1. **What is important to your constituents/colleagues regarding this policy?**

   Thank you for the opportunity to comment on the NC Medicaid Revisions to Clinical Coverage Policy 1E-5, Obstetrical Services. The North Carolina Pediatric Society is in support of this policy being updated to reflect the legislative update for the 12-month postpartum extension with the full package of Medicaid services plus strengthened dyad care. Improving access to health coverage in turn increases access to care and improves health outcomes. Consistent healthcare results in healthier pregnancies and fewer complications for parents and babies.

   New parents may also be dealing with postpartum depression or a host of other underlying medical conditions, all while caring for a newborn. The health and wellness of a parent has important implications for a baby’s overall health including cognitive and social-emotional development. Uninterrupted health care coverage is important in not only managing pregnancy related complications, but also to maintain access to mental health treatment, breastfeeding support, chronic disease management, and prescription drugs, to name a few. Disruptions in health care coverage can adversely affect access to medically necessary health care during the postpartum period.

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From a child health perspective it is also important to note that postpartum care is needed even when the infant has been lost. Research shows that siblings of infants who die are at greater risk of death and that supporting parents during this time is critical.\(^2\) Thus coverage should exist 12 month postpartum at the end of any pregnancy regardless of the birth outcomes including miscarriage, fetal demise and neonatal death, as permissible by CMS.\(^3\) Postpartum coverage improves mom’s health during the first year of baby’s life and also improves inter-pregnancy intervals, future pregnancies, etc.

We also urge coverage of and linkage to important parenting resources, such as Healthy Opportunities, Reach Out and Read, Family Connects, Parents as Teachers, Triple P, WIC, SNAP, EITC and other tax credits. CMS guidance allows coverage and payment of home-visiting services.\(^4\)

2. **Would you recommend any unit or other limitations to the services?**
   No, there are no further recommended units or limitations to this service.

3. **If this service should be limited to certain diagnoses, please include your recommendations with evidence to support the diagnoses that you have recommended.**
   No, there are no further recommendations.

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4. Is there any additional evidence in medical literature on the services in the policy that you would like to present?

The infant and the mother-infant dyad relationship are a central concern within pediatrics. Treatment, when focused solely on the adult, is often less effective than treatment that is focused on the mother-infant dyad. An AAP policy statement, titled Incorporating Recognition and Management of Perinatal Depression into Pediatric Practice, highlights the impact of postpartum depression on the infant, the mother-infant dyad and the family. Pediatric providers see new parents earlier and more frequently than other physicians, giving multiple opportunities to assess and screen parental mental health. These visits are the perfect time to begin screening for postpartum depression in the pediatric primary care setting. The Patient Health Questionnaires (PHQ-2, PHQ-9), the Edinburgh Postnatal Depression Scale (EPDS), and other maternal mental health screens are valuable at assessing a broad range of issues including maternal depression other family risk factors and child development and behavior.

Providers should be able to provide care by billing to Medicaid ID of the baby or the mother. Dyad care should be prioritized and strengthened. For example:

- Pediatricians should be able to inoculate pregnant and postpartum people against influenza, Tdap, and other diseases.

- Breastfeeding coverage should explicitly cover International Board Certified Lactation Consultants (IBCLCs) and other properly credentialed experts and it should be easy to bill for both mother and baby. Research shows that breastfeeding offers many health benefits for mothers and infants. Breast milk provides essential nutrition and antibodies to protect against common childhood infections, as well as an opportunity for early skin-to-skin contact and suckling that has its own physical and emotional benefits.

- Residential substance abuse treatment should include options with dyad care, not solely programs that require the new parent to leave their baby.

- Home visiting and other supports should be covered to fullest extent allowed in the December 2021 letter from CMS to State Health Officials.

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6 Earls MF; AAP News, AAP reports: Perinatal depression screening, referral needed. December 2018

7 CDC - https://www.cdc.gov/pertussis/pregnant/mom/get-vaccinated.html#:~:text=When%20women%20get%20Tdap,months%20old%20by%20078%251


From a child health perspective, we especially note the importance of strong care for the parent in terms of oral health care, smoking cessation, maternal depression, substance misuse, chronic condition management and family supports.

Additionally, research has been well documented on the relationship between oral health and overall wellness. Pregnant and postpartum people are more susceptible to poor oral health to include gum disease, cavities, and dental disease. We urge continued coverage of the full array of oral health benefits throughout the 12 month period with a minimum of prior authorizations given the time limited nature of the benefit. To improve the oral health outcomes of mothers, inclusion in this policy is imperative.10

5. **What additional criteria would you include in the policy to define the service and identify community standards of practice?**

We urge the full array of Medicaid benefits, including oral health care, contraception and family planning, Baby Love and strong dyad care, be extended to people at least 12 months postpartum. We further urge a minimization and/or “fast-tracking” of prior authorizations so that postpartum people are not denied services due to administrative delays. We applaud the permanent status of select telehealth flexibilities and note the challenges of travel with a newborn, especially when the family does not have access to a car. We also urge clarity that NEMT can include all the children in the household if the new parent needs to bring all children to the appointment/cannot leave them alone/etc.

We would like to advocate for inclusive language so instead of “pregnant women” or “female beneficiaries” the use of “birthing individuals” or “pregnant persons” would include people who do not identify as female.

The presumptive eligibility (2.1.4) appears to be very restrictive and could result in pregnant and postpartum people not receiving needed care. Eligibility determination should be permissible any time before birth of the baby (including retroactively to the extent permitted by CMS) in order for people to receive 12 months postpartum care to improve the health of the parent and baby.

For fetal surveillance testing (3.2.4) policies should ensure that fetal echocardiograms and other needed imaging is covered and listed out clearly, as well as fetal cell free DNA, when medically necessary. We would want to ensure that this policy includes prenatal pediatric consultations (3.4) and that contraceptive counseling and provision, like all current Medicaid benefits, are also extended to 12 months (3.6).

We urge that redetermination periods be aligned across the family (or minimally the newborn and parent) to reduce administrative burden for both families and county DSS officers.

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