



VIA ELECTRONIC MAIL

May 29, 2020

Dr. Nina Brown-Ashford, Acting Director
Office of Minority Health
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

**Re: Request for Information Regarding Maternal and Infant Health
Care in Rural Communities**

Dear Dr. Brown-Ashford:

We are writing in response to the Office of Minority Health's (OMH) request for information (RFI) regarding maternal and infant care in rural communities. Thank you for your continued leadership and commitment to improving health care access, quality, and outcomes for women and infants in our nation's rural communities. We commend your efforts to reduce and target the racial and geographic disparities in maternal and infant care across the United States.

The Medicaid Health Plans of America (MHPA) is the national trade association representing over 90 member health plans that contract with state Medicaid agencies in 37 states to provide comprehensive, high-quality health care to more than 23 million Medicaid beneficiaries in a coordinated and cost effective way. We appreciate the opportunity to share the perspectives of our member plans on opportunities to address health disparities for beneficiaries in rural communities and to improve access to care, quality of care, and health outcomes in maternal and infant health.

Over the past two decades, the U.S. maternal mortality rate has risen continually reaching a maternal mortality rate for 2018 of 17.4 deaths per 100,000 live births. The Centers for Disease Control and Prevention (CDC) has found that roughly one-third of all pregnancy-related deaths occur one week to one year after a pregnancy ends. It is estimated that approximately 50 percent of maternal deaths are preventable. Notably, wide racial and ethnic gaps exist between non-Hispanic black (37.1 deaths per 100,000 live births), non-Hispanic white (14.7), and Hispanic (11.8) women. MHPA strongly supports continued efforts to reduce preventable maternal mortality and morbidity and to ensure access to maternity care for all beneficiaries across the country.

With Medicaid as the largest single payer of maternity care in the U.S., covering 43 percent of all births in 2017, MHPA believes the Medicaid program should be a central focus of any effort to reduce maternal mortality and to address racial and ethnic disparities in maternal and infant health, particularly in rural communities. Findings presented at the January Medicaid and CHIP Payment Advisory Committee (MACPAC) meeting showed that Medicaid beneficiaries face almost double the risk of severe maternal morbidity and mortality during childbirth hospitalizations, compared with privately insured women.¹ Among Medicaid beneficiaries, rural residents and women of color (especially Black and Indigenous people) face elevated risks of complications and death around the time of childbirth. MHPA urges OMH to consider and support approaches that would maximize access to the Medicaid program and would extend and enhance Medicaid coverage during pregnancy and postpartum.

We have responded to two of the four questions (#2 and #4) included in the RFI; our specific recommendations for opportunities to improve access, quality of care, and health outcomes for maternal and infant health in rural communities are as follows:

2. What opportunities are there to improve the above areas (i.e., access, quality and outcomes)?

Medicaid Eligibility

- *Medicaid Coverage for Postpartum Women beyond 60-days*

MHPA supports extending Medicaid coverage for pregnant women from 60 days to 12 months postpartum to address the current “postpartum coverage cliff” faced by beneficiaries who would otherwise lose their Medicaid eligibility at 60 days postpartum. While babies born to mothers receiving Medicaid or CHIP coverage are automatically eligible for coverage in 19 states, Medicaid eligibility for mothers ends at 60-days postpartum. This policy essentially blocks beneficiaries from access to coverage and care during the critical post-pregnancy period following birth.

The postpartum period is a time of vulnerability during which many beneficiaries are at risk of serious health care conditions. Pregnancy-related health issues, such as cardiovascular disease or postpartum depression, can emerge more than 60 days after childbirth. The CDC notes that “[i]n the postpartum period, follow-up care is critical for all women, particularly those with chronic medical conditions and complications of pregnancy (e.g., hypertensive disorders of pregnancy.)”² Notably, cardiac disease is the leading cause of maternal mortality in the United States and is particularly linked to maternal deaths in the late postpartum period up to one year after the end of pregnancy.

¹<https://www.macpac.gov/wp-content/uploads/2020/04/Medicaid’s-Role-in-Maternal-Health-and-Substance-Use-Disorder-and-Maternal-and-Infant-Health.pdf>; <https://www.modernhealthcare.com/medicaid/medicaid-changes-could-address-maternal-mortality-driven-social-determinants>

² https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w

A state option to extend Medicaid/CHIP coverage during the 12-month postpartum period, as provided in H.R.4996, the Helping Medicaid Offer Maternity Services (MOMS) Act of 2019, would allow states to extend Medicaid coverage to 12-months postpartum, which has demonstrated improvements in health outcomes for both moms and babies. Another consideration is looking to federal actions that create alternative coverage pathways such as through state plan amendments. We believe extending coverage is an important option for states seeking to reduce maternal mortality and could play an important role in addressing racial and ethnic disparities in maternal health.

- ***Promote Awareness of Postpartum Coverage Options***

MHPA believes educational efforts to promote awareness of available coverage options for beneficiaries who lose their pregnancy-related Medicaid eligibility after 60-days postpartum would help support continuity of care. Given that state income requirements for Medicaid eligibility for parents are typically lower than for pregnant women, many new mothers risk losing their insurance after 60 days postpartum effectively curtailing access to postpartum care. One study found that approximately 55 percent of women covered by Medicaid for their delivery were uninsured at some point in the following six months.³

In the absence of an expansion of Medicaid coverage beyond the 60-day postpartum period, MHPA recommends that beneficiaries who are at risk of losing their coverage be made aware of their eligibility for other types of coverage or potential sources of care through the provision of resources and/or referrals. We also recommend that any materials developed for this purpose should be clear, consistent, available in multiple languages, culturally appropriate, and should account for varying degrees of health literacy.

Workforce Issues

- ***Recruitment of Clinicians to Rural Areas***

MHPA encourages the investment of resources in the recruitment of physicians and nurses to rural communities. According to a survey by the American Congress of Obstetricians and Gynecologists (ACOG), only about 6 percent of the nation's obstetrician-gynecologists work in rural areas. A 2017 study in *Health Affairs* found that 9 percent of rural counties lost access to obstetric services between 2004 and 2014, while another 45 percent of rural counties had no hospital obstetric services at all.⁴ The gaps identified in the study leave more than half of all rural U.S. counties without hospital obstetric services impacting 2.4 million women of reproductive age, according to the 2017 study.⁵

The closure of rural hospitals, the increasing shortage of health professionals nationwide, and difficulties in recruiting providers to rural communities, are contributing factors to why pregnant women living in rural areas face barriers getting needed health care.⁶ The lack of

³ <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1241>

⁴ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0338>

⁵ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0338>

⁶ <https://www.commonwealthfund.org/blog/2019/rural-maternity-care-crisis>

clinicians who specialize in behavioral health and maternal behavioral health, specifically, is exacerbated in rural communities. This is particularly troubling given the impact of the opioid epidemic and the prevalence of substance use disorder in rural communities.

Approaches for encouraging recruitment of clinicians to rural communities have included student loan repayment and scholarship programs, pipeline/pathway programs, education and training programs, and online job databases.⁷ In a survey of practicing obstetrician-gynecologists, it was found that “medical professionals appear to work in rural areas due to preference for a smaller community, the opportunity to return to one’s hometown, or participation in a rural training program.”⁸

We recommend further study on the effectiveness of each of these approaches. We also support efforts to recruit and train a culturally competent and linguistically diverse workforce that could include incorporating cultural sensitivity into the curriculum for rural training programs.

- ***Expanding the Use of Non-Physician Clinicians & Community Health Workers***

The development of pathways for expanding the use of non-physician clinicians and community health workers would maximize an evidence-based approach for increasing access to maternal health care in rural communities.

The use of nurse midwives and doulas are two types of non-physician clinicians has been shown to positively impact maternal health outcomes.⁹ A 2018 study in the scientific journal PLOS ONE found that states that integrate midwives into their health care systems have better outcomes for mothers and babies.¹⁰ Studies suggest that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies, lower health care costs, reduce cesarean sections, decrease maternal anxiety and depression, and help improve communication between low-income, racially/ethnically diverse pregnant women and their health care providers.

Currently, 26 states plus the District of Columbia allow certified nurse midwives to practice independent of physicians, while four states require physician supervision and twenty require collaborative practice agreements. Across states, there also exists a varying level of uniformity in requirements for safe operation of freestanding birth centers, including nine states that have no regulations or licensure requirements whatsoever. Consistency across the states regarding licensing, credentialing, and reimbursement of certified nurse midwives and doulas could help increase the availability of these providers for pregnant women and help promote positive maternal health outcomes.

⁷ <https://www.ruralhealthinfo.org/topics/scholarships-loans-loan-repayment>

⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5607916/#bibr6-2333392817723981>

⁹ [https://www.medicaidinnovation.org/_images/content/2020-IMI-Improving Maternal Health Access Coverage and Outcomes-Report.pdf](https://www.medicaidinnovation.org/_images/content/2020-IMI-Improving%20Maternal%20Health%20Access%20Coverage%20and%20Outcomes-Report.pdf)

¹⁰ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523>

Community health workers (CHWs) are trained public health workers who serve as a bridge between communities and health care systems. CHWs typically live in the communities they serve, and meet with individuals in their homes, in clinics, or in community settings to assess and reduce risks, inform and educate individuals about healthy behaviors, and connect them and their family members to needed care and community resources. While not practicing medicine, CHWs can play a critical role in improving maternal and infant health¹¹ through their support of pregnant and postpartum beneficiaries and their children on prenatal care; education on relevant topics such as breastfeeding, safe sleep, and childbirth; and assistance with health insurance coverage options. States currently have several options for using Medicaid funds to cover CHWs. However, given the limited training of most CHWs, credentialing is often a challenge. Standardized certification requirements could be an initial step in working to incorporate CHWs in Medicaid maternal health programs.

- ***Bias Training for Healthcare Workers***

MHPA views bias training for healthcare workers as an important tool for improving the quality of care beneficiaries receive related to pregnancy, delivery, and postpartum care. Implicit bias is defined as unconscious and automatic attribution of particular qualities to a member of a racial, cultural, or social group that might have an effect on clinical care. As noted in the CMS issue brief, *Improving Access to Maternal Health Care in Rural Communities*, “women of color in rural areas reported experiencing discrimination and/or feelings of stigmatization when accessing maternal health care services, resulting in health care avoidance.”¹²

MHPA believes that “educating clinicians and staff about shared-decision making, cultural competency, and implicit bias are important steps to address disparities in care.”¹³ Support for efforts to train providers and other stakeholders about implicit bias, discrimination, and stigma can help ensure that rural residents receive care and services that are patient-centered, culturally sensitive, and ultimately improve maternal and infant health outcomes.

Behavioral Healthcare Needs

- ***Removing Barriers to Maternal Behavioral Healthcare***

MHPA strongly recommends that OMH include approaches for addressing barriers to maternal behavioral health care needs as part of its effort to reduce and target the racial and geographic disparities in maternal and infant care.

Prenatal and postpartum depression and anxiety disorders are common medical complications affecting beneficiaries during pregnancy and after childbirth. These conditions can have lasting effects on the overall health and well-being of beneficiaries and their families. Research shows that postpartum depression can be associated with a number

¹¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6577316/>

¹² <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>

¹³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5592149/>

of adverse outcomes for both the mother and infant, such as poor parent-child bonding, negative parenting approaches, and increased risk of developmental, health, and safety concerns for the child.¹⁴

Low-income women, including those enrolled in the Medicaid program, and women of racial or ethnic minorities are disproportionately affected by maternal behavioral health disorders.¹⁵ African-American, American Indian, and Latina women are more likely to experience postpartum depression than white women are and Asian/Pacific Islander (non-Hispanic) women are almost three times more likely to report postpartum behavioral health symptoms than white women (non-Hispanic).¹⁶

Medicaid coverage improves access to health care for low-income women, including access to behavioral health care. For example, among insured low-income mothers with depression, mothers with Medicaid or commercial/other health insurance had similar rates of treatment; 65 percent of mothers with Medicaid received treatment, compared to 70 percent of mothers with commercial/other insurance.¹⁷

The Medicaid program also offers a unique benefit to address maternal behavioral health through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. The EPSDT program is a comprehensive child health benefit that covers periodic screening services (i.e., well-child exams) for any eligible individual under 21 years of age. A number of states cover maternal depression screening as part of these assessments for the child, which may be billed for either the child or the mother (if the mother is eligible for Medicaid). Since screenings for maternal depression are considered for the benefit of the child, state Medicaid agencies are able to allow these screenings to be claimed as child services under the EPSDT. As of 2016, maternal depression screenings are being billed under well-child exams in Colorado, Illinois, North Dakota, and Virginia.¹⁸

While state Medicaid programs are allowed to pay for maternal depression screenings during a well-child visit, states must be proactive in the implementation of EPSDT coverage for maternal depression screenings and retain discretion regarding payment for these services.

¹⁴ <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>

¹⁵ Rates of depressive symptoms among low-income women are estimated to fall between 40 and 60 percent (Centers for Medicare and Medicaid Services, 2016). Reports show that 11 percent of infants among families living below the federal poverty level have had a mother who experienced severe depression and that among all infants living in poverty, 55 percent are being raised by mothers experiencing some form of depression (Centers for Medicare and Medicaid Services, 2016).

¹⁶ <https://www.medicaidinnovation.org/images/content/2018-IMI-Medicaid-Maternal-Depression-Anxiety-Report.pdf>

¹⁷ <https://www.medicaidinnovation.org/images/content/2018-IMI-Medicaid-Maternal-Depression-Anxiety-Report.pdf>

¹⁸ https://www.ncsl.org/Portals/1/Documents/cyf/Pregnancy-to-Postpartum_v05.pdf

MHPA believes that increased use of the EPSDT screenings could play an important role in identifying maternal behavioral health needs that enable access to early and appropriate treatment and would recommend federal guidance that encourages states to consider this approach.

- ***Addressing Substance Use Disorder and Neonatal Abstinence Syndrome***

Approximately 5.7 percent of pregnant women covered by Medicaid reported illicit drug dependence or abuse in the past year compared to just 1.9 percent of pregnant women with other types of health coverage.¹⁹ From 2008 to 2016, the rate of babies born with neonatal abstinence syndrome grew about three-fold for newborn hospitalizations under the Medicaid program. This trend parallels the troubling increase in the number of pregnant women suffering from opioid use disorder.

Substance abuse has long been prevalent in rural areas with the opioid epidemic taking a particular toll on rural communities. Access to health care services, whether pregnancy-related or related to the treatment of substance use disorders, are particularly challenging for pregnant and postpartum beneficiaries with a substance use disorder. The lack of a comprehensive approaches to their care compounds the issue of access when care and services are not coordinated.

MHPA applauds the Center for Medicare and Medicaid Innovation's (CMMI) Maternal Opioid Misuse model²⁰ as an important initiative intended to address the lack of coordinated care for pregnant and postpartum beneficiaries with a substance use disorder. We believe approaches that support the delivery of coordinated and integrated physical health care, behavioral health care, and wrap-around services are important steps forward for helping beneficiaries with substance use disorders focus on their health and recovery.

Transportation

Transportation continues to be an important need for Medicaid enrollees in rural communities. Transportation barriers can directly affect access to health care by causing individuals to miss or delay health care appointments and can contribute to poorer health outcomes.²¹ As noted in the CMS issue brief, *Improving Access to Maternal Health Care in Rural Communities*, up to 40 percent of women do not complete a postpartum visit, in part because of geographic isolation, limited transportation, and a lack of child care.²²

¹⁹ https://www.macpac.gov/public_meeting/january-2020-macpac-public-meeting/

²⁰ <https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model>

²¹ <https://www.nytimes.com/2018/08/09/business/health-care-transportation.html> ; Gier J., Missed Appointments Cost the U.S. Healthcare System \$150B Each Year. *Health Management Technology*. May 2017.

²² <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>

Authorized in federal regulations²³, the non-emergency medical transportation (NEMT) benefit provides transportation to and from medical appointments for Medicaid beneficiaries with no other means of accessing services. States are also required to provide assistance with transportation to children and their families as part of Medicaid's EPSDT benefit.

The NEMT benefit varies from state to state and typically includes transportation by taxi, wheelchair van, private vehicle, and public transportation. In general, Medicaid beneficiaries are eligible for the benefit, as long as the transportation is necessary and the beneficiary does not have another means of transportation. An estimated 10 percent of Medicaid beneficiaries rely on NEMT for rides to kidney dialysis appointments, substance abuse treatment programs, pharmacies, and other routine care.

MHPA recommends that OMH look to reducing transportation barriers and increasing the availability of reliable transportation as important considerations when seeking to connect beneficiaries to health care treatment and services.

Telehealth

The coronavirus pandemic has focused significant attention on telehealth as an important option for enhancing access to care. In recent weeks, CMS has taken action to revise and relax policies across federal programs to remove barriers to the use of telehealth during the current pandemic.

MHPA recommends that OMH explore and prioritize investments in telehealth, such as the Federal Communication Commission's Rural Health Program.²⁴ We believe many of these recent policy changes have the potential to make a meaningful difference in connecting beneficiaries and infants in rural communities to health care services; we also encourage an evaluation of these policy changes to determine which are appropriate to be made permanent. We believe that permanent telehealth policies promote clinically rational care, understanding that some services require in-person visits.

Given the growing shortage of behavioral health providers nationwide, we also believe that expanding telehealth is a valuable and viable option to help meet maternal behavioral health needs. Telehealth can be used to coordinate treatment for mental health and substance use disorders. Telehealth services have been proven to drive important advancements for patients, expand access to care, improve health outcomes, reduce inappropriate use of psychotropic medications, overcome the stigma barrier, and reduce costs.²⁵

However, despite the recent relaxation of federal regulations, variations in state laws and originating site restrictions continue to create barriers for telehealth adoption. MHPA encourages CMS to partner with states to create uniform standards for licensing, credentialing, reimbursement, and site/geographic requirements to allow more opportunities for care, including telehealth, across state lines. As a part of state coordination efforts, CMS could work with states to consider the impact of originating site restrictions, which puts financial constraints on patients

²³ 42 CFR 440.170

²⁴ <https://www.fcc.gov/general/rural-health-care-program>

²⁵ http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf

at home who want to use telehealth services, and encourage states to relax these site restrictions, which would subsequently expand access to telehealth in rural communities and provide reimbursement for home-based telehealth services that were not previously covered. We also recommend the establishment of an Interstate Compact to develop national standards for telehealth in Medicaid.

As noted earlier in our letter, the availability of telehealth services can also be a factor that helps with the recruitment of clinicians to rural areas. Since upfront costs can be a barrier for setting up a telehealth infrastructure in rural communities, we would recommend the provision of additional funds for telehealth start-up grants to assist providers, particularly smaller ones such as behavioral health, small skilled nursing and assisted living facility providers, and community health centers.

Addressing Social Determinants of Health

Tackling the social determinants of health that affect pregnant and postpartum beneficiaries can facilitate access to needed resources and promote positive maternal health outcomes. As noted in a 2017 study, “[p]overty, lack of education, poor nutritional status, smoking, and neighborhood have been associated with poor maternal and infant outcomes.”²⁶ MHPA recommends consideration of additional coverage options for non-clinical services to address the social determinants of health that contribute to higher morbidity and mortality rates for low-income beneficiaries as well as looking toward improvements in data collection to spur innovation.

Home Visiting Programs

Home visiting is an effective prevention strategy used to support beneficiaries to promote maternal and infant health and address family social needs. Participation in these programs are generally voluntary and families may choose to opt out at any time. Home visitors may be trained nurses, social workers or child development specialists. These programs help address postpartum needs such as interventions for maternal depression.

Since 2010, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program has been helping children and families get off to a better healthier start. In FY 2019, 51 percent of all counties served by the MIECHV program were rural.²⁷

MHPA recommends the MIECHV program for further review by OMH and evaluate the further scalability of this approach. We also note that states vary on how and whether Medicaid funds can be used for home visitation programs and would recommend additional guidance on how Medicaid funding can be used and connected with other funding streams for home visiting programs.

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5592149/>

²⁷ <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>

Maternal Mortality Measurement

Accuracy and data completeness are core contributors to quality decision-making when assessing the impact of current policies on maternal mortality and morbidity. Yet, historically, maternal mortality has been inconsistently reported across the United States.

To improve identification of maternal deaths, a pregnancy question was added to the 2003 revision of the U.S. Standard Certificate of Death. Vital registration systems are controlled individually by each state; the standardized checkbox was implemented as funding, technology, and state laws allowed over several years. The last state added the checkbox to the death record form in 2017. MHPA believes that support for states to update their systems for maternal health surveillance will help contribute to better reporting and provide a more complete and accurate picture of maternal health outcomes across the country.

Another issue impacting quality measurement relates to the use of different definitions of maternal mortality. The National Center for Health Statistics (NCHS) is the official source for U.S. maternal mortality statistics used in international, state, and demographic comparisons. NCHS uses the definition of maternal death from the World Health Organization (WHO) which is “the death of a woman while pregnant or within 42 days of termination of pregnancy,” but excludes those from accidental or incidental causes. However, the CDC focuses its surveillance and research on “pregnancy-related deaths,” defined as the death of a woman while pregnant or within 1-year of pregnancy termination—regardless of the duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes; and from pregnancy-associated deaths, defined as all deaths during pregnancy or within 1 year of pregnancy, regardless of cause.” Some states also use varying definitions of maternal mortality. These differing terms and definitions can cause confusion when analyzing trends in maternal mortality.

MHPA recommends having a standardized term and definition across the United States for all state and federal reporting and monitoring of maternal deaths that would contribute to a better understanding of trends and track progress.

Perinatal Quality Collaboratives

MHPA recommends that OMH consider strategies to further support perinatal quality collaboratives (PQCs). PQCs are state or multi-state networks of teams working to improve the quality of care for mothers and babies. PQC members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible.

PQCs²⁸ have contributed to important improvements in health care and outcomes for mothers and babies, including:

²⁸ <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm>

- Reductions in deliveries before 39 weeks of pregnancy without a medical reason
- Reductions in health care–associated bloodstream infections in newborns
- Reductions in severe pregnancy complications
- Social determinant of health (SDOH) solutions.

Although some perinatal quality collaboratives receive support from the CDC, we believe that more consistent and sustainable support would help ensure these collaboratives can operate in each state with a long-term plan for improvement over time.

4. How can CMS/HHS support these efforts?

We have included recommendations for public policy actions in our earlier responses to this RFI; we are succinctly restating our recommendations here for CMS and HHS in response to this specific question:

- **Medicaid Eligibility**
 - *Facilitate state efforts to extend Medicaid coverage for postpartum beneficiaries beyond 60-days*
 - *Develop and distribute resources that promote the awareness of available coverage options for beneficiaries who lose their pregnancy-related Medicaid eligibility*
- **Workforce Issues**
 - *Support efforts to encourage the recruitment of clinicians to rural areas*
 - *Support efforts to recruit and train a culturally competent and linguistically diverse workforce*
 - *Expand coverage and payment options for the non-physician clinicians and community health workers*
 - *Promote consistent credentialing and certification across states for certified nurse midwives, doulas, and community health workers*
 - *Develop and distribute resources for bias training for healthcare workers*
- **Maternal Behavioral Health Care Needs**
 - *Provide federal guidance to promote the increased state use of EPSDT screenings*
- **Telehealth**
 - *Partner with states to create uniform standards for licensing, credentialing, reimbursement, and site/geographic requirements*
- **Transportation**
 - *Support state efforts to reduce transportation barriers in rural communities*
- **Social Determinants of Health**
 - *Support coverage for non-clinical services that could address the social determinants of health*
- **Quality & Outcomes**

- *Continue to support the federal Maternal, Infant and Early Childhood Home Visiting program and consider additional guidance for how Medicaid funds can be used and braided with other funding for home visiting programs*
- *Support states in future updates to maternal health surveillance system reporting*
- *Create uniform, standardized terms and definitions for measuring maternal mortality to be used across federal and state agencies*
- *Support perinatal quality collaboratives in all states*

Thank you for your consideration of our comments in response to this RFI. We recognize the importance of working collaboratively to address the significant barriers to care faced by beneficiaries and their families in rural communities. Given the significance of Medicaid coverage for this population, our member plans are well-positioned and available to help you in your efforts to make a meaningful difference for this vulnerable population. Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

Shannon Attanasio

Shannon Attanasio
Vice President, Government Relations and Advocacy