, it is necessary to explore coverage and reimbursement options for these providers outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR) methodology. By expanding coverage and reimbursement for these services, greater access to comprehensive care and improvement in maternal and birth outcomes will be realized. To implement this recommendation, Virginia Medicaid should explore options for coverage through either a state plan amendment or waiver.

Recommendation 11: Expand Preventive Dental Services for Expectant Mothers

The Task Force recommends extending dental coverage for pregnant individuals to address the high prevalence of pregnancy gingivitis and its association with preterm birth rates. The coverage should go beyond preventative dental services to include two additional covered cleanings during the pregnancy. By providing comprehensive dental care for pregnant individuals, the Commonwealth can effectively reduce the risk of preterm births and improve maternal and birth outcomes.

Recommendation 12: Implement Multi-Year Continuous Eligibility for Children up to Five Years of Age

The Task Force recommends the Commonwealth use the authority granted through the 1115 waiver process to implement multi-year continuous eligibility in Medicaid and the Children's Health Insurance Program (CHIP) to ensure uninterrupted access to essential healthcare services for children under the age of five. Extending coverage for these young children will ensure continuity of screenings, check-ups, and immunizations, which will lead to improved health outcomes and reduced healthcare costs.

Recommendation 13: Expand Medicaid Facility Reimbursement to Birthing Centers

The Task Force recommends Medicaid recognize and provide facility reimbursement for freestanding birthing centers. Studies have shown that states with Medicaid reimbursement for freestanding birthing centers have better birth outcomes compared to states without such reimbursement (Alliman et al., 2019, 2022; Courtot et al., 2020; Medicaid and CHIP Payment and Access Commission, 2023). Birthing centers provide a more affordable and accessible option for low-risk pregnancies, leading to reduced rates of interventions and cesarean deliveries. Additionally, they promote the involvement of midwives and offer a more personalized and integrated approach to childbirth.

Recommendation 14: Expand Access and Utilization of State Certified Doula Services

The Task Force recommends that Medicaid expand the doula benefit to address the number of eligible visits, reimbursement rate for prenatal, labor and postpartum support, and support for the doula workforce to ensure network adequacy. The Task Force recommends an evaluation of the benefit for state certified community doulas to identify additional areas for improvement to increase access and utilization.

Recommendation 15: Mandate 12 Months of Postpartum Coverage for Commercial Insurance Plans

The Task Force recommends mandating 12 months of postpartum coverage for commercial insurance plans. Many pregnancy-related deaths and injuries occur months after delivery. 12 months of postpartum coverage will help protect new moms from medical debt and ensure that they have time to seek care for any postpartum health issues they may face, such as postpartum depression. The Task Force further recommends insurance coverage for remote patient monitoring for high risk pregnant and postpartum women.

Charge V: Evaluate the impact of Social Determinants of Health (SDoH) screening on pregnant women and its impact on outcomes data

Focusing solely on improving access to and quality of clinical care will not fully resolve disparities in maternal health outcomes. The Task Force recognizes the importance of holistically improving life conditions for pregnant women. Social Determinants of Health are the conditions in the environments where people are born, live, learn, work and play that affect health, well-being, and quality of life. Using established metrics, the impact of conditions such as economic stability, education access and quality, social and community context, and neighborhood and built environment, on maternal health outcomes can be assessed. From there, policy, systems and environmental changes can be undertaken to support healthy pregnancies for all of Virginia's communities. The Task Force recommends:

Recommendation 16: Increase Sustained Funding for Community Health Workers (CHWs)

Increase sustained funding for community health workers that connect preconception, prenatal, and postpartum care patients to community services. This funding may include Medicaid reimbursement, grants, and additional state plan flexibilities.

Recommendation 17: Identify Reimbursements to Incentivize SDoH Screenings

Identify reimbursement options that will incentivize maternal health providers to conduct screenings related to Social Determinants of Health, mental health, intimate partner violence, substance use, and chronic disease, and appropriately refer patients to health and community-based providers, including screening and care navigation by community health workers and case managers.

Recommendation 18: Improve Collection of SDoH Data

Enhance the quality of care by improving how Social Determinants of Health data are collected, shared, and analyzed. The Task Force recommends the use of evidence-based SDoH assessments across organizations to ensure consistency and effectiveness. The Task Force recommends building upon existing e-referral infrastructure to facilitate sharing social care data bi-directionally across health systems, health plans, state agencies, and community-based providers.

Recommendation 19: Incentivize Collection of Z Codes

Create incentives for providers to consistently and accurately capture and submit Z codes using the electronic health record. Educate care providers on screening best practices and the importance of using Z codes, a diagnosis and billing code that captures social needs that influence health.

Recommendation 20: Improve Screening for Intimate Partner Violence

Enhance screening and collection of data on the occurrence of intimate partner violence (IPV) for women during pregnancy and the 12-month postpartum period. Use validated screening tools and methodology to clarify prevalence rates of IPV during pregnancy, improve understanding of associated morbidities and mortality, and inform improved resource allocation for support services.

Charge VI: Collect and analyze data one year after delivery

Recommendation 21: Improve Existing Data Surveillance Systems to Understand Experiences Up to One Year Postpartum

The Task Force recognizes that many pregnancy-related deaths and injuries occur months after delivery. Collecting and analyzing emergency department, hospitalization, and claims data for a full year postpartum would support data-informed decision-making by policymakers seeking to improve maternal health outcomes. The Task Force recommends:

- Increase funding to expand the number of participants surveyed for Pregnancy Risk Assessment Monitoring System (PRAMS)
- Provide sustainable funding for ongoing implementation of Postpartum Assessment of Health Survey (PAHS), preferably in partnership with a Virginia public university
- Require inclusion of ED data in the outpatient dataset to better understand postpartum ambulatory care.
- Enhance patient-level linkage of delivery hospitalizations with ambulatory ED visits and inpatient follow-up admissions in the postpartum period to understand healthcare needs including, but not limited to, chronic disease, injury, and other non-urgent care services.

Charge VII: Develop recommendations for standard quality metrics on maternal care

Recommendation 22: Develop a Fetal Infant Mortality Review Team

Over 20,000 babies born each year in the United States do not make it to their first birthday (National Center for Fatality Review & Prevention, 2021). Many states have implemented Fetal and Infant Mortality Review (FIMR) programs to better understand the factors leading to fetal and infant deaths with a focus on prevention and translating data into action. FIMR, as defined by National Center for Fatality Review and Prevention, is a community based, action-oriented process aimed at improving services, systems, and resources for women, infants, and families. FIMR brings a multidisciplinary community team together to examine confidential, de-identified cases of fetal and infant deaths. FIMR is not a procedure for designating responsibility or fault for a death. Per the 2021 Workgroup Study report on FIMRT, the work of the FIMRT may promote collaboration with other fatality review teams and public health programs (Virginia Department of Health, 2021). FIMRs also have the potential to stimulate community improvement and could support the development of local and regional efforts, particularly in communities affected by higher rates of fetal and infant death. The purpose of fatality review is to take the tragedy of fetal and infant death and make positive and meaningful change to improve outcomes for moms and babies.

The Task Force recommends to:

- Develop a Fetal and Infant Mortality Review Team (FIMRT) to review fetal deaths using a standardized case definition guided by the National Center for Fatality Review and Prevention and building on the framework of the Maternal Mortality and Child Fatality Review Teams

- Explore the addition of Community Based Organizations to the FIMRT to highlight the importance of community action in fatality review
- Provide funding to support development of a Fetal and Infant Mortality Review in order to improve tracking of and better understand fetal/infant loss
- Ensure that data collected for the purpose of FIMR is not used to pursue criminal investigations against people experiencing a fetal death

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APPENDIX A – CHAPTER 215 OF THE 2021 ACTS OF ASSEMBLY, SPECIAL SESSION I

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the State Health Commissioner shall establish the Task Force on Maternal Health Data and Quality Measures (the Task Force) for the purpose of evaluating maternal health data collection processes to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The Task Force shall consist of three members of the Senate to be appointed by the Senate Committee on Rules and five members of the House of Delegates to be appointed by the Speaker of the House of Delegates, the Director of the Department of Medical Assistance Services or his designee, the Director of the Office of Health Equity or his designee, the Director of the Virginia Neonatal Perinatal Collaborative or his designee, the Chief Executive Officer of Virginia Health Information or his designee, and such other persons as the State Health Commissioner deems appropriate, including: (i) two individuals who are licensed obstetricians or gynecologists practicing in the Commonwealth; (ii) two individuals who are licensed nurse practitioners or registered nurses who work in the area of maternal health in the Commonwealth; (iii) two experts in postpartum care and depression in the Commonwealth, ensuring regional representation; (iv) at least one individual who is an expert in maternal health data collection processes; (v) four representatives from organizations or groups in the Commonwealth that specialize in serving vulnerable populations and improving equity and outcomes in maternal health; (vi) individuals who are licensed in neonatal and premature infant care and nutrition; (vii) a representative in maternal health from each of the health care payers in the Commonwealth; (viii) health care experts who serve underserved and minority populations in the Commonwealth; (ix) two members of the Virginia Hospital and Healthcare Association; (x) the Program Manager for the Maternal Mortality Review Team; (xi) two individuals who are certified nurse midwives and one certified midwife and one certified professional midwife; and (xii) any other stakeholders as may be appropriate. The Task Force shall:*

1. Monitor progress and evaluate all data from state-level stakeholders, including third-party payers, and all available electronic claims data to examine quality of care with regard to race, ethnicity, and other demographic and clinical outcome data;

2. Monitor progress and evaluate all data from existing state-level sources mandated for maternal care, including new Healthcare Effectiveness Data and Information Set (HEDIS) measure updates to Prenatal and Postpartum Care and Postpartum Depression;

3. Examine the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers;

4. Examine current maternal health benefit requirements and determine the need for additional benefits to protect the health of birthing people;

5. Evaluate the impact of Social Determinants of Health (SDoH) screening on pregnant women and its impact on outcomes data;

6. Collect and analyze data one year after delivery; and

7. Develop recommendations for standard quality metrics on maternal care.

All agencies of the Commonwealth shall provide assistance to the Task Force upon request. The Task Force shall report its findings and conclusions to the Governor and General Assembly by December 1 of each year regarding its activities and shall conclude its work by December 1, 2023.

APPENDIX B – ACRONYMS, ABBREVIATIONS, AND TERMS

CHW – Community Health Worker, a frontline public health worker who is a trusted member or has a particularly good understanding of the community served.

Insurance – Medicaid and fully insured payors.

Pregnancy-associated mortality – Death while pregnant or within one year of the end of the pregnancy, irrespective of cause.

Pregnancy-related mortality – Death during pregnancy or within one year of the end of pregnancy from: a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

Maternal mortality ratio – Death while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

MCO: Managed Care Organization – A health plan with a group of doctors and other providers working together to give health services to its members.

PMHC – Perinatal Mental Health Certification.

Screening – The evaluation of something as part of a methodical survey for a particular purpose.

SDoH – Social determinants of health, non-medical factors that influence health outcomes.

VDH – Virginia Department of Health.

Z code – ICD-10-CM diagnosis codes used to document social determinants of health data.

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