



FY 25 State Budget Can Support Better Birth Outcomes

House Health & Human Services
Appropriations Subcommittee

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Michigan Council for Maternal and Child Health

Established in 1983, the purpose of MCMCH is to influence public policy that will improve maternal and child health outcomes, and to collaborate with other organizations to promote comprehensive maternal, child, and family health and wellbeing.

Organizational Members:

- Corewell Health
- Children's Hospital of Michigan
- Henry Ford Health System
- University of Michigan C.S. Mott Children's Hospital and Von Voigtlander Women's Hospital
- Michigan Section of ACOG
- Mott Children's Health Center
- School-Community Health Alliance of Michigan
- Honor Community Health
- Michigan Association for Infant Mental Health
- Michigan Association of School Nurses
- Michigan Breastfeeding Network
- Michigan Organization on Adolescent Sexual Health
- Michigan School Health Coordinators' Association
- Michigan State Medical Society
- Northern Michigan Health Consortium
- Washtenaw County Public Health
- Maternal-Newborn Nurse Professionals of Southeastern Michigan
- Michigan Chapter, National Association of Pediatric Nurse Practitioners

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- MCMCH staff and board members participate in over two dozen state advisory committees where policy is on the agenda, including:

- Medical Care Advisory (Medicaid)
- Family Planning Advisory
- Maternal Infant Health Equity Collaborative (state Perinatal Quality Collaborative)
- Maternal Mortality Surveillance and Policy Recommendations Comm
- Home Visiting Advisory
- MI AIM Steering Committee
- Think Babies Executive Comm
- Perinatal Oral Health Advisory



MCMCH is at the table

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MCMCH policy agenda

Each year the MCMCH board establishes an Action Agenda to build on our long-standing policy platforms. In 2024 our agenda includes:

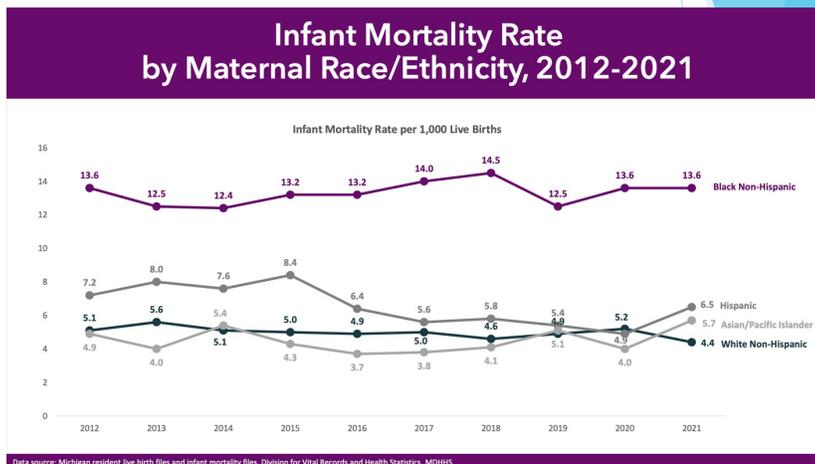
- Highlight strategies that emphasize health equity and reduce racial disparities
- Preserve and enhance Medicaid rates for all relevant services
- Support a full continuum of mental health and substance use disorder services for children and pregnant individuals, prenatal and postpartum
- Ensure access to all reproductive health services
- Promote home visiting programs during pregnancy and early childhood
- Expand preventive oral health care and access to dental homes
- Promote childhood immunizations
- Advance breastfeeding and access to human milk
- Maintain and enhance services for children with special health care needs
- Prevent sleep-related infant deaths
- Support coordinated school health, school-based health centers, school nurses and comprehensive health education
- Expand access and resources for families in need of grief supports or pediatric palliative care and hospice
- Address environmental toxins impacting maternal and child health
- Promote programs and policies that support the economic health of families, inc. paid family and medical leave

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Infant Mortality in Michigan

Infant mortality is defined as a death of a live-born baby before his or her first birthday and is expressed as a rate per 1,000 live births. Black Non-Hispanic infants die 3 times more often than White NH infants.

For additional information see: Michigan Infant Mortality data at <https://www.michigan.gov/mdhhs/inside-mdhhs/statisticsreports/vitalstats/infantdeaths>



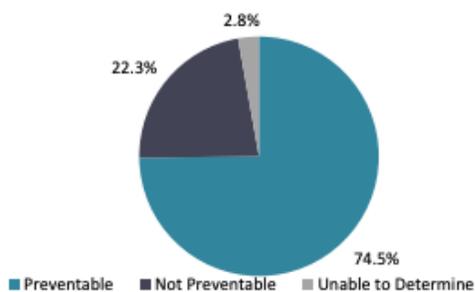
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Maternal mortality – pregnancy related

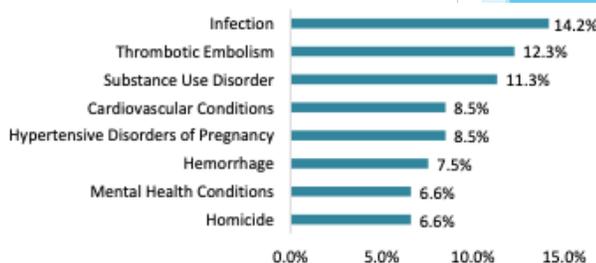
Pregnancy-related mortality is the death of an individual while pregnant or within one year following the end of a pregnancy from any cause related to or aggravated by the pregnancy or its management. It does not include accidental or incidental causes.

From 2016-2020 - 106 Michigan women died for a rate of 19.4 per 100,000 live births.

PREVENTABILITY



CAUSES



From 2016-2020, Black women were 2.2x more likely to die from pregnancy-related causes.

All data from the Michigan Maternal Mortality Surveillance Program
Maternal Deaths in Michigan, 2016-2020 Data Update

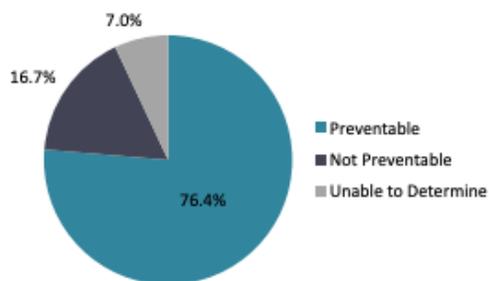
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Maternal mortality – pregnancy associated

Pregnancy-associated mortality is the death of an individual within one year following the end of a pregnancy for a cause unrelated directly to the pregnancy.

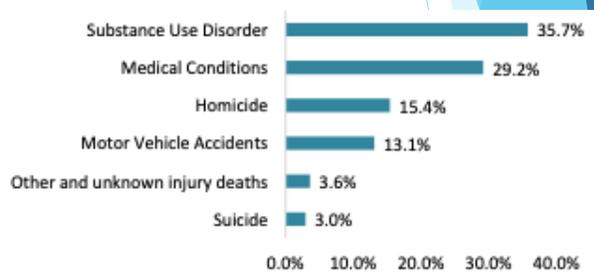
From 2011-2020 - 786 Michigan women died for a rate of 70.5 per 100,000 live births.

PREVENTABILITY



All data from the Michigan Maternal Mortality Surveillance Program
Maternal Deaths in Michigan, 2016-2020 Data Update

CAUSES



From 2016-2020, Native American women had the highest rate of death from pregnancy-associated causes.

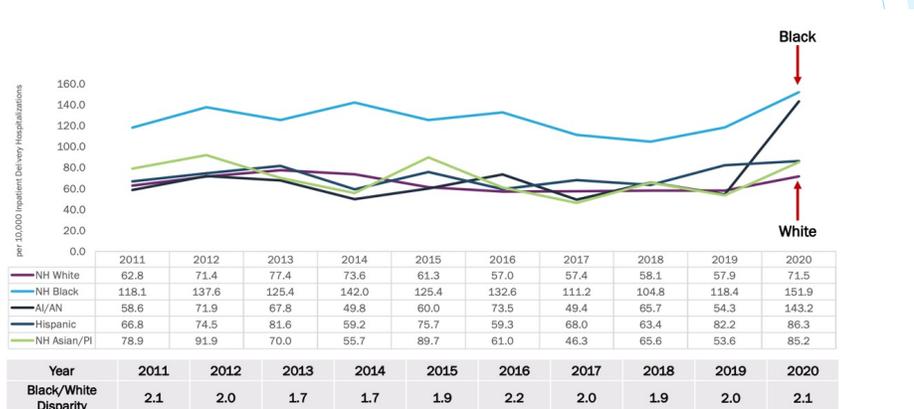
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Severe Maternal Morbidity in Michigan

Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.

SMM examples include **heart attack, heart failure, eclampsia, sepsis/blood infection and hysterectomy.**

Non-Hispanic (NH) Black individuals have consistently higher rates of SMM than other races and ethnicities.



Data Source: Michigan Resident Inpatient Files created by the Division for Vital Records and Health Statistics, Bureau of Epidemiology and Population Health, Michigan Department of Health and Human Services, using data from the Michigan Inpatient Database obtained with permission from the Michigan Health and Hospital Association Service Corporation (MHASC).

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Climate ripe for change and collaboration to improve outcomes



Much greater awareness of need to focus on maternal health



Ongoing state commitment - Snyder and Whitmer administrations



Appropriations - targeted investments with over \$60m additional just in last year



Importance of hearing and honoring voices of those most impacted, amplified by community organizations



Partnership and collaboration at national, state and local level

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Appropriations Gains

- ▶ Primarily under the “Healthy Moms, Healthy Babies” initiative the administration has made significant budget proposals over the last several years
- ▶ The Legislature has helped shape many of these proposals and steady gains have been made including Medicaid extension to 12 months postpartum, increasing home visiting, adding counties in the MC3 psychiatric consultation services and building infrastructure to support the state’s plan (such as the doula advisory)

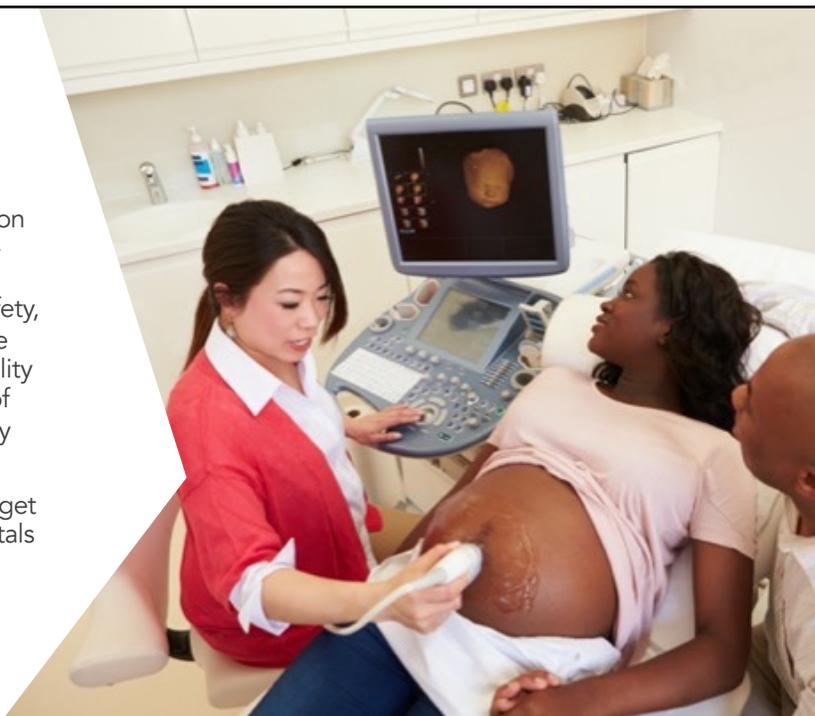
In current year budget over \$68 million appropriated:

- Remove the 5-year waiting period for recently immigrated pregnant individuals and children
- Reinstate Plan First family planning benefit to 200% FPL
- \$10m included to support and expand Centering Pregnancy (group-based perinatal care model) sites
- \$10m each for hospital quality improvement incentives and Perinatal Quality Collaborative

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Ensuring quality, responsive care

- Michigan Alliance for Innovation in Maternal Health (MI AIM)) – CQI effort to improve hospital culture regarding maternal safety, decreasing preventable severe maternal morbidity and mortality through the implementation of early recognition patient safety bundles.
- \$10 million in FY 24 state budget to provide incentives to hospitals for participation which can be paired with Levels of Maternal Care designation in statute.



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Empower and sustain collaboration



AN EQUITY PLAN FOR MICHIGAN FAMILIES & COMMUNITIES

Perinatal Quality Collaborative and the regional entities bring together all partners working with perinatal families in their area to focus on local data and local strategies.

Efforts are linked back to the state's plan to reduce maternal and infant mortality and morbidity. Funding in FY 24 budget to fund locally-led projects.

Centering community led organizations whenever system, policy and funding decisions are considered.

Sustainability including statutory recognition is key to long term success - \$10 million is in FY 24 state budget

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FY '24-'25 Executive Recommendations

Healthy Moms Healthy Babies

- \$3,335,000 (\$918,700 GF) to increase reimbursement rates to MIHP service providers for additional care mgmt. services
- \$2 million (\$545K GF) increases in Medicaid reimbursement for doulas as follows:
 - \$748,700 gross (\$209,100 GF) to increase Medicaid rates
 - \$1.2 million gross (\$336,000GF) to double allowable visits
- \$2.9 million (\$1.4m GF) for doula training and outreach (*included as one-time*)
- \$7.5 million GF to continue state grants for Centering Pregnancy and the Regional Perinatal Quality Collaboratives (*included as one-time*)

MCMCH supports these recommendations but would strongly encourage commitment to the work of the RPQC's with agreement to fully fund them at the current level in FY '25 and remove "one-time".

Additionally we would encourage Medicaid reimbursement for CenteringPregnancy to reduce GF need and create sustainability plan.

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FY '24-'25 Executive Recommendations

- \$14.2 million for additional family planning local grants
- \$7 million gross (\$2.5m GF) to increase reimbursement rates for Vaccines for Children
- Funding to remove the \$10/month premium for MICHild coverage
- \$24 million in TANF funds for prenatal and infant allowance (similar to RxKids Flint)
- \$13.7 million gross (\$4.8m GF) to fund ending Medicaid birth expenses recovery program
- Behavioral health increases including Expansion of CCBHCs, MiCAL (Crisis and Access Line), \$36.1 m gross (\$10.2m GF) to increase outpatient reimbursement rates, \$3 million of American Rescue Plan Funds to support expansion of internship and scholarships (one-time) and \$500K for assistance grants to fund continuing education, exam fees and supervision costs

MCMCH supports these recommendations.

We encourage continuation of boilerplate sections to strengthen the evaluation and accountability of funding.

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FY '24-'25 Maternal and Infant Budget Asks

- Home visiting
 - Inflationary increases and infrastructure support
- Safe sleep and suffocation prevention
 - Very small line in budget - not increased in over 15 years
- Breastfeeding supports
- Study of perinatal payment structures

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Questions?



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