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Commentary

Optimizing Medicaid Extended Postpartum Coverage to Drive Health Care System Change

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With recent changes in federal law, states now have an opportunity to improve maternal postpartum health and survival by extending postpartum coverage to 1 full year for all people with Medicaid financing during pregnancy. Every state has an opportunity to use additional financing to increase quality and equity in maternal health care and improve postpartum health for their Medicaid populations. This commentary discusses leverage points and potential areas for state, community, and clinical action.

Medicaid pays for more than 40% of U.S. births and covers more than 6 in 10 Black, Indigenous, and Hispanic infants (Artiga, Pham, Ranji, & Orgera, 2020; Martin, Hamilton, & Osterman, 2021). Current federal policy requires pregnancy-related Medicaid coverage to only 60 days postpartum for many birthing people (Medicaid and CHIP Payment and Access Commission, 2020; McMorrow, Dubay, Kenney, Johnston, & Caraveo, 2020). As of April 1, 2022, states have the option to extend postpartum coverage for a full year using a state plan amendment (SPA), and approximately one-half of states have taken steps toward doing so (Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services [CMS-CMCS], 2021; CMS, 2022a; Kaiser Family Foundation, 2022). Using a SPA would have advantages for most states in terms of federal funding, approval process, and administrative simplicity. For birthing people, a SPA would typically have advantages in terms of eligibility, covered benefits, and provider choice (Zephyrin, Johnson, Coleman, & Nuzum, 2021). Moreover, state-to-state variations in postpartum coverage will be decreased. In 2021, states' Medicaid income eligibility limits for parents beyond 60 days postpartum ranged from 17% of the federal poverty level in Texas to 160% federal poverty level in Connecticut. A recent federal report estimates that 720,000 birthing people would gain expanded Medicaid postpartum coverage each year if all states were to take action under the current option or a new mandate (Gordon et al., 2021).

Why extend Medicaid coverage to 1 year postpartum? Five key reasons (Zephyrin, 2021). Too many people experience pregnancy-related deaths after 60 days. Disparities in maternal outcomes persist and have worsened. Among those who survive, many birthing people experience serious complications and severe health conditions (morbidity) throughout the first year postpartum. Extending postpartum coverage to 1 year would parallel the mandatory year of coverage for infants with a Medicaid financed birth and ease administrative burdens for states, health plans, and families (Johnson, 2021a). And, last but not least, extended coverage offers financing and administrative levers to make health care system transformations that can improve maternal health and survival.

Overall, approximately 2 million pairs of mothers and babies across the nation could have more continuous and comprehensive health coverage under Medicaid in the year after the end of pregnancy (Johnson, 2021a; Johnson, Rosenbaum & Handley, 2020). This strategy would create opportunities for more services and supports during that year, to benefit mothers, infants, and their mutual, dyadic health and emotional well-being (Clark, 2022; Willis, Ellis, & Johnson, 2022).

Better Coverage to Drive Health Care System Change

Continuous health coverage is only one element of what needs to be done—albeit an important and fundamental one. As was learned from the Medicaid prenatal expansions of the 1980s and Affordable Care Act Medicaid expansions since 2010, greater coverage alone will not change outcomes for birthing people (Johnson, 2021b). To make expanded Medicaid coverage meaningful in terms of improving care and outcomes, it should be used to help finance and incentivize changes in health care delivery systems. To achieve Medicaid aims for decreasing costs,

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advancing equity, achieving population health, and improving patient experience, state agencies must go beyond extending coverage.

Support for Health Care System Transformation

Coverage before, during, and beyond pregnancy can anchor and finance health care system transformations (Bellerose, Collin & Daw; 2022; Daw, Eckert, Allen, & Underhill, 2021; Haley & Johnston, 2021; Johnston, McMorrow, Thomas, & Kenney, 2020). The need for transformation of primary care for women is well-documented. One big challenge is the lack of continuity when women transition from pregnancy to routine primary care (Zephyrin, Suennen, Viswanathan, Augenstein, & Bachrach, 2020; McCloskey, Bernstein, & The Bridging The Chasm Collaborative, 2021). Medicaid financing can be used to finance and incentivize access to more team-based and woman-centered care, maternity health care homes, enhanced care coordination, and other innovative care models. CMS has signaled support for states that seek to use value-based payment arrangements to incentivize the use of innovative maternal health care delivery models and improve health outcomes. State Medicaid agencies and their contracting managed care organizations can increase incentives for such high-value and high-quality primary care (Bigby, Anthony, Hsu, Fiorentini, & Rosenbach, 2020; Phillips, McCauley, & Koller, 2021).

Because states electing the extended postpartum coverage option must provide full benefits to all pregnant and postpartum individuals, many birthing people will have enriched benefits compared to other adults in Medicaid. In addition, states that have elected in the past to provide only services related to pregnancy or a condition that may complicate pregnancy must submit a SPA to remove this coverage limitation while the extended postpartum coverage option is in effect (CMS, 2021). For example, mental health, dental care, family planning, and services to address chronic conditions (e.g., diabetes or hypertension) would be covered during the postpartum extension period (CMS-CMCS, 2021; Gomez, Ranji, & Salfanicoff, 2022).

Integrated Clinical and Community Workforce

Using the full array of perinatal care providers—including doulas, midwives, nurses, physicians, and others—is an essential step to promote optimal maternal health. Efforts are needed to increase the racial and ethnic diversity of the perinatal workforce and, in turn, improve cultural competency and responsiveness. Although Medicaid is not the mechanism to finance health professional training, some Medicaid benefit and payment approaches can maximize the use of the full workforce available. This point is particularly true in the case of the community-based workforce composed of nonlicensed health providers such as doulas and community health workers (Zephyrin et al., 2021)

States aiming to support individuals in the prenatal, childbirth, and postpartum periods can use Medicaid to fund doula services. Doula support, which can be delivered in a home, clinic, or hospital setting, is associated with improved health outcomes, such as a decreased likelihood of postpartum depression and near-universal breastfeeding. Medicaid coverage of doula services may be through various benefit categories, including, but not limited to, preventive services, services of nonlicensed practitioners, clinic services, and freestanding birth center services (CMS, 2022a; CMS-CHCS, 2021).

The Medicaid preventive services benefit is also being used to finance community health worker services in a growing number of states. Notably, most states are using the community health worker services for the elderly and adults with chronic conditions or disabilities. More attention is needed to financing community health workers' role in improving maternal and infant health.

Improved Medicaid policies for freestanding birth centers are another area of opportunity. Federal law requires states to cover birth center services. For low-medical risk and uncomplicated births, birth centers are a safe option and have shown positive outcomes (Alliman & Phillippi, 2016). The national evaluation of Strong Start for Mothers and Newborns found that patients receiving prenatal care in birth centers had health outcomes better than those served in typical Medicaid arrangements (Courtot, Hill, Cross-Barnet, & Markell, 2020; Dubay et al., 2020). Although states list it as a covered benefit, many place limits on the groups of beneficiaries or services and personnel to be covered. Many birth centers face challenges in becoming contract providers with Medicaid managed care plans; birth center reimbursement rates are sometimes too low to cover the cost of care and out-of-pocket costs are untenable for many.

Quality, Safety, and Equity

Improving the quality, safety, and equity of care must be a priority in efforts to improve maternal health and survival (Zephyrin, Serrvai, Lewis, & Katon, 2021). Studies point to unequal treatment and lower quality in birth facilities serving high concentrations of Black mothers and infants (Harrell et al., 2022; Howell et al., 2018; Howell et al., 2020). Key strategies for change include perinatal quality collaboratives partnered with Maternal Mortality Review Committees, safety bundles, and measurement by race/ethnicity.

One new federal Medicaid initiative will identify "birthing friendly" hospitals (CMS, 2022a,b; CMS-CCSQ, 2021). A proposed rule for fiscal 2023 hospital payments includes a "Maternal Morbidity Structural Measure" under which a hospital must attest both to 1) participating in a Perinatal Quality Improvement Collaborative, and 2) implementing patient safety practices or bundles. The approach is designed to encourage hospitals to build health equity into their core functions. In addition, with publicly reported hospital designations, pregnant and birthing people can better assess the quality of birthing hospitals (CMS, 2022b).

Greater use of outcomes-driven maternity care is another opportunity (Health Care Transformation Task Force, 2020). CMS has identified a Maternity Core Set of 11 measures for voluntary reporting by state Medicaid and CHIP agencies. This includes 7 measures from CMS's Child Core Set and 4 measures from the Adult Core Set. The areas of maternal health include timeliness of prenatal care, postpartum care visits, contraceptive care, elective delivery, and low-risk cesarean section births. Additional measures in the Adult Core Set can help to assess use patterns in well-woman care and to monitor care for conditions that are associated with maternal morbidity and mortality (e.g., controlling high blood pressure and screening for depression and follow-up plan). CMS strongly encourages states to collect and stratify data for these quality measures and related metrics by race, ethnicity, geography, language, and other indicators to identify disparities in access to care and health outcomes and to develop targeted initiatives to improve maternal health equity (CMS-CMCS, 2021).

More could be done in using these metrics and data to point to disparities and then drive changes in the health care system.

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes" (CMS, 2022). Medicaid has a central role to play in advancing health equity.

Accelerating health care system transformation as discussed elsewhere in this article could advance maternal health equity. Without incentives for high-quality care and maximum financing for the full range of providers in the perinatal workforce, disparities will not be reduced, and equity will not be achieved (McCloskey, Bernstein, Goler-Blount, et al., 2021).

And, although Medicaid cannot eliminate discrimination and bias with coverage alone, it can apply equity-oriented measurement and quality improvement tools to drive and monitor change (Hardeman, Kheyfets, Mantha, et al., 2022). In addition to the maternity core set, measures of structural racism, discrimination, and other drivers of health should be developed and applied in Medicaid (Hardeman, Homan, Chantarat, Davis, & Brown, 2022; Megibow, Gwam, Godbolt, Powell, & Crear-Perry, 2021).

Conclusion

Medicaid can help to decrease the human and fiscal costs of maternal mortality and morbidity (O'Neil et al., 2021). We know that social and structural determinants, along with root causes such as racism, are drivers of excess and preventable maternal mortality and morbidity (Akinade et al., 2022; Crear-Perry et al., 2021). Although other maternal health proposals have not yet been adopted by Congress—such as provisions in the comprehensive Black Maternal Health Momnibus suite of bills and the Build Back Better Act maternal health provisions—states can leverage Medicaid coverage through direct financing and managed care arrangements to address the maternal health crisis this year and into the future (Clark & Johnson, 2022). Providing every birthing person and new baby in Medicaid 1 year of continuous coverage and using that coverage to finance equitable access to high-quality and appropriate care is essential to advancing health and racial equity and reducing disparities in maternal and infant deaths.

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