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*Maternal Health Strategic Plan*

SECRETARY OF HEALTH AND HUMAN RESOURCES  
OFFICE OF THE GOVERNOR OF VIRGINIA

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## ABSTRACT OF NATIONAL MATERNAL MORTALITY

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The United States ranks last among industrialized countries with a maternal mortality rate of 17.4 per 100,000 pregnancies.<sup>1</sup> Racial disparities in maternal mortality rates are stark—the maternal mortality rate for Black women is 2.5 times the rate for white women. While for many health conditions higher income and advanced education are associated with better outcomes, these protective effects do not bear out for Black women as it relates to maternal mortality. College educated Black women in the U.S. are at 60% greater risk of maternal death than a white or Hispanic woman with less education.<sup>2</sup>

## VIRGINIA'S MATERNAL HEALTH DISPARITY

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Virginia largely mirrors the national statistics. Virginia's maternal mortality rate is 15.6 per 100,000 pregnancies and impacts women of all backgrounds (Image 1).<sup>3</sup> While women of color are at increased risk for poor outcomes, particularly in Native American and some Latina communities, the racial disparities for Black women are most significant. The maternal mortality rate of Black women (47.2) is over two times higher than that for white women (18.1) (Image 2).<sup>4</sup> According to Pregnancy Risk Assessment Monitoring System (PRAMS) data from 2019, Black women were more likely to report chronic conditions like hypertension and depression and more likely to report experiencing discrimination or harassment due to their race/ethnicity or insurance or Medicaid status. The 2019 Maternal Mortality Review Team (MMRT) report on chronic conditions further highlighted significant racial disparities among Black women and showed that Black women with at least one chronic condition had a maternal mortality rate over twice that of their white counterparts (51.4 versus 25.1, respectively). The 2019 MMRT report identified several factors that were associated with higher rates of maternal mortality. In particular, a lack of care coordination contributed significantly to higher rates of death for women with chronic conditions. Care coordination and pregnancy support are critically important given that over 62 percent of women with a chronic condition died after the six-week postpartum period (between 43 and 365 days of pregnancy termination). Additionally, the MMRT data showed the second leading cause of pregnancy-associated death among Black women is homicide, and there are significant racial disparities in the family and intimate partner homicide rate.

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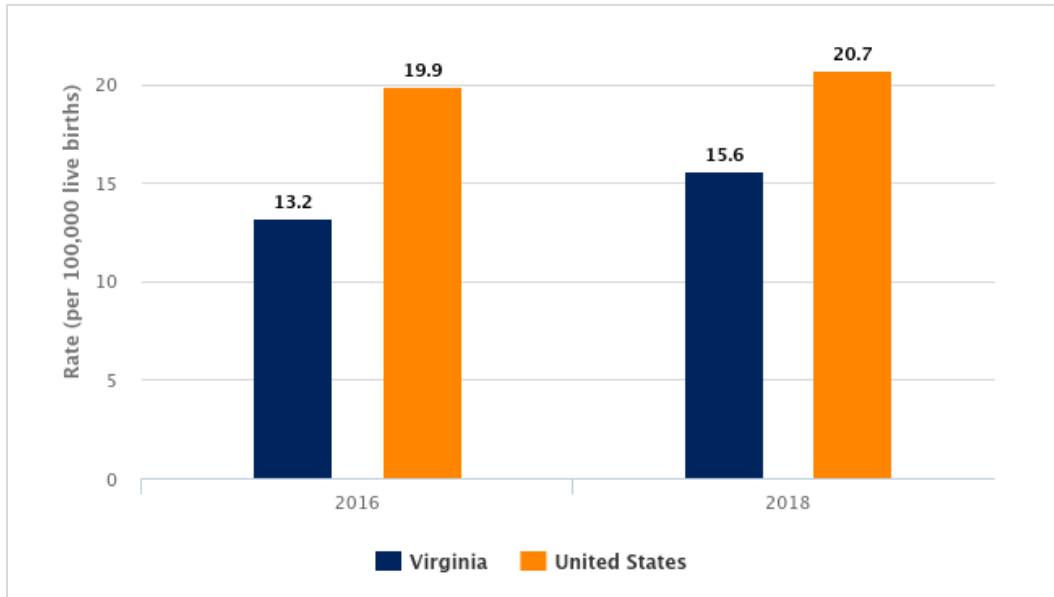
<sup>1</sup> DeClercq, Eugene, and Laurie Zephyrin. "Maternal Mortality in the United States: A Primer." *The Commonwealth Fund: Advancing Equity*, 2020, <https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer#:~:text=The%20most%20recent%20U.S.%20maternal,after%20the%20day%20of%20birth>. Accessed 29 March 2021

<sup>2</sup> *ibid*

<sup>3</sup> Maternal Mortality by State, 2018. CDC. <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf>

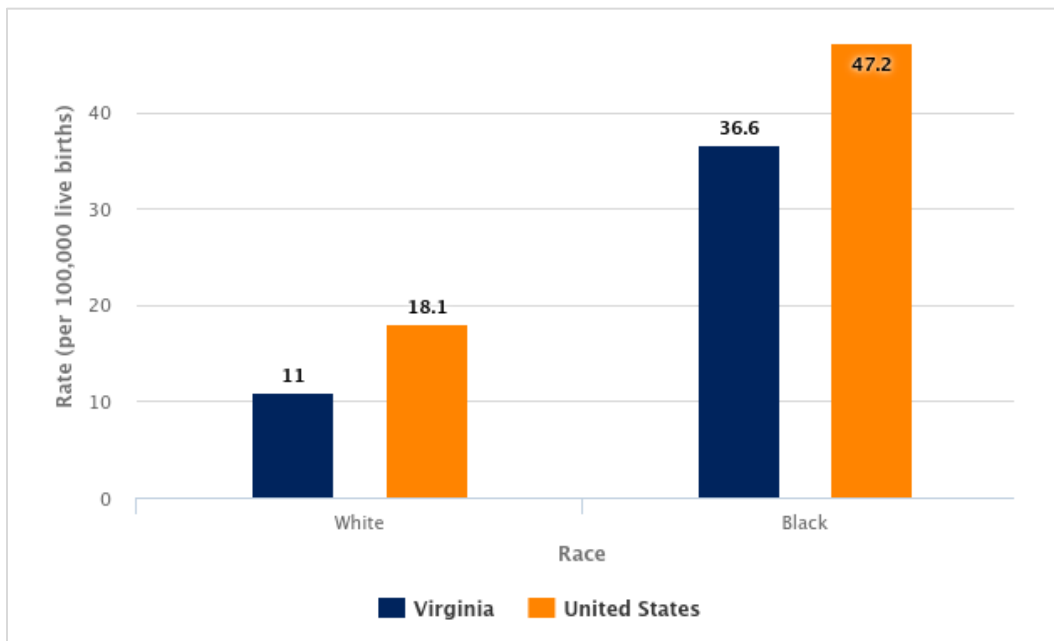
<sup>4</sup> Maternal Morbidity and Mortality. Virginia Maternal & Child Health. <https://insight-editor.livestories.com/s/v2/pregnant-women-and-infants---morbidity-and-mortality/dbcdd202-7b14-4143-af2c-bdafdef945d>

## Maternal Mortality Rate (per 100,000 births), By Year



Source: CDC WONDER; retrieved from American Health Rankings 2016 and 2018

## Maternal Mortality Rate, by Race/Ethnicity



SOURCE: CDC Wonder; retrieved from American Health Rankings 2018

Among white women, the leading cause of pregnancy-associated death is accidental overdose. Department of Medical Assistance Services (DMAS) data shows that pregnant women with substance use disorder are less likely to seek care, further increasing the risk for poor pregnancy outcomes.

The Virginia Department of Health (VDH) reports that nearly fifty percent of all pregnancies in Virginia are unplanned, highlighting the importance of access to comprehensive contraceptive options for all women of reproductive age in order to allow individuals to decide if and when to have children and to appropriately space and plan between pregnancies. The CHOICE Project and the Colorado Family Planning Initiative both demonstrated that increasing access to contraceptive methods, including LARCS, regardless of ability to pay leads to declines in unintended pregnancy rates.

Addressing the racial disparities in maternal mortality will take concerted effort. Specifically, policies that seek to dismantle the structural racism that is at the root of the disparately negative outcomes for Black women are urgently needed. Structural racism in healthcare and social service delivery systems has resulted in reduced access to care and poorer quality of care for Black women. In particular, Black women seeking care are often not believed when enduring pain and providers fail to treat them with dignity and respect. Compounding these barriers, the cumulative impact of daily experiences of racism and sexism have physiologic consequences, known as weathering, that place Black women at increased risk for myriad medical conditions, such as preeclampsia, eclampsia, diabetes, embolisms, and mental health conditions.<sup>5,6</sup>

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<sup>5</sup> For further discussion, see Cristina Novoa and Jamila Taylor, “Exploring African Americans’ High Maternal and Infant Death Rates,” (Washington: Center for American Progress, 2018), available at <https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/>.

<sup>6</sup> Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from [http://reviewtoaction.org/Report\\_from\\_Nine\\_MMRCs](http://reviewtoaction.org/Report_from_Nine_MMRCs). Accessed March 31, 2021.

## GOVERNOR NORTHAM'S RESPONSE

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As a pediatrician by training, Governor Northam directed Virginia's health teams to dramatically increase the Commonwealth's focus on maternal health. In light of Virginia's maternal health impacts, in 2019, Governor Northam declared an ambitious goal of eliminating the racial disparity in maternal mortality by 2025. In support of achieving this goal and recognizing the importance of getting as proximate to the issue as possible, the Administration undertook a series of maternal health listening sessions and community forums to ensure that strategies developed to close the gap in maternal mortality outcomes would be community-informed and driven. The Administration met with and heard from community leaders across Virginia. Partnering with Black women state legislators, free clinics, sororities and fraternities, local healthcare providers, hospital systems, local/state officials, and area United Way affiliates to bring together community organizations, the Administration received feedback from individuals with lived experiences of disparately negative maternal health outcomes and discussed strategies to improve maternal health across the Commonwealth. These sessions served to inform the Administration's maternal health strategic plan. This plan outlines six specific strategies and twenty recommendations for achieving the Governor's goal to address the racial disparity in maternal health outcomes.

## COMMON THEMES ACROSS VIRGINIA'S COMMUNITIES

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The Administration heard from individuals and community leaders in ten localities across Virginia—Hampton, Annandale, Lynchburg, Petersburg, Prince William, Portsmouth, Danville, Abingdon, Richmond and Winchester. A synthesis of the all the comments and feedback received from these different communities resulted in several universal themes:

- Individual, system and structural bias are negatively impacting the healthcare environment and maternal health outcomes
- Healthy pregnancies start with healthy individuals prior to pregnancy.
- Women and families want more choices for maternal care providers and a support team, and our current reimbursement models do not allow for a full range of choices.
- Certain policies and practices are leading to women being fearful of seeking prenatal and postpartum care.
- There is a need for greater emphasis on mental health/trauma screenings in the prenatal and postpartum periods; specifically, more focus on care and services in the postpartum period is needed.
- All solutions must be community-driven and community-specific.

Listening session participants highlighted the following areas in need of community-specific solutions:

- Economic justice
- Safe and affordable housing
- Accessible and affordable transportation
- Food justice
- Community and domestic violence
- Shortage of specialists in local communities
- Lack of a labor and delivery unit at local hospitals

In December 2019, as a result of the feedback received, Governor Northam unveiled his maternal health budget package and a final statewide strategic planning session was held with stakeholders, which included: community-based organizations, health systems, certified professional midwives, doulas, obstetricians and gynecologists (OB/GYNs), reproductive health advocates, state agency representatives, child advocates, and other stakeholders with an interest in maternal health.

**The Governor's Proposed Budget** invested nearly \$22 million in strategies to improve maternal health outcomes as follows:

- Extend postpartum coverage for FAMIS Moms up to 12 months. As of now, the program only provides Medicaid coverage for women during pregnancy and 60-days postpartum. (restored in the 2020 Special Session Budget)
- Ensure FAMIS Moms can access substance use disorder treatment.
- Provide funding for affordable, reliable contraception through the Long-Acting Reversible Contraception (LARC) Program. (restored in the 2020 Special Session Budget)
- Invest in community-driven, wrap-around treatment models:
  - \$12.8 million to fund Medicaid reimbursement for home visiting to promote the health and well-being for women, children, and their families.
  - Mandate the Secretary of Health and Human Resources to conduct a study and make recommendations regarding a community doula benefit for women covered by Medicaid.
- Appropriate \$879,000 to fund the Healthy Birthday Virginia program to address racial disparities in maternal, reproductive, and child health and strengthen care coordination for high-risk pregnancies through Medicaid.
- Appropriate \$400,000 for episodic payment models, or bundled payments, to improve maternity care and delivery outcomes.

Policy recommendations from the statewide strategic planning session included:

- Identifying ways to hold institutions accountable—creating a metric, mandating reporting of race/demographic data relating to maternal health outcomes, including reporting cesarean section rate
- Establishing maternal health equity coordinator positions at DMAS/Medicaid and other state agencies
- Requiring maternal mortality specific education for primary care and other physicians – specific to warning signs of pre-eclampsia and providing trauma-informed and trauma-responsive care
- Ensuring health systems are connected with community programs, allowing for the creation of warm referrals
- Requiring bias and competency training in medical school education and as continuing education for maternal healthcare teams such as OB/GYNs, nurses and midwives
- Providing more care coordination and system navigation support
- Providing a doula benefit through Medicaid reimbursement
- Investing in community health workers and home visiting services



The Administration identified six focus areas of improvement for maternal health based on feedback and input received from stakeholders who participated in the listening sessions and statewide strategic planning session:

1. Insurance coverage
2. Healthcare environment
3. Criminal justice and child welfare response
4. Community-based services
5. Contraception
6. Data collection

The six focus areas are described in greater detail below in the Strategies and Recommendations section.

An uncertain financial outlook in the midst of the COVID-19 pandemic led to the unallotment of several of the proposed maternal health budget priorities by the 2020 General Assembly. With an improving financial position over the course of the pandemic response, the General Assembly restored funding in Chapter 56 of the 2020 Special Session:

- Extend postpartum coverage for FAMIS Moms up to 12 months. As of now, the program only provides Medicaid coverage for women during pregnancy and 60-days postpartum.
- Provide funding for affordable, reliable contraception through the Long-Acting Reversible Contraception (LARC) Program.

The 2021-2022 Governor's Proposed Budget for the 2021 General Assembly Session continues to invest substantially in maternal health:

- \$13.5K to cover substance use disorder treatment benefit for FAMIS Moms
- \$1.2M to establish a community doula benefit through Medicaid reimbursement
- \$137K to provide 12 months prescription contraceptives for Medicaid members
- Additional \$1.0M for LARC program (non-general funds)

## STRATEGIES AND RECOMMENDATIONS

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The strategies outlined in this plan seek to improve maternal health outcomes for all pregnant and postpartum women and, in particular, to eliminate racial disparities in maternal mortality for Black women. The strategies build upon ongoing efforts by the legislature (Appendix 1), state agencies, community based organizations, reproductive health advocates and others to improve maternal health for all pregnant persons in Virginia and address the racial disparities in maternal health outcomes.

The authors acknowledge that not all pregnant persons identify as women and that the strategies detailed in the plan are largely based on research, guidelines and best practices identified for “women.”

Transgender and non-binary persons face unique barriers in accessing healthcare, and the challenges specific to their pregnancy experiences deserve additional study so that tailored recommendations can be made to improve their pregnancy outcomes.

The strategies are framed using the six focus areas of improvement identified through the maternal health listening sessions and statewide strategic planning session led by the Administration: insurance coverage, healthcare environment, criminal justice and child welfare response, community-based services, contraception, and data collection.

### Insurance Coverage

The strategy and recommendations for this focus area are aimed at improving maternal health through Virginia’s Medicaid program and the private insurance market. Stakeholder discussions centered on how to expand access to health insurance coverage through Medicaid eligibility and in the private marketplace, as well as expanding the types of services covered and the types of providers that are reimbursable for those services.

#### STRATEGY 1—Improve health insurance coverage for women of reproductive age

**RECOMMENDATION 1:** Increase the availability and affordability of insurance coverage

- Invest in programs that reduce insurance premiums for persons who do not qualify for federal subsidies or do not have employment based insurance
- Invest in processes that facilitate enrollment into insurance affordability programs

**RECOMMENDATION 2:** Eliminate maternity care deserts

- Establish a maternity care workforce, training and certification pipeline inclusive of people of color
- Ensure the ability of midwives to work fully and autonomously in the scope of their practice without unnecessary restrictions, within both traditional (hospitals) and nontraditional health settings (birthing centers and home births)

- Review and revise restrictive training, licensure, and regulatory requirements across all classes of midwives in ways that support expanding access to and opportunities for people of color who seek to practice midwifery
- Provide insurance coverage for remote patient monitoring for pregnant and postpartum women
- Expand insurance coverage for doula services to promote access regardless of income or source of insurance
- Expand insurance coverage for a range of birth options that include hospitals, birthing centers, and planned home births that are attended by a physician, midwife, or doula
- Explore virtual service delivery models such as Babyscripts and the feasibility of implementation in the Virginia Medicaid program
- Maximize the use of remote patient monitoring throughout pregnancy and postpartum periods

**RECOMMENDATION 3:** Improve patient ability to navigate the complex healthcare system

- Enhance health literacy among pregnant and postpartum women of color and healthcare providers by partnering with organizations led by women of color to develop and implement health literacy education and training
- Implement maternity navigation tools and resources such as peer support, patient navigators, and community health workers for African American, Indigenous, and Latina women

**RECOMMENDATION 4:** Ensure behavioral healthcare access for pregnant and postpartum women

- Expand insurance coverage for wraparound supports needed to access behavioral healthcare, including transportation and childcare
- Conduct a behavioral healthcare rate study to identify changes that would increase provider participation in Medicaid
- Expand insurance coverage for nontraditional, alternative behavioral health therapies such as meditation or art therapy
- Expand use of telehealth to improve maternal mental health outcomes
- Expand insurance coverage for maternal mental health screening conducted at pediatric visits

## Healthcare Environment

The strategy and recommendations of this focus area address improvements to maternal healthcare environments. During the maternal health listening sessions, women across Virginia reported experiencing discrimination in the healthcare environment. Women of color reported being ignored, particularly when they complained of feeling pain or discomfort. The experiences shared included discriminatory treatment by obstetricians and other physicians, as well as other hospital and healthcare practice staff—front desk receptionists, emergency medical technicians, ultrasound technicians, and other staff in the healthcare environment. Women reported that those experiences led them to delay or avoid seeking care, and some reported traveling lengthy distances to seek care elsewhere.

### **STRATEGY 2—Improve the healthcare environment for women of reproductive age and pregnant and postpartum women**

**RECOMMENDATION 5:** Ensure a diverse workforce of healthcare professionals able to integrate cultural humility into the care of pregnant and postpartum women

- Require process-oriented, ongoing cultural humility training in healthcare professional educational programs and as a requirement for licensing all staff who care for pregnant or postpartum women
- Require a service learning component to increase healthcare provider understanding of the communities they serve
- Implement Culturally and Linguistically Appropriate Services standards within healthcare settings in order to promote health equity, improve quality of care, and support women and families for whom English may not be their primary or preferred language

**RECOMMENDATION 6:** Encourage implementation of evidenced-based clinical best practices in preventive medicine and disease management for women of reproductive age to prevent chronic disease or achieve optimal management of chronic conditions prior to pregnancy

**RECOMMENDATION 7:** Encourage adoption of evidence-based clinical best practices to prevent maternal morbidity and mortality

- Establish a workgroup to explore the feasibility and utility of creating a standardized assessment for mothers after delivery and at certain milestones as a way to improve quality and trigger necessary medical interventions, incorporating best practices from maternal safety bundles
- Expand implementation of maternal health safety bundles across Virginia’s maternity centers
- Expand implementation of evidence-based guidelines for chronic disease management by maternity care providers

- Incorporate Levels of Care Assessment Tool (LOCATe) from the CDC, to standardize assessments and to combine with public health surveillance data that support understanding of maternal and infant health outcomes by level of care
- Expand the Maternal Health Learning Collaborative that leverages public-private partnership to promote continuous hospital-based quality improvement focused on achieving equitable maternal health outcomes, including reducing maternal morbidity among Black women who are at highest risk for poor outcomes
- Implement the Improving Perinatal Health and Reproductive Health ECHO project models

**RECOMMENDATION 8:** Implement payment models that reward providers who offer high-quality, evidence-based, culturally competent care

- Establish payment models that incentivize care coordination akin to pregnancy-centered medical homes offered through Medicaid managed care and establish local group programs and service needs connections that emulate the coordination provided by pregnancy-centered medical homes
- Develop and implement evidence-based, patient-reported outcome measures that evaluate experiences during pregnancy and delivery to incentivize the correct care behavior
- Implement care models that emphasize integrated behavioral and primary healthcare and care coordination

**RECOMMENDATION 9:** Ensure integrated behavioral healthcare as part of comprehensive pregnancy and postpartum care

- Establish behavioral health training, certification, licensure, and workforce pipeline that is inclusive of people of color
- Invest in loan repayment programs that bring behavioral healthcare professionals into areas experiencing provider shortages
- Implement evidence based maternal mental health guidelines, including the mental health screening and treatment guidelines endorsed by American College of Obstetricians and Gynecologists and the Council on Patient Safety in Women’s Health Care
- Implement mental health patient safety bundles in clinical settings
- Conduct a culturally appropriate educational campaign to normalize and destigmatize maternal mental health

## Criminal Justice and Child Welfare Response

The strategy and recommendations of this focus area are intended to promote trauma-informed policies and response protocols for law enforcement, prosecutors, child welfare staff, judges, domestic violence advocates, first responders, and healthcare providers when responding to pregnant and postpartum women interacting with the criminal justice and child welfare systems. MMRT data shows that the second leading cause of pregnancy-associated death among Black women is homicide, and there are significant racial disparities in the family and intimate partner homicide rate. DMAS data shows that pregnant women with substance use disorder are less likely to seek care. During the listening sessions, women reported delaying or avoiding prenatal and postpartum care for fear of healthcare providers reporting them or their families to government authorities because of their immigration status, when they were experiencing intimate partner or family violence, or due to a substance use disorder diagnosis.

### **STRATEGY 3—Improve criminal justice and child welfare response for pregnant and postpartum women seeking care**

**RECOMMENDATION 10:** Ensure trauma-informed, humane treatment of pregnant and postpartum women in the criminal justice system

- Align reproductive healthcare provided in prisons, local and regional jails with best practices from American College of Obstetricians and Gynecologists, American Jail Association, American Correctional Association, and National Correctional Healthcare
- Provide access to nutritional counseling and nutrition supports programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Provide access to pregnancy supports such as lactation consultants, doulas, and other perinatal birth workers
- Mandate bonding time for postpartum women in prisons

**RECOMMENDATION 11:** Address social services needs

- Reduce the harmful effects of poverty on children and families by using a two-generation approach, and supporting them through the TANF (Temporary Assistance for Needy Families) block grant
- Ensuring pregnant women have sustainable access to clothing and diapers, healthcare, safe and affordable housing, and nutritious foods

## Community-based Services

The strategy and recommendations of this focus area are aimed at increasing the capacity of community-based services and resources serving pregnant and postpartum women. MMRT data concluded there is a lack of coordination of care in maternal health, with many women left to navigate the complicated healthcare system on their own. During the listening sessions, women supported by a doula, midwife, or home visiting program during their pregnancy and in the postpartum period reported positive birth outcomes and experiences. Community-based program models offer individual support, care coordination, group prenatal and postpartum classes, childcare assistance, and workforce training. It is common for these programs to hire individuals from within the community, including many who receive services by the programs, and train them to serve other women and families. However, current reimbursement models and regulations can present barriers for increasing the access, capacity and workforce needed for these services.

### **STRATEGY 4—Improve availability and access to wrap around services that support pregnant and postpartum women and their families**

#### **RECOMMENDATION 12:** Enhance supports for families before, during and after birth

- Expand access to home visiting
  - Study and design a home visiting benefit in Medicaid
- Simplify enrollment across public benefit programs to increase access to all benefits for which families are eligible, including nutrition assistance programs
  - Integrate eligibility and enrollment systems to allow for WIC eligibility screening at the time of application for Temporary Assistance to Needy Families (TANF) and Supplemental Nutrition Assistance Program
- Expand access to safe, affordable housing
  - Increase community awareness of local and state initiatives on community revitalization and housing accessibility, including homebuyer and homeowner assistance programs
- Expand access to safe, reliable, affordable transportation
  - Partner with community stakeholders to ensure resources and tools developed through the Mobility for All Project are widely accessible and used
- Expand access to asset and wealth building programs for low and moderate income families
  - Conduct a study to determine potential impact of a refundable earned income tax credit (EITC) on maternal and infant health outcomes
  - Expand access to locality-driven pilots of targeted, reoccurring direct cash assistance (universal basic income)

- Increase community awareness of and participation in local and state first time homebuyer programs
- Expand access to affordable high-quality, culturally sensitive early childcare education
  - Increase awareness of expanded eligibility for the Child Care Subsidy Program that makes childcare and early childhood education affordable for more families

**RECOMMENDATION 13:** Maintain access to intimate partner and domestic violence programs including but not limited to support groups, counseling, advocacy, transportation, clothing and housing assistance, and court services to clients.

**RECOMMENDATION 14:** Expand access to community-led maternal health programs

- Use Title V Maternal Child Health Block Grant funds to support evidence-based, community-led interventions designed to improve maternal health outcomes
- Invest in community-based education and communication initiatives to support families
- Ensure that public health programs are adequately staffed, funded and resourced to support community-led interventions

**RECOMMENDATION 15:** Invest in community programs that offer one-stop comprehensive services

- Expand access to school-based community health centers staffed with empathetic, culturally sensitive staff from within the community



## Contraception

The strategy and recommendations of this focus area address increasing access to contraception and reproductive health literacy. During the listening sessions, healthcare practitioners and women across the state urged the Administration to increase access and affordability of contraception and to increase reproductive health literacy among Virginians. VDH reports that nearly fifty percent of all pregnancies in Virginia are unplanned.

### **STRATEGY 5—Increase access to comprehensive reproductive counseling and contraception choice**

**RECOMMENDATION 16:** Encourage use of culturally competent, non-coercive contraceptive counseling by reproductive healthcare providers

**RECOMMENDATION 17:** Adopt a person-centered contraceptive counseling (PCCC) quality measure to assess contraception access, particularly in the Virginia LARC Initiative

**RECOMMENDATION 18:** Invest in the VDH-administered Virginia Contraceptive Access Initiative, now expanded to include all FDA-approved methods of contraception

## Data Collection

The strategy and recommendations of this focus area highlight the need for more available standardized health data. Stakeholder representatives who participated in the statewide strategic planning session identified maternal health data as a priority for improved maternal health outcomes.

### **STRATEGY 6—Improve data collection and oversight in order to drive action and enhance accountability to improve maternal health outcomes**

**RECOMMENDATION 19:** Standardize birth and death certificate data

**RECOMMENDATION 20:** Mandate and fund fetal and infant mortality review committees

- Ensure FIMR membership is diverse and reflects the population being served

**RECOMMENDATION 21:** Ensure there are adequate quality metrics for maternity care

- Expand use of National Quality Forum (NQF) perinatal and reproductive health measures by Virginia Medicaid managed care entities
- Support the work of the maternal health data taskforce

## CONCLUSION

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This strategic plan provides a blueprint of key strategies and recommendations that the Administration has put forth to address the racial disparity in maternal health. It is critical to acknowledge that structural racism is at the root of maternal health disparities just as it is for many other health disparities. Success to achieving the goal of eliminating the racial disparity in maternal mortality in Virginia by 2025 requires the continued shared responsibility and commitment of doctors, hospitals, insurers, policymakers, government agencies, communities and future governors. Virginia is making progress, yet crucial work remains. Together, stakeholders across the Commonwealth can make significant strides through the implementation of this plan to ensure optimal maternal health outcomes in Virginia.

## APPENDIX 1

### General Assembly Actions on Maternal Health 2021

Bill	Code Section(s)	Description
<p><b>HB1817</b></p> <p>Certified nurse midwives; practice.</p>	<p>§§ 54.1-2957, 54.1-2957.01, and 54.1-2957.03</p>	<p>HB 1817 expands the categories of practitioners with whom a certified nurse midwife may enter into a practice agreement to include other certified nurse midwives who have practiced for at least two years and allows a certified nurse midwife who has practiced at least 1,000 hours to practice without a practice agreement. The bill also provides that certified nurse midwives shall practice in accordance with regulations of the Boards of Medicine and Nursing and consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives and shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.</p>
<p><b>HB1950</b></p> <p>Fetal and Infant Mortality Review Team; Va. Department of Health, et al., to establish, report.</p>	<p>§1 Bill</p>	<p>HB 1950 directs the Office of the Chief Medical Examiner of the Department of Health to convene a work group to develop a plan for the establishment of a Fetal and Infant Mortality Review Team (FIMRT). A FIMRT is a multidisciplinary, community team that examines a fetal or infant death case that is comprehensive, de-identified, confidential, and includes investigative interviews. The purpose of a FIMRT is to develop policy and programmatic recommendations aimed at reducing fetal and infant deaths.</p>
<p><b>HB1953/SB1320</b></p> <p>Licensed certified midwives; licensure; practice.</p>	<p>§§ 54.1-2900, 54.1-3005, 54.1-3303, and 54.1-3408 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2957.04</p>	<p>These bills define "practice of licensed certified midwifery," and direct the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife, and requires licensed certified midwives to practice in consultation with a licensed physician in accordance with a practice agreement. The bill also directs the Department of Health Professions to convene a work group to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.</p>

<p><b>HB1962</b></p> <p>Foster care; termination of parental rights; relatives and fictive kin.</p>	<p>§§ 16.1-281, 16.1-283, 63.2-906, and 63.2-910.2</p>	<p>HB 1962 Requires local departments of social services and licensed child-placing agencies to involve in the development of a child's foster care plan the child's relatives and fictive kin who are interested in the child's welfare. The bill requires that a child 12 years of age or older be involved in the development of his foster care plan; under current law, a child's involvement is mandatory upon reaching 14 years of age. The bill contains other amendments to provisions governing foster care and termination of parental rights that encourage the placement of children with relatives and fictive kin.</p>
<p><b>HB1987/SB1338</b></p> <p>Telemedicine.</p>	<p>§§ 32.1-325, 38.2-3418.16, and 54.1-3303</p>	<p>These bills, aimed at expanding access to telemedicine require the Board of Medical Assistance Services to amend the state plan for medical assistance to provide for payment of medical assistance for remote patient monitoring services provided via telemedicine for certain high-risk patients. High risk patients as identified in this bill include: (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic health condition who have had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months</p>
<p><b>HB2002</b></p> <p>Child support; health care coverage</p>	<p>§§ 16.1-260 and 63.2-1903</p>	<p>HB2002 provides that in any case in which a petitioner is seeking to establish child support, the intake officer shall provide the petitioner information on the possible availability of medical assistance through the Family Access to Medical Insurance Security (FAMIS) plan or other government-sponsored coverage through the Department of Medical Assistance Services. The bill also requires the Department of Social Services to refer children for whom it has issued an order directing the payment of child support to the FAMIS plan if it appears that the gross income of the custodial parent is equal to or less than 200 percent of the federal poverty level.</p>
<p><b>HB2111</b></p> <p>Task Force on Maternal Health Data and Quality Measures; report.</p>	<p>§1 Bill</p>	<p>HB2111 directs the State Health Commissioner to establish the Task Force on Maternal Health Data and Quality Measures 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. Some goals of the task force include: Examining the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers and examining current maternal health benefit requirements and determine the need for additional benefits to protect the health of birthing people.</p>

<b>SB1178</b>	repeal § 54.1-2957.21 of the Code of Virginia	SB1178 repeals the conscience clause for genetic counselors who forgo participating in counseling that conflicts with their deeply held moral or religious beliefs, provided that they inform the patient and offer to direct the patient to the online directory of licensed genetic counselors maintained by the Board of Medicine. When individuals choose genetic counseling they are choosing to receive professional guidance and medical information pertinent to vital choices for themselves and their family; with the passage of SB1178 mothers will no longer have to worry or fear of any roadblocks or any concern that they can't be open without jeopardy of losing that counselor or being seeing through a lens of judgment.
<b>SB1227</b>	§§ 32.1-325 and 32.1-351 of the Code of Virginia	SB1227 directs the Board of Medical Assistance Services to include in the state plan for medical assistance a provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month supply of hormonal contraceptives at one time for Medicaid and Family Access to Medical Insurance Security (FAMIS) enrollees. The bill prohibits the Department of Medical Assistance Services from imposing any utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month supply.
<b>SB1276/HB1896</b>	§ 38.2-3451	Removes the prohibition on the provision of coverage for abortions in any qualified health insurance plan that is sold or offered for sale through a health benefits exchange established or operating in Virginia.
<b>SB1307</b>	§§ 32.1-325 and 32.1-326.3 of the Code of Virginia	SB1307 directs the Board of Medical Assistance Services to amend the state plan for medical assistance services to provide for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions, regardless of whether the student receiving care has an individualized education program or whether the health care service is included in a student's individualized education program. The bill specifies that such services shall include those covered under the state plan for medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services.

<b>SB1313</b>	§§ 2.2-5211 and 2.2-5212	<p>SB1313 requires that funds expended for private special education services under the Children's Services Act only be expended on educational programs that are licensed by the Board of Education or an equivalent out-of-state licensing agency. The bill also provides that as of July 1, 2022, such funds may only be expended for programs that the Office of Children's Services certify as having reported their tuition rates.</p> <p>The bill adds children and youth previously placed in approved private school educational programs for at least six months who will receive transitional services in a public school setting to the target population for eligibility for the state pool of funds. The bill provides that state funds shall be allocated for no longer than 12 months for transitional services.</p>
<b>SB1316</b>	<p>§§ 19.2-389, as it is currently effective and as it shall become effective, 22.1-289.035, as it shall become effective, 22.1-289.039, as it shall become effective, 63.2-1720.1, and 63.2-1724</p>	<p>The bill also requires the Department, in collaboration with the School Readiness Committee, to (a) identify and analyze financing strategies that can be used to support the systemic costs of high-quality child care services, ensure equitable compensation for child care staff, and better prepare children for kindergarten and (b) analyze the effectiveness of using a cost-of-quality modeling system for the child care subsidy program.</p>
<b>SB1328</b>	<p>§§ 16.1-228, 16.1-282.1, 63.2-100</p>	<p>SB1328 creates the State-Funded Kinship Guardianship Assistance program (the program) to facilitate child placements with relatives, including fictive kin, and ensure permanency for children. The bill sets forth eligibility criteria for the program, payment allowances to kinship guardians, and requirements for kinship guardianship assistance agreements.</p>