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THE VOICE FOR HEALTH CARE CONSUMERS

What's Next in Maternal Health? Transforming Medicaid to Combat the Maternal Health Crisis

Introduction

Medicaid is a vital source of health care coverage for nearly 1.5 million nationwide, including more than 65% of births among Black, American Indian and Alaska Native (AIAN) people.[1] While all states are required to provide pregnancy-related services to pregnant individuals with incomes of up to 138% of the federal poverty level (FPL), the experiences of pregnant women attempting to access health care and services in each state is not uniform and leads to devastating disparities in health outcomes.[2] State Medicaid programs and the Child Health Insurance Program (CHIP) offer a patchwork of pregnancy-related coverage, benefits and covered services vary widely across states as does access to care. Further, the features of Medicaid and CHIP do not exist in a vacuum. Barriers to timely care, culturally incongruent services, and inconsistent benefits, and a lack of attention to non-medical social needs persist across states and have a significant impact on health outcomes for mothers.

The lack of a more holistic Medicaid maternal health benefit across states is particularly concerning as the United States remains in the midst of a maternal health care crisis. Women are dying at rates the U.S. has not experienced since the 1960s.[3] Stark disparities in maternal mortality between Black and white women persist, with the weight falling heaviest on Black women who have long experienced worse maternal health outcomes in the U.S.[4]

To improve outcomes for women, and in particular women of color, individual state Medicaid programs must reimagine the coverage pathways, accessibility, and delivery of maternal health care, ensuring that care is holistic, patient-centered, and equally accessible to every pregnant person* covered by Medicaid. To achieve this goal, states must therefore consider both barriers and opportunities that exist within state Medicaid programs, Medicaid managed care organizations (MCOs), and community-based organizations (CBOs) and take steps to expand care and services, improve health care infrastructure, and expand the clinical and nonclinical provider workforce.

To improve outcomes for women, and in particular women of color, individual state Medicaid programs must reimagine the coverage pathways, accessibility, and delivery of maternal health care, ensuring that care is holistic, patient-centered, and equally accessible.

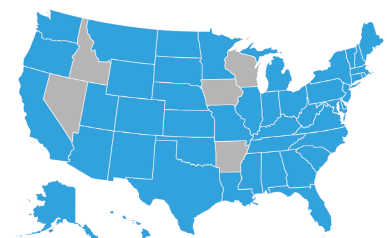
Reimagining Medicaid maternal health coverage is critical to solving the maternal health crisis, as Medicaid is uniquely situated to have a powerful impact on pregnancy outcomes and the overall health of pregnant and postpartum individuals in every state and in every community. Federal and state policymakers therefore must strive to improve Medicaid to provide gold-standard maternal health coverage that truly centers the needs and interests of mothers.

Current pathways to Medicaid pregnancy coverage

There are currently several pathways for women to obtain Medicaid coverage for their pregnancies, with each state maintaining different income eligibility requirements and coverage options. Women enrolled in Medicaid prior to becoming pregnant continue to access coverage for the duration of pregnancy and as long as they remain eligible. Women who are pregnant but do not have sufficiently low income to qualify for adult Medicaid coverage in their state may qualify for Medicaid pregnancy coverage due to expanded eligibility requirements. It is also worth noting that as of April 2024, 45 states plus D.C. have extended Medicaid pregnancy coverage for mothers for a period of 12 months after a baby has been delivered.[5]

12 MONTHS POSTPARTUM COVERAGE

45 STATES + DC



* Families USA supports the interests and experiences of all individuals, including those who identify as transgender or nonbinary, and embraces inclusive language to describe the experience of all people who give birth. We also recognize that many people who give birth identify with the terms “woman,” “mother” and “maternal” and that embracing more inclusive language does not mean abandoning these terms. Some of the data and research cited in this paper also assumes cisgender identity, and the data and research are described using gender labels when necessary to avoid misrepresenting the data.

Medicaid and the Maternal Health Crisis

Medicaid provides coverage for more than 40% of all births in the United States.* As such, Medicaid is uniquely situated to have an impact on pregnancy outcomes and the overall health of pregnant and postpartum people. For Medicaid to move toward becoming the preeminent model for maternal health coverage, certain challenges need to be discussed:

- Pregnant people face barriers accessing Medicaid pregnancy coverage.
- Covered benefits can be inadequate and inconsistent.
- Pregnancy-related Medicaid coverage is not focused on the whole person.

*Source: Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey | KFF)

Select states also offer coverage options though CHIP for women with incomes above Medicaid pregnancy eligibility requirements, including six states that offer full Medicaid pregnancy benefits through the CHIP "pregnant woman" option. An additional 20 states offer coverage through the CHIP "unborn child" option, but this coverage option does not include any postpartum care.[6] Taken together, these coverage options led to 96% of women being insured for their delivery in 2021.[7]

Despite major strides in expanding coverage eligibility, hundreds of thousands of women continue to experience barriers to coverage, often not having coverage prior to becoming pregnant, experiencing delays obtaining coverage once pregnant, being made to self-pay for pregnancy care or losing coverage soon after the birth.[8] In addition, barriers to coverage can also begin even before pregnancy as hundreds of thousands of women of reproductive age fall into the so-called Medicaid coverage gap — they have incomes too high to qualify for Medicaid but too low to qualify for Affordable Care Act (ACA) Marketplace coverage.[9] When women of reproductive age are uninsured, they are more likely to miss out on important health and preconception care and are more likely to go without routine preventive care once pregnancy coverage ends.[10]

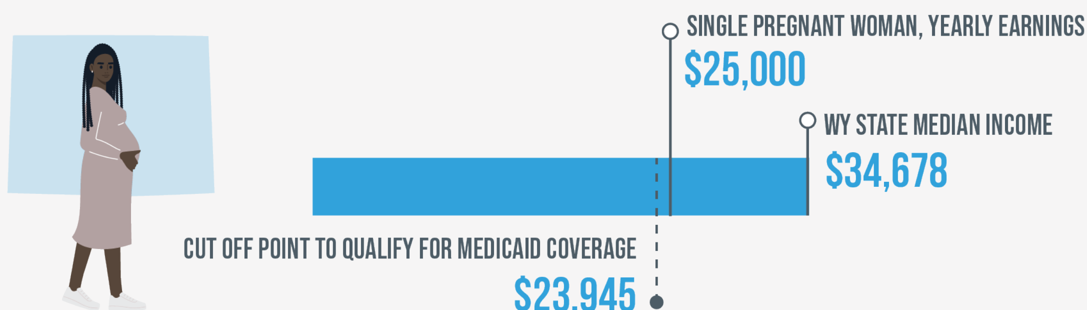
The best way to improve access to health coverage for pregnant women is to ensure they are covered prior to becoming pregnant and long after. Under the ACA's Medicaid expansion, states can receive enhanced federal Medicaid funding for covering adults with incomes up to 138% of

the FPL. A total of 40 states and Washington, D.C., have expanded Medicaid coverage under this option; many have gone even further to expand coverage specifically for pregnant people. States like Connecticut, Iowa, and New Mexico have expanded income eligibility for Medicaid pregnancy coverage well beyond the minimum 138% FPL, bringing the average income eligibility limit to 200%. Still, 10 states have yet to adopt the expansion at all, leaving many of reproductive age without needed health care coverage.[11] And while Medicaid expansion is an integral step toward closing the coverage gap, many pregnant women in expansion states are still failing to qualify for Medicaid while struggling to afford other sources of health care. In Wyoming, where income eligibility for Medicaid pregnancy coverage is capped at 159% of the FPL, a single pregnant woman earning $25,000 a year would be ineligible for coverage despite making notably less than the state median income of $34,678.[12]

Pregnant women who are not U.S. citizens face enormous barriers to pregnancy-related care even though their children become U.S. citizens at birth. Immigrants only qualify for Medicaid coverage if they have held a qualified immigration status for five or more years, meaning their immigration status falls in one of several lawfully present immigration categories, such as having refugee or permanent resident status.[13] With few exceptions, undocumented immigrants are often fully excluded from pregnancy-related coverage pathways in Medicaid, regardless of how long they have resided in the U.S. However, individuals who do not qualify for Medicaid coverage due to immigration status can receive labor and delivery coverage under emergency Medicaid or limited coverage in states that offer the CHIP unborn child coverage option.[14] These coverage options are not adequate substitutes for the comprehensive and full-term pregnancy coverage offered to fully eligible Medicaid beneficiaries. Research demonstrates that Medicaid exclusions for immigrant women are driving disparities in perinatal health care access and contributing to worse health outcomes for pregnant immigrants and their babies.[15]

Falling Through the Cracks: Medicaid Pregnancy Coverage In Wyoming

A single pregnant woman earning $25,000 per year would be ineligible for Medicaid pregnancy-related coverage despite making notably less than the state median income of $34,678.



Even when women are eligible for Medicaid coverage during pregnancy, administrative barriers and delays can prolong the time it takes to actually become enrolled and begin receiving covered services. The recommendation is that women attend their first prenatal checkup at the eight-week gestational mark, typically one month after their first missed period.[16] This means that women without insurance who become eligible for Medicaid once pregnant have little time to enroll and begin receiving coverage before they should be seeking care. To facilitate immediate access to health care services, many states adopt presumptive eligibility for pregnancy coverage, which allows women to begin receiving covered services while their Medicaid application is processed. In the 11 states without presumptive eligibility, it can take up to 45 days for state Medicaid agencies to process and approve applications.[17] While maternal health care is not a replacement for reproductive care, in the wake of the Dobbs decision and growing limitations and bans on abortion, it is more important than ever for women to have immediate access to prenatal services.[18]

Current state of pregnancy coverage

While federal guidance requires state Medicaid plans to cover pregnancy-related services necessary to support the health of pregnant women, the scope and range of those services is largely up to the state — and to the specific contracts they establish with MCOs.[19] Fortunately, a majority of states go beyond exclusively covering pregnancy-related services and provide minimal essential coverage to women covered under Medicaid or CHIP pregnancy pathways.[20] This means that women who qualify for Medicaid due to pregnancy have access not only to services related to their pregnancy but the full scope of services provided under traditional Medicaid coverage in that state.[21]

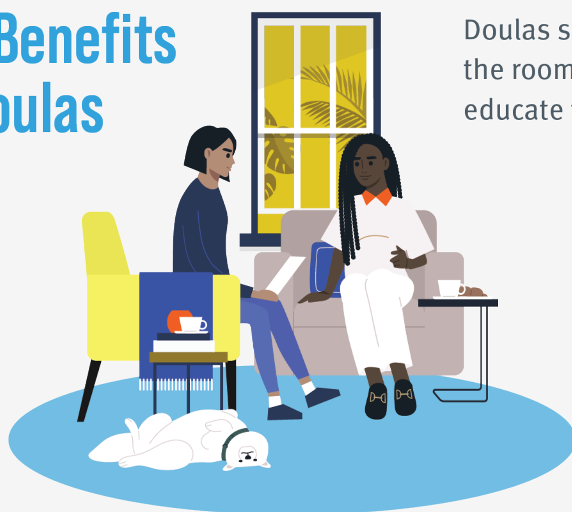
That said, across the country, there is considerable variation in which services are covered and to what extent. Home births, dental services, substance-use disorder services, and many other evidence-backed benefits remain uncovered services in a majority of state Medicaid programs. Even when a benefit is covered under a state plan, pregnant Medicaid beneficiaries may still face barriers to utilizing that coverage. For example, prenatal vitamins are federally required to be covered by every state plan but limitations and utilization controls, such as prior authorization requirements and prescription requirements, can make it challenging to utilize such coverage.

Home births, dental services, substance-use disorder services, and many other evidence-backed benefits remain uncovered services in a majority of state Medicaid programs.

While coverage limitations are designed to prevent unnecessary or wasteful service utilization, they can also unintentionally create barriers to much needed care. Take blood pressure monitors as an example: Up to 16% of women experience high blood pressure during pregnancy, a condition associated with life threatening complications such as stroke and eclampsia. Black women are particularly impacted by the risks of high blood pressure and are more than twice as likely to experience uncontrolled high blood pressure while of childbearing age. The CDC recommends women with a history of high blood pressure levels monitor their blood pressure with at-home blood pressure monitors. Unfortunately, several states provide no coverage for blood pressure monitors and many others place significant limitations on the coverage of this important device, such as prior authorization, prescription requirements, or medical necessity requirements.

Still, many Medicaid programs also fail to consistently and adequately cover a number of key services for pregnant beneficiaries. For example, as of 2023, only 11 state plans included doula services within their Medicaid pregnancy benefits.[22] Data show that the support of a doula leads to lower rates of C-sections and preterm birth, in turn reducing risks of maternal mortality and morbidity.[23] Further, women who have a high risk of adverse birth outcomes and receive doula care are “two times less likely to experience a birth complication, four times less likely to have a low birthweight baby, more likely to breastfeed, and more likely to be satisfied with their care.”[24] Despite the ample evidence that doulas help improve the health of pregnant people and babies, most states still fail to cover this important service and many other vital community-based services.[25]

The Benefits of Doulas



Doulas serve as patient advocates, a non-clinical voice in the room to provide physical and emotional support, and to educate the patient throughout the perinatal period.

PATIENTS WHO UTILIZE A DOULA ARE:

- **Less likely to experience a birth complication.**
- **Less likely to have a low birthweight baby.**
- **More likely to be satisfied with their care.**
- **More likely to breastfeed.**

Kea D.

For Kea, obtaining care at a birth center meant being able to utilize doulas and midwives. This allowed her to have an experience that honored her as a whole person.

"Every appointment was great. It was a very warm and friendly place. It wasn't like the 15-minute appointment where you wait, get your blood pressure taken, are asked if you are good, and then you go home. I was there in the room having one-on-one connection at least for 45 minutes. Like, how are you mentally? What are you eating? How are you doing? If you feel something that feels weird, let us know. It was like, I'm not going to feel like a burden if I call."

Further, workforce or supply shortages can make it difficult or even impossible to access and receive select services.[26] Some pregnant Medicaid beneficiaries seeking services have difficulty gaining information about which are included in their coverage, and Medicaid enrollees experience some of the biggest challenges finding and scheduling appointments with in-network providers.[27] This is particularly challenging for marginalized and rural communities who disproportionately bear the impacts of a nationwide health care workforce shortage, increasing rates of maternity ward and freestanding birth center closures.[28]

Strengthening the roles of CBOs and community-based providers

The maternal health crisis has underscored the need to explore comprehensive health solutions that lie beyond the boundaries of traditional medical services. Traditional health care providers are often ill-equipped to address the complex social drivers contributing to inequities in perinatal care, such as nutrition, housing, transportation, and language barriers. Egregiously, many providers fail to offer even the most basic foundations of dignified, culturally competent and responsive care. According to a national survey, one in six women reported experiencing mistreatment during childbirth, enduring instances of being shouted at, scolded, or even ignored by health care providers.[29] This mistreatment disproportionately affects women of color, individuals from lower socioeconomic backgrounds, and those giving birth in hospitals rather than at home, highlighting systemic disparities in care provision. During pregnancy and throughout the postnatal period, CBOs can play a critical role in helping women navigate a fragmented health care system, accessing a holistic array of community-based services, facilitating care across services and providers, and ensuring access to respectful and culturally competent care.

In response to the critical need for dignified and respectful maternity care, Centers for Medicare and Medicaid Services (CMS) is exploring novel solutions in community-based settings. One

TMaH Model

In December 2023, CMS announced the development of the new TMaH model which is specifically designed to improve access to care as well as issues of quality and equity for pregnant people enrolled in Medicaid and CHIP. The model explicitly strives to improve integration of community-based services, such as community health workers and doulas as well as clinical care in order to target and address the health-related social needs (HRSN) driving poor health outcomes and health disparities.

Under TMaH, state Medicaid agencies will receive direct support improving access to a variety of maternal health care resources and services, implementing quality initiatives and working toward certain quality designations, and improving the delivery of whole person care. The model will:

- **Address barriers** to community-based service access through relationship-building and education.
- **Improve information-sharing** between CBOs and providers.
- **Create referral pathways** between CBOs and providers to enable the delivery of community-based services.

potential solution is the Transforming Maternal Health (TMaH) model, aimed at increasing access to a variety of maternal health community-based providers, including midwives, freestanding birth centers and doula services. By integrating these providers and CBOs into the health care system, TMaH focuses on the multifaceted needs of pregnant individuals, particularly those from marginalized communities who often face mistreatment and inadequate care. Moreover, TMaH emphasizes the importance of addressing social determinants of health, recognizing that factors such as access to transportation, language barriers, and cultural competence play significant roles in shaping maternal health outcomes.

CBOs, with their expertise in providing social support services and reaching at-risk groups, are essential partners in this effort. Unlike traditional health care entities, most CBOs are embedded in the communities they serve, engender trust with community members, and deeply understand the health opportunities and challenges in communities. They also have unique experience in providing a comprehensive array of support services in maternal child health programs and in encompassing health education, mental health support, family programs, food assistance, transportation, language assistance, housing support, childcare, financial services, legal services, disability services, and energy or fuel assistance.

States such as Indiana, Minnesota, New Jersey, New York and Oregon have recognized the value of integrating CBOs into Medicaid programs, thereby leveraging their expertise to improve maternal health outcomes while reducing health care costs.[30]

See our previous publication on "Community-Based Models That Are Improving Equity and Black Maternal Health Outcomes: A Focused Analysis."

Similarly, North Carolina, Texas and Wisconsin have implemented pregnancy medical home models that integrate CBOs into care delivery.[31] These initiatives have resulted in improved postpartum care utilization, a 7% reduction in rates of low birthweight and lower rates of maternal mortality.[32] By partnering with CBOs, state Medicaid agencies can provide pregnant individuals and new mothers access to comprehensive support that addresses their medical, social and emotional needs, ultimately leading to better health outcomes for both mothers and babies and generating cost-savings for the state.

One of the most significant contributions of CBOs is their ability to build trust within communities often wary of traditional health care systems by employing individuals who live in that specific community.[33] Through their deep-rooted community connections and cultural competence, CBOs have a unique rapport with community members, enabling them to facilitate access to care and promote health-protective behaviors. This is particularly crucial in communities with high rates of maternal mortality and morbidity, where trust in healthcare providers is essential for improving outcomes.[34]

In addition to CBOs, community providers play an increasingly important role in delivering whole person care. By expanding the array of care providers, including doulas, non-nurse midwives, community health workers, and other community-based professionals, health care systems can offer tailored and culturally responsive support that aligns with women's preferences and needs.

Barriers preventing CBO integration within Medicaid

Despite these encouraging examples, there are operational challenges that threaten the sustainability of promising CBO models. Issues such as inadequate reimbursement mechanisms and unsustainable funding, a lack of infrastructure and administrative support for CBOs and insufficient guidance on how to develop partnerships between CBOs and Medicaid MCOs hinder the ability of CBOs to fully participate in Medicaid initiatives.

The vast majority of people enrolled in Medicaid receive their care through MCOs, making them crucial players in the maternal health space.

The vast majority of people enrolled in Medicaid receive their care through MCOs, making them crucial players in the maternal health space.[35] MCOs are tasked with implementing expanded benefits and incentivizing increased access to doulas, midwives, home visitors, providers at birthing centers and group prenatal care facilitators for Medicaid enrollees.[36] They are also playing an increasing role in delivering the array of support services available to pregnant women and families, encompassing social determinants of health and HRSN.

Historically, CBOs offer maternal health services to individuals within their community by utilizing a patchwork of grant funding. Access to consistent federal grant funding has been challenging, and reports from CBOs highlight trouble filling out applications, slow turnaround times, a lack of technical assistance, and perceived grant scarcity.[37] MCOs can help financially support CBOs by permanently integrating them into their service delivery models. One way of doing so is by taking advantage of recent efforts by CMS to develop MCO-CBO partnerships through 1115 demonstration waiver opportunities aimed at addressing HRSN. Such needs as housing stability and nutrition assistance go hand in hand with the goal of improving maternal health outcomes. CMS currently allows state Medicaid programs to spend up to 3% of the total annual Medicaid budget to address HRSN.[38]

1115 Waivers

An opportunity for state Medicaid programs and CMS to address the need for more holistic maternal health care and create a standard continuum of care is through Medicaid section 1115 demonstrations, commonly referred to as Medicaid 1115 waivers.

The Commonwealth Fund conducted a survey of Medicaid contracts from all states that use comprehensive managed care and found there is no consistency in how states approach maternal health.[39] The contracts take a fragmented approach to addressing family planning and prenatal and postpartum care, and they do not discuss maternal health within a continuum of care.

Researchers suggest that CMS should look back at past demonstrations that created guidelines for holistic care, such as with substance-use disorder demonstrations, and craft new guidelines for maternal health for states that focus on how managed care contracting can improve coverage and provide more holistic health care.[40]

When considering opportunities for more formal integration of CBOs into MCO care delivery models, an issue of significant concern is the compatibility of existing MCO payment structures and the types of services that CBOs provide to their community members. For example, as CBOs are not clinical health care providers, they do not usually track the same data metrics as traditional health care providers. They also don't charge for individual services, which makes it difficult to monetize the value of their work and provide appropriate reimbursement. Further, when they communicate with beneficiaries, they do not use technical medical terminology, which means that CBOs and MCOs have to work to understand one another's common language.[41] For example, the process of integrating doulas into managed care contracts can present challenges, particularly for independent doulas who lack experience with billing processes and contracting with MCOs.[42]

As CBOs integrate more permanently into the MCO space, it is critical to consider how MCOs can invest in shared data platforms, providing financial incentives for CBO capacity-building and contracting and training CBOs as care coordinators. For instance, in New Jersey, each MCO designates a point of contact to assist doulas with contracting and claims assistance, streamlining the process for providers. Other states have adopted similar strategies to simplifying the contracting process for doulas.[43] States can facilitate this process by educating enrollees about the role of CBOs in care coordination and social determinants of health services and by developing pathways to integrate CBOs into Medicaid systems based on their readiness, scope, capacity and commitment.

By leveraging the expertise of CBOs and strengthening partnerships between health care providers, MCOs and states, Medicaid can enhance its capacity to address health inequities and improve outcomes for pregnant individuals and their children.

To propel Medicaid toward becoming the preeminent model for maternal health coverage, CMS, Medicaid agencies, provider organizations and MCOs must continue this momentum. This entails not only implementing current best practices but also actively seeking to improve upon them and scaling successful initiatives across states. By fostering ongoing collaboration among Medicaid and CBO stakeholders, we can ensure that every individual, regardless of background or circumstances, receives comprehensive pregnancy, birth and postpartum care as well as the support they need for a healthy start for the whole person and whole family.

By leveraging the expertise of CBOs and strengthening partnerships between health care providers, MCOs and states, Medicaid can enhance its capacity to address health inequities and improve outcomes for pregnant individuals and their children.

Policy Recommendations

Despite the notable barriers currently preventing mothers across the country from getting needed pregnancy-related care, CMS and states have the ability to transform Medicaid into the preeminent model of maternal health coverage that American mothers deserve. In pursuit of the best quality coverage accessible to all pregnant women, states should consider the following policy recommendations:

Broaden access to Medicaid coverage.

- **States should ensure women have access to health coverage throughout the perinatal period** by adopting the ACA Medicaid adult coverage expansion, raising income eligibility for Medicaid pregnancy coverage to at least 200% FPL, eliminate the five-year waiting period for qualified immigrants to obtain Medicaid coverage, and providing unrestricted extensions of postpartum coverage beyond the existing 12-month option.
- **States should facilitate timely access to prenatal care** by requiring presumptive eligibility for pregnancy coverage and ensuring that a wide range and sufficient number of maternal health care providers are able to facilitate eligibility determinations.

Improve the quality of Medicaid coverage.

- **States should require coverage of all evidence-backed services, devices and treatments** without unnecessary barriers to coverage utilization. This includes coverage of integral community-based services that address social drivers of health and HRSN.
- **CMS and the state Medicaid programs should provide guidance on cultural congruency between clinical (MCO providers) and nonclinical stakeholders (CBOs)** to ensure a uniform practice of collecting data, providing resources, billing and communicating with beneficiaries.

Provide robust delivery of services.

- **CMS should strengthen opportunities for Medicaid to fund CBO-provided services** by making the inclusion of sustainable funding for CBOs in Medicaid permanent in all states. This will provide stability for CBOs offering maternal health services and will allow for significant workforce, infrastructure and administrative growth. States and MCOs must consider the compatibility of existing payment structures within Medicaid and provide technical assistance to support the integration of Medicaid, MCOs and community-based service providers.
- **States must take necessary steps to ensure reimbursement is appropriate to enroll a sufficient number of providers to meet the needs of mothers covered by Medicaid.** This includes developing clear pathways to reimbursement for the broader maternal health community-based workforce, including doulas, community health workers and peer support professionals, and ensuring that reimbursement is sufficient to meet demand.

States hold the key to drive real change by expanding access, improving quality and establishing a system of care delivery that targets the holistic needs of pregnant and postpartum women.

As our nation struggles to address the maternal health crisis, now is the time for Medicaid to follow the data to create a robust and consistent foundation of coverage to ensure the strongest possible prenatal, birth and postpartum outcomes. CMS and state Medicaid agencies must address the current patchwork of coverage and ensure that women are able to access high quality and robust care no matter where they live. Medicaid has the potential to provide best-in-class coverage for pregnant women in the U.S. and to meaningfully address the stark disparities in maternal health. To do so, CMS must continue to test innovative models, such as TMaH, and state Medicaid agencies should take advantage of existing flexibilities and make meaningful, evidence-backed changes to their program. States hold the key to drive real change by expanding access, improving quality and establishing a system of care delivery that targets the holistic needs of pregnant and postpartum women.

Endnotes

[1] Madeline Guth, Sweta Haldar, Robin Rudowitz, and Samantha Artiga, "Medicaid and Racial Health Equity," *KFF*, June 2, 2023, https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/#:~:text=Medicaid%20covers%20more%20than%2040%25%20of%20births%20nationally%2C,mortality%20and%20morbidity%20as%20compared%20to%20White%20individuals.

[2] Ibid.

[3] Eugene Declercq and Laurie C. Zephyrin, "Maternal Mortality in the United States: A Primer," The Commonwealth Fund, Issue Brief & Report, December 16, 2020, https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer.

[4] Ibid.

[5] National Academy for State Health Policy, "State Efforts to Extend Medicaid Postpartum Coverage," updated March 13, 2024, https://nashp.org/state-tracker/view-each-states-efforts-to-extend-medicaid-postpartum-coverage/#:~:text=The%20American%20Rescue%20Plan%20Act,60%20days%20to%2012%20months.

[6] KFF, "Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level," State Health Facts, n.d., https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Maggie Clark, "Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options," Georgetown University Health Policy Institute, Center for Children and Families, November 2020, https://ccf.georgetown.edu/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf.

[7] Claudia P. Valenzuela and Michelle J. K. Osterman, "Characteristics of Mothers by Source of Payment for the Delivery: United States, 2021," Centers for Disease Control and Prevention, National Center for Health Statistics, Brief No. 468, May 2023, https://www.cdc.gov/nchs/products/databriefs/db468.htm.

[8] Judith Solomon, "Closing the Coverage Gap Would Improve Black Maternal Health," Center on Budget and Policy Priorities, July 26, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health; Valenzuela and Osterman, "Characteristics of Mothers."

[9] Solomon, "Closing the Coverage Gap."; Patrick Drake et al., "How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible If All States Adopted the Medicaid Expansion," *KFF*, February 26, 2024, https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

[10] Solomon, "Closing the Coverage Gap."

[11] KFF, "Status of State Medicaid Expansion Decisions: Interactive Map," April 8, 2024, https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

[12] Data Commons Place Explorer, "Wyoming," n.d., https://datacommons.org/place/geoId/56?utm_medium=explore&mprop=income&popt=Person&cpv=age,Years15Onwards&hl=en; HealthCare.gov, "Federal Poverty Level (FPL)," n.d., https://www.healthcare.gov/glossary/federal-poverty-level-fpl/; KFF, "Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level," n.d., https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[13] National Immigration Law Center, "Table 1: Overview of Immigrant Eligibility for Federal Programs," revised April 2024, https://www.nilc.org/issues/economic-support/table_ovrw_fedprogs/#:~:text=%E2%80%9CQualified%E2%80%9D%20immigrants%20are%3A%20(,as%20defined%20in%2045%20C.F.R.

[14] Clark, “Medicaid and CHIP Coverage.”

[15] Teresa Janevic, et al., “Analysis of State Medicaid Expansion and Access to Timely Prenatal Care Among Women Who Were Immigrant vs US Born,” JAMA Network Open, October 28, 2022, https://doi.org/10.1001/jamanetworkopen.2022.39264.

[16] March of Dimes, “Prenatal Care Checkups,” Healthy Moms Strong Babies, n.d., https://www.marchofdimes.org/find-support/topics/planning-baby/prenatal-care-checkups; Boston Medical Center, “Newly Pregnant?,” n.d., https://www.bmc.org/newly-pregnant.

[17] Erica L. Eliason and Jamie R. Daw, “Presumptive Eligibility for Pregnancy Medicaid and Timely Prenatal Care Access,” *Health Services Research* 57, no. 6 (December 2022): 1288–94, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9643081/.

[18] Janevic et al., “Analysis of State Medicaid Expansion.”

[19] 42 C.F.R. § 440.210(a)(2)(i); Kathy Gifford et al., “Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey,” *KFF*, April 27, 2017, https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/#:~:text=By%20federal%20law%2C%20all%20states,up%20to%2060%20days%20postpartum.

[20] Medicaid.gov, “Minimum Essential Coverage,” n.d., https://www.medicaid.gov/medicaid/eligibility/minimum-essential-coverage/index.html.

[21] Ibid.

[22] Amy Chen, “Q&A on Pregnant Women’s Coverage Under Medicaid and the ACA,” National Health Law Program, September 5, 2018, https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/#_ftnref10; Usha Ranji et al., “Medicaid Coverage of Pregnancy-related Services: Findings from a 2021 State Survey,” *KFF*, May 19, 2022, https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/.

[23] Alexis Robles-Fradet and Mara Greenwald, “Doula Care Improves Health Outcomes, Reduces Racial Disparities and Cuts Cost,” National Health Law Program, August 8, 2022, https://healthlaw.org/doula-care-improves-health-outcomes-reduces-racial-disparities-and-cuts-cost/.

[24] Laurie Zephyrin et al., “Community-based Models to Improve Maternal Health Outcomes and Promote Health Equity,” The Commonwealth Fund, Issue Briefs, March 4, 2021, https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity.

[25] National Academy for State Health Policy, “State Medical Approaches to Doula Service Benefits,” updated April 16, 2024, https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits/.

[26] National Institute for Health Care Management (NIHCM) Foundation and the Association of Maternal and Child Health Programs (AMCHP), “Maternal Health in Crisis: Ensuring Nationwide Access to Maternity Care Providers,” webinar, August 22, 2017, https://www.nihcm.org/publications/maternal-health-in-crisis-ensuring-nationwide-access-to-maternity-care-providers#:~:text=Nearly%20half%20of%20all%20U.S.,will%20be%20needed%20in%202020; March of Dimes, “New March of Dimes Research Shows Access to Maternity Care Worsening for Millions of Women in the U.S.,” Healthy Moms Stronger Babies, August 1, 2023, https://www.marchofdimes.org/about/news/new-march-dimes-research-shows-access-to-maternity-care-worsening-millions-women-us.

[27] Amaya Diana, Robin Rudowitz, and Jennifer Tolbert, “A Look at Navigating the Health Care System: Medicaid Consumer Perspectives,” *KFF*, November 27, 2023, https://www.kff.org/medicaid/issue-brief/a-look-at-navigating-the-health-care-system-medicaid-consumer-perspectives/.

[28] Joint Economic Committee, “Addressing Rural Health Worker Shortages Will Improve Population Health and Create Job

Opportunities," January 30, 2024, https://www.jec.senate.gov/public/index.cfm/democrats/issue-briefs?ID=7C66C497-A4AE-440A-81E0-67F64D11D99D#:~:text=Health%20worker%20shortages%20in%20rural,unequal%20access%20to%20health%20care.

[29] Saraswathi Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States," *Reproductive Health* 16, no. 77 (2019), https://doi.org/10.1186/s12978-019-0729-2.

[30] Jennifer E. Moore and Indra Lusero, "A Blueprint for Improving Maternal and Infant Health Outcomes Under Medicaid: Recommendations from the 2023 Maternal Health Policy Equity Summit," Institute for Medicaid Innovation, 2024, https://medicaidinnovation.org/wp-content/uploads/2024/01/01.31.24.IMI_Blueprint_MHPES_FINAL.pdf.

[31] Maggie Clark and Elisabeth Wright Burak, "Opportunities to Support Maternal and Child Health Through Medicaid's New Postpartum Coverage Extension," Georgetown University McCourt School of Public Policy, Center for Children and Families, July 15, 2022, https://ccf.georgetown.edu/2022/07/15/opportunities-to-support-maternal-and-child-health-through-medicaids-new-postpartum-coverage-extension/.

[32] Ibid.

[33] Estemaye P. Agonafer et al., "Community-based Organizations' Perspectives on Improving Health and Social Service Integration," *BMC Public Health* 21, no. 452 (2021), *https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10449-w*.

[34] Rebecca West et al., "Addressing Racial/Ethnic Inequities in Maternal Health Through Community-based Social Support Services: A Mixed Methods Study," Maternal and Child Health Journal 26, no. 4 (2022): 708–18, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8724658/.

[35] Hannah Maniates, "Why Did They Do It That Way? Understanding Managed Care," National Association of Medicaid Directors, January 22, 2024, https://medicaiddirectors.org/resource/understanding-managed-care/.

[36] Clark and Burak, "Opportunities to Support."

[37] Anna Bernstein and Vina Smith-Ramakrishnan, "How the Federal Government Can Make Funding Accessible to Maternal Health Community-based Organizations," The Century Foundation, July 10, 2023, https://tcf.org/content/report/how-the-federal-government-can-make-funding-accessible-to-maternal-health-community-based-organizations/.

[38] Elizabeth Hinton and Amaya Diana, "Section 1115 Medicaid Waiver Watch: A Closer Look at Recent Approvals to Address Health-Related Social Needs (HRSN)," *KFF*, March 4, 2024, https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-waiver-watch-a-closer-look-at-recent-approvals-to-address-health-related-social-needs-hrsn/.

[39] Sara Rosenbaum, "The Road to Maternal Health Runs Through Medicaid Managed Care," The Commonwealth Fund, May 22, 2023, https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care.

[40] Ibid.

[41] Diana Crumley, Rob Houston, and Amanda Bank, "Incorporating Community-based Organizations in Medicaid Efforts to Address Health-related Social Needs: Key State Considerations," Center for Health Care Strategies, April 2023, https://www.chcs.org/media/Incorporating-Community-Based-Organizations-in-Medicaid-Efforts-to-Address-Health-Related-Social-Needs_050523-1.pdf.

[42] Priti Khanal et al., "Covering Doula Services Under Medicaid: Design and Implementation Considerations for Promoting Access and Health Equity," Center for Health Care Strategies, December 2022, https://www.chcs.org/media/Covering-Doula-Services-Under-Medicaid-Brief_120822.pdf.

[43] Amy Chen, "Current State of Doula Medicaid Implementation Efforts in November 2022," National Health Law Program, November 14, 2022, https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/.

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