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Making the Case for Extending Medicaid Coverage Beyond 60 Days Postpartum: A Toolkit for State Advocates

— June 2020 —





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Executive Summary

The U.S. is battling a maternal health crisis. It is the only industrialized nation with a maternal mortality rate that is on the rise.[1, 2] The crisis is disproportionately impacting women of color, and the majority of pregnancy-related deaths are preventable.[3] Furthermore, for every woman who dies from pregnancy-related causes, another 70 suffer from severe maternal morbidity.[4]

Medicaid has a vital role to play in improving maternal health outcomes. Nearly half of all births are financed by Medicaid, and Medicaid-enrolled pregnant women are more likely than women enrolled in private coverage to have certain chronic conditions and have a preterm birth or low birthweight baby, putting them at higher risk for poor maternal outcomes.[5, 6] Today, women who are eligible for Medicaid on the basis of their pregnancy only receive Medicaid coverage for 60 days postpartum, resulting in many women in both Medicaid expansion and non-expansion states losing coverage and continuity of care very soon after giving birth despite the fact that pregnancy-related deaths occur beyond 60 days.[7]

Since Congress established the 60-day postpartum period for Medicaid coverage for pregnant women in 1986, much more is known about maternal deaths and the delivery of postpartum care. Based on the science, there is broad agreement among healthcare providers, health plans, and consumer advocacy groups that the Medicaid postpartum coverage period should be 12 months. The simple step of extending postpartum coverage in Medicaid provides an automatic 12-month coverage pathway during a very vulnerable time, providing coverage for women without other options, mitigating barriers to other coverage pathways, and preventing disruptions in care. In addition to improving maternal and child health outcomes, a Medicaid postpartum coverage extension will reduce certain Medicaid costs because postpartum complications and chronic conditions will not be left untreated only to worsen over time. Many of the women who lose Medicaid coverage postpartum re-enroll in Medicaid at a later time; timely interventions will avoid more expensive care later on.

Leveraging lessons learned from advocacy efforts across the country, this toolkit aims to help those working at the state level to extend Medicaid postpartum coverage beyond 60 days. Absent a change in federal law, an extension that seeks federal Medicaid funding requires a Medicaid Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS). This toolkit describes important cost and design considerations, including estimating offsetting savings; answers key questions about how states can seek federal matching funds through a Medicaid waiver; and provides advocacy tips gleaned from efforts in various states. Currently, three states have pending Section 1115 waivers at CMS for authority to receive federal matching funds for a postpartum coverage extension, and many other states are considering taking this step.

Given the alarming maternal health crisis across the U.S., states face an imperative to act. With nearly half of all U.S. births covered by Medicaid, states have an opportunity and responsibility to improve maternal health and address disparities in health outcomes. Extending the Medicaid postpartum coverage period from the current 60 days to a full 12 months is the simplest and most targeted way to address coverage loss and continuity of care for postpartum women in both expansion and non-expansion states. While a Medicaid postpartum coverage extension will not single-handedly solve the maternal health crisis, it is foundational to most other efforts because it provides vital coverage and continuity of care to postpartum women during an extremely vulnerable time.

Introduction

In the context of the nation's growing maternal health crisis, many have sought policy and delivery system changes that will improve outcomes for women and their babies. One key opportunity is to extend the postpartum coverage period in Medicaid from the current 60 days to a full year in line with clinical evidence. Extending the postpartum coverage period at the state level typically requires state legislation and budget authority. In addition, until pending federal legislation is enacted, states will need to propose a Section 1115 waiver in order to receive federal Medicaid matching funds for the extended postpartum period.

Leveraging lessons learned from advocacy efforts across the country, this toolkit aims to help those working at the state level to extend postpartum coverage in Medicaid. It reviews the coverage and care barriers for women associated with the current 60-day postpartum period, outlines key reasons for extending Medicaid's postpartum coverage period, and describes important cost and design considerations. Some arguments and design options will be more applicable to certain states than others depending on the state's maternal health coverage landscape and particularly whether the state has expanded Medicaid. In all cases, collaboration among state Medicaid agencies, advocates, physicians and other health care providers, Medicaid beneficiaries, state legislators, and others will help strengthen the effort to improve maternal health outcomes.

The Imperative for Action: The United States is Experiencing a Maternal Health Crisis

- **The U.S. is the only developed country where the maternal mortality rate has been steadily rising.**[8, 9] The U.S. maternal mortality rate jumped from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016.[10] In 2018, the maternal mortality rate was 17.4 deaths per 100,000 live births; the Centers for Disease Control and Prevention (CDC) adopted a new method in 2018 for coding maternal deaths to mitigate the effect of reporting errors and collect more cause-of-death, the 2018 rate is not comparable to earlier rates.[11]
    - Black women and American Indian/Alaska Native women are 3.3 and 2.5 times more likely, respectively, to die from pregnancy-related causes than non-Hispanic white women.[12]

Figure 1: Medical Conditions Defined by the CDC that Indicate Severe Maternal Morbidity[18]

1. Acute myocardial infarction (heart attack)
2. Aneurysm
3. Acute renal failure (kidney failure)
4. Adult respiratory distress syndrome
5. Amniotic fluid embolism
6. Cardiac arrest/ventricular fibrillation
7. Conversion of cardiac rhythm
8. Disseminated intravascular coagulation
9. Eclampsia
10. Heart failure/arrest during surgery or procedure
11. Puerperal cerebrovascular disorders
12. Pulmonary edema / Acute heart failure
13. Severe anesthesia complications
14. Sepsis
15. Shock
16. Sickle cell disease with crisis
17. Air and thrombotic embolism
18. Blood products transfusion
19. Hysterectomy
20. Temporary tracheostomy
21. Ventilation

- A majority of the pregnancy-related deaths are preventable and often stem from lack of coverage and access to care in the critical time following birth or from changes in coverage that can disrupt continuity of care. Approximately 60 percent of pregnancy-related deaths reviewed by state maternal mortality review committees from 2011 to 2015 were preventable, regardless of race.[13]

- **For every woman who dies from pregnancy-related causes, significantly more suffer from severe maternal morbidity (see Figure 1).**[14]

  - In 2014, more than 50,000 women in the U.S. experienced severe maternal morbidity that resulted in significant short- or long-term consequences to their health.[15]

  - Severe maternal morbidity disproportionately impacts women of color; for example, black, college-educated mothers who gave birth in New York City from 2008 to 2012 were more likely to suffer severe complications from pregnancy or childbirth than white women who never graduated from high school.[16]

  - Women in New York City with an underlying chronic condition, such as hypertension, diabetes, or heart disease, were three times more likely to have severe maternal morbidity from 2008 to 2012 than women with no chronic conditions.[17]

Medicaid is Key to Improving Maternal Health and Addressing Disparities in Outcomes

- **Nearly half of all U.S. births are financed by Medicaid, and in some states the rate is much higher.**[19, 20]
  - The maternal health crisis is not limited to Medicaid-enrolled women, but Medicaid-enrolled pregnant women are more likely than women enrolled in private coverage to have had a preterm birth, to have had a low birthweight baby, and to experience certain chronic conditions, putting them at higher risk for poor maternal outcomes.[21]
  - More than half of women from 2005 to 2014 with at least one chronic condition at delivery were covered by Medicaid.[22]
  - Compared to women with private insurance at delivery, those covered by Medicaid are more likely to be black.[23]
- **Pregnancy-related deaths occur well beyond the 60-day postpartum period.**
  - Nationwide, approximately 29 percent of pregnancy-related deaths—not including those caused by accidents, homicides, and suicides—occur 43 to 365 days postpartum.[24, 25]
  - Some states' analyses of pregnancy-related deaths, which include behavioral health-related causes, find that 50 percent or more of deaths occur beyond the 60-day period. For example, in Illinois, 51 percent of all maternal deaths occurred more than 60 days postpartum between 2014 and 2016.[26] In Texas, between 2012 and 2015, 56 percent of all maternal deaths occurred more than 60 days postpartum.[27] And in West Virginia, the rate of maternal deaths occurring more than 60 days postpartum was 62 percent from 2007 to 2013.[28]
- **The 60-day postpartum coverage period in Medicaid results in many women losing coverage very soon after giving birth.**
  - Between 2015 and 2017, 17 percent of women became uninsured between delivery and three to six months postpartum.[29, 30]
  - Nearly 1 in 4 women in non-expansion states and more than 1 in 10 women in expansion states lost insurance coverage between delivery and postpartum.[31]
- **There is broad agreement that women with a Medicaid-covered birth should receive 12 months of postpartum coverage (see Appendix 1).**[32, 33, 34]
  - Since Congress established the 60-day postpartum period for Medicaid coverage for pregnant women in 1986, much more is known about maternal deaths and the delivery of postpartum care.
  - Notably, the CDC defines the postpartum period to be 12 months after delivery.[35]

- State maternal mortality review committees, as well as the American Medical Association, the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians, the Society for Maternal-Fetal Medicine, numerous health plans, and consumer advocacy groups, recommend that policymakers extend Medicaid coverage from the current standard of 60 days to 12 months postpartum.[36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47]

- **State legislation is currently being debated or has been passed in a diverse array of states across the country, and multiple federal legislative proposals seek to require or give states authority to continue Medicaid coverage beyond 60 days postpartum.**[48]

Barriers to Postpartum Coverage and Care: Special Considerations for Expansion States

Although most women in expansion states who lose Medicaid eligibility following the postpartum period are likely eligible for either continued coverage under the Medicaid expansion or subsidized Marketplace coverage at 60 days postpartum, barriers lead to gaps in coverage and discontinuity in care continues to persist (see Figure 2).

- **Women with incomes at or below 138 percent of the FPL in an expansion state should generally be eligible for coverage under the expansion, but states must redetermine eligibility, which may require action by the mother during a particularly busy and vulnerable time and risks creating an unsafe gap in coverage.**

  - 30 percent of uninsured new mothers in 2017 with incomes below 138 percent of the FPL were in Medicaid expansion states, which indicates that many women in expansion states are not experiencing smooth transitions from pregnancy-related Medicaid coverage to parental Medicaid coverage.[49]

- **Women who have incomes above 138 percent of the FPL in an expansion state are likely eligible for subsidized Marketplace coverage; however, many experience gaps in coverage because they have to manage the Marketplace enrollment process and in certain circumstances pay premiums that they may not be able to afford.**

  - Research has shown that even small amounts of cost-sharing can dissuade or prevent low-income people from accessing coverage and care.[50, 51] The RAND health insurance experiment demonstrated that premiums and cost-sharing reduced utilization of both effective and less effective services equally, and that premiums and cost-sharing were associated with worse health outcomes among the poorest and sickest patients.[52] A multi-state study found that among low-income enrollees, premiums as low as 1 percent of income could reduce enrollment in health insurance by 15 percent.[53] In Oregon, when premiums and co-payments were introduced in 2003 for non-disabled adults with incomes below poverty, enrollment dropped by 77 percent.[54]

  - Women are more likely than men to report forgoing needed health care due to cost (26 percent of women vs. 19 percent of men).[55] After out-of-pocket costs for preventive women's health services were eliminated under the Affordable Care Act (ACA), women were more likely to have a long-acting reversible contraceptive inserted. Furthermore, women with low to moderate out-of-pocket costs for preventive care office visits prior to the ACA were more likely to use these services after cost-sharing was eliminated compared to women with persistent low to moderate out-of-pocket costs.[56]

- **Even if women successfully enroll into Marketplace coverage, they may have to change plans and providers and may lose access to critical services such as dental care, certain behavioral health benefits, and care coordination services.**

  - For example, women transitioning from an Illinois Medicaid managed care plan to a qualified health plan on the Marketplace lose access to care coordination services or referrals to assist with social determinants of health despite these services being important to help prevent maternal mortality.[57]

Barriers to Postpartum Coverage and Care: Special Considerations for Non-Expansion States

There are two main postpartum coverage barriers in non-expansion states.

Figure 2. Example of Postpartum Coverage Barriers in an Expansion State (Illinois)[58, 59, 60, 61]

MIA, Age 26

Lives in Chicago, Illinois
Monthly Income for Family of 3: $2,715 (150% FPL)
Medicaid-enrolled, just gave birth

- **Burdensome Transitions:** Mia will lose Medicaid coverage in 60 days; she can enroll in Marketplace coverage—but she must apply for a Marketplace Special Enrollment Period while recovering from childbirth and caring for a newborn.
- **Cost-Sharing:** To purchase a Silver plan on the Marketplace, Mia must pay a monthly premium of $110, along with other out-of-pocket costs.
- **Disruptions in Care:** If Mia successfully enrolls in the Marketplace, her provider network will likely vary from her current providers.

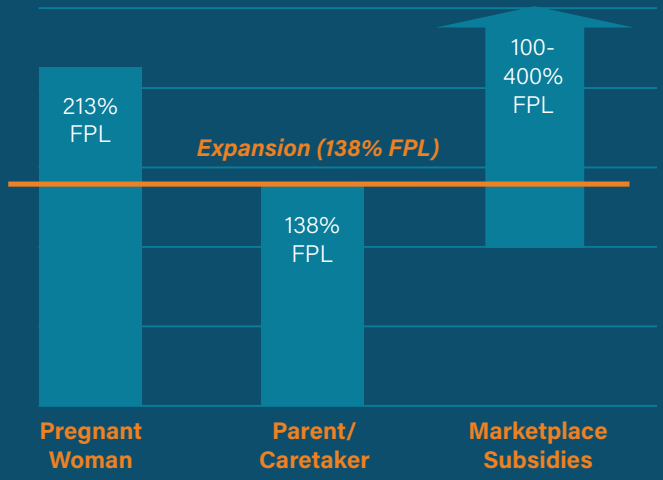
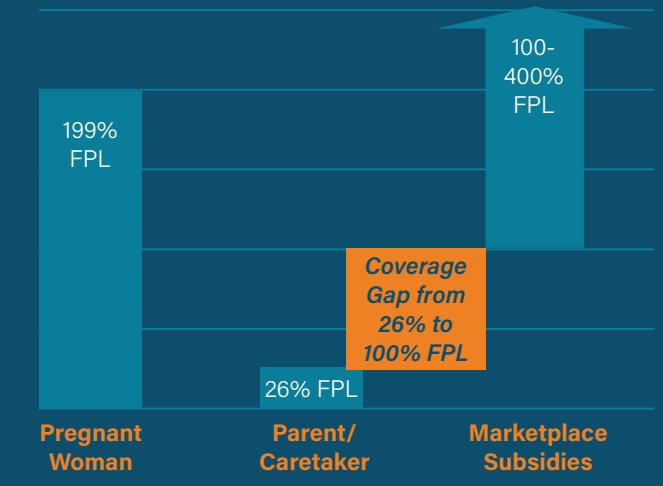


Figure 3. Example of Postpartum Coverage Barriers in a Non-Expansion State (Mississippi)[63, 64, 65, 66]

CARLA, Age 26

Lives in Jackson, Mississippi
Monthly Income for Family of 3: $724 (40% FPL)
Medicaid-enrolled, just gave birth

- **Coverage Gap:** When Medicaid coverage ends in 60 days, Carla will not be eligible for Medicaid or Marketplace tax credits.
- **Affordability:** Without Marketplace tax credits, Carla could purchase a Silver plan on the Marketplace for $373 per month —or 52% of her household income.



- **Women with a Medicaid-covered birth in non-expansion states with income below 100 percent of the FPL face a steep coverage gap at the end of the 60-day Medicaid postpartum period.** Unless a woman qualifies for parent/caretaker relative Medicaid eligibility or Aged, Blind and Disabled eligibility, a new mother will lose her Medicaid eligibility 60 days after giving birth. The median parent/caretaker eligibility threshold across states that have not adopted the Medicaid expansion is 40 percent of the FPL, or $8,688 per year for a family of three in 2020.[62] Because Marketplace subsidies are only available to individuals between 100 percent and 400 percent of the FPL (between $21,720 and $86,880 per year for a family of three in 2020), a new mother whose incomes falls above her state's parent/caretaker relative threshold but below 100 percent of the FPL fall into the coverage gap (see Figure 3).
- **Women with income at or above 100 percent of the FPL face the same postpartum coverage barriers that women with comparable incomes in expansion states face at the end of the 60-day Medicaid postpartum period.** As Figure 3 illustrates, women have to navigate the Marketplace special enrollment process, pay a new premium, and likely change provider networks during a vulnerable time, resulting in gaps in coverage and care.

Key Reasons States Should Pursue Extending Medicaid Postpartum Coverage Beyond 60 Days Postpartum

- **Ensures and Simplifies Postpartum Coverage.** As Figure 4 and Figure 5 illustrate the simple step of extending postpartum coverage can solve the coverage issues women face in both expansion and non-expansion states. Extending postpartum coverage in Medicaid provides an automatic 12-month coverage pathway during a very vulnerable time, providing coverage for women without other options, mitigating barriers to other coverage pathways, and preventing disruptions in care.
  - Extending Medicaid postpartum coverage is the surest, simplest, and most targeted way to address loss of insurance or gaps in coverage among postpartum women in both expansion and non-expansion states.
  - No new eligibility category, application, or redetermination is required, and cost-related barriers to coverage and care are eliminated. The 12-month postpartum period would allow a new mother to stay on coverage automatically (just as she does now for 60 days). Neither the new mother nor the state Medicaid agency would have to take any action for coverage and care to continue uninterrupted.
- **Improves Continuity of Care and Care Coordination.** By extending the Medicaid postpartum coverage period to 12 months, new mothers do not have to switch from providers they trust that understand their

Figure 4: Medicaid Postpartum Coverage Extension in a Non-Expansion State[67, 68]

CARLA
Lives in Jackson, Mississippi
Monthly Income for Family of 3: $724 (40% FPL)

Pregnant Women Eligibility Level: 199% FPL
Parent/Caretaker Eligibility Level: 26% FPL

Current Health Coverage Pathways:

January 2018: Childless adult; ineligible for Medicaid and Marketplace subsidies

March 2018: Becomes pregnant, enrolls in Medicaid

November 2018: Gives birth

January 2019: Loses Medicaid eligibility 60 days postpartum; ineligible for Marketplace subsidies

Medicaid Postpartum Coverage Extension:

January 2018: Childless adult; ineligible for Medicaid and Marketplace subsidies

March 2018: Becomes pregnant, enrolls in Medicaid

November 2018: Gives birth

November 2019: Loses Medicaid eligibility 12 months postpartum; ineligible for Marketplace subsidies

- 12 months continuous Medicaid coverage for new mothers
- Continuous access to care without cost-sharing
- No Medicaid redeterminations or Special Enrollment Period for the Marketplace that can cause gaps in coverage and care
- Continuity of care with physicians and other providers
- Aligned Medicaid redetermination for mother and baby

health history and may be treating their chronic condition(s) during a vulnerable time. Providers can also better coordinate care over a 12-month period versus 60 days.

- Lapses in insurance coverage and related systems of care issues have been credited as one of many contributing factors to the nation's growing maternal mortality crisis.[71]
- Poor continuity of care and/or a lack of care coordination were identified as factors that contributed to death in 93 percent of preventable pregnancy-related deaths in Illinois during the late postpartum period (61-364 days postpartum).[72]

- **Aligns Continuous Coverage for both Mother and Baby for 12 Months Postpartum Regardless of Changes in Family Income.** Under federal law, babies born to mothers with Medicaid coverage at the time of birth receive automatic and continuous Medicaid eligibility for their first year of life.[73] Extending the Medicaid postpartum coverage period to 12 months ensures continuous coverage for both mother and baby, improving care coordination for the mother-baby dyad and creating administrative efficiencies for the states at redetermination.
- **Improves Maternal Health Outcomes.** The point of the postpartum coverage extension policy, of course, is to reverse the trends in maternal health and improve maternal health outcomes. It is well documented that access to health insurance increases access to and use of health care services and improves health outcomes.[74, 75, 76, 77, 78, 79, 80, 81, 82] For example, Medicaid expansion is associated with 7.01 fewer maternal deaths per 100,000 women relative to

Figure 5: Medicaid Postpartum Coverage Extension in an Expansion State[69, 70]

MIA
Lives in Chicago, Illinois
Monthly Income for Family of 3: $2,715 (150% FPL)

Pregnant Women Eligibility Level: 213% FPL
Parent/Caretaker Eligibility Level: 138% FPL

Current Health Coverage Pathways:

January 2018: Eligible for Marketplace subsidies; ineligible for Medicaid

March 2018: Becomes pregnant, enrolls in Medicaid

November 2018: Gives birth

January 2019: Loses Medicaid eligibility 60 days postpartum; eligible for Marketplace subsidies – however, must enroll through Special Enrollment Period within 60 days of giving birth, is subject to premiums and other cost-sharing, and likely must change provider networks

Medicaid Postpartum Coverage Extension:

January 2018: Eligible for Marketplace subsidies; ineligible for Medicaid

March 2018: Becomes pregnant, enrolls in Medicaid

November 2018: Gives birth

November 2019: Loses Medicaid eligibility 12 months postpartum; eligible for Marketplace subsidies

- 12 months continuous Medicaid coverage for new mothers
- Continuous access to care without cost-sharing
- No Medicaid redeterminations or Special Enrollment Period for the Marketplace that can cause gaps in coverage and care
- Continuity of care with physicians and other providers
- Aligned Medicaid redetermination for mother and baby

non-expansion.[83] Improving access to Medicaid has also been associated with increased use of postpartum outpatient care, particularly for women with severe maternal morbidity.[84] Extending the Medicaid postpartum coverage period to 12 months would increase access to and use of health care services and improve maternal health outcomes.

- **Improves Child Health Outcomes.** Continuing Medicaid coverage for postpartum mothers will also improve health outcomes for children because children's healthy development is dependent on healthy parents.
  - Maternal depression negatively impacts young children's cognitive and social-emotional development, and future educational and employment opportunities.[85, 86, 87]
  - Extending health coverage to adults results in increased health coverage for children. Most uninsured children are eligible but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP); their enrollment increases as their parents get covered.[88]
  - Parental enrollment in Medicaid is associated with a 29-percentage point higher probability that a child will receive an annual well-child visit.[89]
- **Saves Billions of Dollars in Annual Severe Maternal Morbidity Costs.** The average total per-patient costs in 2013 for Medicaid-enrolled pregnant women with severe maternal morbidity was $10,134 compared to $6,894 for women without severe maternal morbidity.[90]
  - In 2011, Medi-Cal paid more than $210 million to treat maternal hemorrhage and hypertensive disorders.[91, 92]
  - Perinatal mood and anxiety disorders (PMADs), which are the number one complication of pregnancy and childbirth, affect at least 1 in 7 women, yet only half of perinatal women with depressive symptoms receive any treatment. Examining PMADs alone, the national economic costs of not treating these disorders amounted to $14.2 billion in 2017.[93]
- **Reduces Medicaid Costs.** Women who are eligible for Medicaid on the basis of their pregnancy are likely to become enrolled in Medicaid again. However, without the benefit of extended postpartum coverage, or by churning between sources of coverage, many re-enrolled women will be sicker, and therefore may have more costly health care conditions upon re-enrollment.
  - Medicaid and other public insurance programs bear a significant portion of the cost of untreated postpartum complications. New Jersey found that 53 percent of women who were eligible for Medicaid on the basis of their pregnancy and lose coverage 60 days postpartum re-enrolled in the program within two years.[94]
  - Reducing movement in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, reduces the likelihood of inpatient hospital admissions and emergency room visits, and prevents disruption for enrollees, health plans, and providers.[95]
- **Advances Accountable Care Models.** Gaps in coverage and changes in the source of coverage make implementing value-based payment models for maternity care very challenging because no payer maintains responsibility for the mother-baby dyad's care during pregnancy and the postpartum period. By extending the Medicaid postpartum coverage period, states can better incentivize health systems and health plans to provide high-quality and efficient care and be accountable for health outcomes, adding to the benefits that can be accomplished through the extension of the postpartum coverage period.
  - The Center for Medicare and Medicaid Innovation (CMMI) has taken note of the importance of continuity of coverage for advanced payment models. In their Notice of Funding Opportunity for the Maternal Opioid Misuse (MOM) Model, priority was given to applicants that proposed "sustainable postpartum coverage plans that address[ed] the period beyond 60 days after birth."[96]

Cost and Design Considerations

Below are common cost and design questions that arise as states consider extending their Medicaid postpartum coverage period.

- **How should a state estimate the number of women that would be covered by a postpartum coverage extension each year?** Different states will have different ways to project the number of women who would be covered depending on their data capacity. Most states will have at least an overall number of women enrolled in Medicaid who gave birth over a year. Therefore, a relatively simple way to estimate the number of women

that would be covered by a postpartum coverage extension that provides full Medicaid coverage to all postpartum women is to:

- Use historical Medicaid enrollment data to determine how many Medicaid births occurred in one year;
- Subtract the number of births where the mother was covered by an alternative eligibility category that offers continuing coverage instead of on the basis of her pregnancy (e.g., Medicaid expansion, parent/caretaker relative, Aged, Blind, Disabled); and
- Subtract the number of births covered by Emergency Medicaid since these women would not be eligible for the postpartum coverage extension due to their immigration status.[97] (see Figure 6 for discussion of options relating to women's immigration status)

This could provide states with an upper bound estimate as it assumes that all mothers who historically did not maintain Medicaid eligibility after 60 days postpartum would receive the postpartum extension coverage. Downward adjustments should then be made as some of these women will likely not continue Medicaid eligibility for reasons such as moving out of state, obtaining subsidized Marketplace coverage, or receiving employer-sponsored coverage. In states where more limited eligibility is under consideration, such as only for women with a substance use disorder (SUD), states would need to factor in other assumptions based on available state data.

Figure 6: State Options for Covering Otherwise Ineligible Immigrant Women

- **In general, Medicaid coverage is available to citizens and certain "qualified" noncitizens, many of whom are subject to a five-year waiting period—meaning they must have had their qualified status for at least five years before they can enroll in coverage.**[133] **States have the option to cover noncitizen pregnant women (and children) who are "lawfully residing" in the U.S., regardless of whether they would otherwise be subject to the five-year waiting period.**[134, 135] This option is often referred to as the "ICHIA option" because it incorporates earlier legislation called the Immigrant Children's Health Improvement Act.[136] As of January 2019, 25 states have adopted this option.[137]
  - If states currently cover lawfully residing noncitizens through the ICHIA option, an extension of the Medicaid postpartum coverage period would apply to that population of immigrant women because they already receive postpartum coverage for 60 days.
- **For pregnant women who are ineligible for coverage due to their immigration status (e.g., lawful permanent residents subject to the five-year waiting period or individuals who are undocumented), states may use CHIP funds to cover prenatal care and delivery, but have less flexibility for covering comprehensive postpartum care.** Under this policy option, often referred to as the "unborn child" option, states may cover only prenatal, labor and delivery, and postpartum care services if they are reimbursed via a bundled labor and delivery fee payment (e.g., the labor and delivery fee may include outpatient office visits for a predetermined period of time or contraceptive care provided to the mother immediately following delivery).[138] As of January 2019, 16 states have adopted this option.[139]
  - If states currently cover undocumented women through the unborn child option, a postpartum coverage extension would not apply to them because they do not currently receive any postpartum coverage.
- **Some states have also used CHIP Health Services Initiative (HSI) funding, which allows states to use a portion of their CHIP allotments to pay for public health activities/services,**[140, 141] **to cover postpartum services provided to immigrant women otherwise ineligible for Medicaid or CHIP.** For example, Illinois, which has adopted the ICHIA option for children but not for pregnant women, currently uses HSI funding to cover 60 days of postpartum services provided to the mothers of newborns deemed eligible for Medicaid (e.g., mothers who are qualified immigrants still in their 5-year waiting period or undocumented immigrants). Illinois is proposing to extend postpartum coverage for qualified immigrants in the five-year waiting period to 12 months (as part of its 1115 waiver application) also through HSI funding.[142]

- **How should a state estimate the cost of a postpartum coverage extension, including identifying offsetting savings?** To determine the baseline annual cost for a postpartum coverage extension, states can multiply the estimated annual number of women covered by the extension by the estimated per-person cost. For the postpartum period, the most relevant measure of cost is the average monthly expenditures for the parent/caretaker eligibility group (sometimes referred to as the Temporary Assistance for Needy Families (TANF) group) or the new adult eligibility group, depending on whether a state is an expansion or non-expansion state, trended forward. Then states can multiply that by the total number of months the postpartum extension covers not including the current 60-day postpartum period. For example, if a state is doing a 12-month extension, a state can multiply its estimate by 10 months. A state should not use average monthly expenditures for its pregnant women eligibility group when calculating its cost estimate because those expenditures would overstate the postpartum coverage costs.

  The effective date will also affect the cost estimate for the first year. States could consider making the effective day half way through the first state fiscal year to reduce costs as states grapple with tight state budgets during and after the COVID-19 pandemic.

  To estimate offsetting savings, there are a number of factors states should consider:

  - ***Averted Severe Maternal Morbidity and Properly Managed Chronic Conditions.*** While there is currently not definitive data on the long-term cost savings from improved maternal health outcomes through a postpartum coverage extension, it is undeniable that the extension of postpartum coverage would result in cost savings from averted severe maternal morbidity and averted/properly managed chronic conditions. The medical conditions that can arise during the postpartum period – as identified by the CDC to be indicators of severe maternal morbidity (see Figure 1) – can often be averted or mitigated if coverage and care remain in place.[98] Consider the following:

    - From 2008 to 2012, the total excess costs related to severe maternal morbidity in New York City exceeded $85 million, an extra $17 million each year.[99] As discussed above, the national economic costs of not treating PMADs amounted to $14.2 billion in 2017, and Medi-Cal spent more than $210 million in 2011 treating hypertensive disorders.[100, 101]

    - Women in Florida from 2005 to 2015 with severe maternal morbidity had nearly a twofold higher risk of a postpartum SUD within 12 months postpartum.[102] Research has shown that early identification and treatment of postpartum depression can prevent or reverse negative effects of maternal depression for both the mother and child.[103, 104]

    - A CDC study looking at all nonelderly adults found that people with chronic conditions, including hypertension, diabetes, and asthma, who did not have health insurance from 2006 to 2010 were five to six times more likely to forgo needed care compared to individuals with continuous health insurance and the same chronic conditions.[105] Another study found that having health insurance was associated with improved management and control of diabetes, hypercholesterolemia, and hypertension among adults from 1999 to 2012.[106]

  - ***Screening and Certain Treatment for Postpartum Depression.*** Because CMS allows states to cover a mother's screening and certain treatment for postpartum depression through a child's Medicaid. An offset relating to these costs should be considered.[107]

  - ***Averted Administrative Costs from Streamlining Redetermination for Mother and Baby.*** By providing 12 months of continuous coverage to women postpartum, states can create administrative efficiencies and therefore cost savings by conducting a mother's redetermination at the same time as her infant's instead of doing two separate redeterminations at different times. Savings from these efficiencies can also offset the cost of extending postpartum coverage.

  - ***Averted Family Planning Program Costs and Averted Unplanned Pregnancies.*** First, because the Medicaid postpartum coverage extension would provide family planning benefits, a state can offset the costs that the state would have spent on family planning under other authorities. Second, because family planning benefits avert unplanned pregnancies,

states can offset the costs states would have otherwise spent on those future unplanned pregnancies. States can estimate averted births and related maternal and infant care as a result of the postpartum coverage extension by utilizing the methodology used for family planning waiver applications.[108, 109] For example, Alabama's family planning waiver extension application submitted in 2014 compared the birth rate of women in their family planning waiver program to the birth rate of the general population in the state before the start of the program and estimated 10,703 averted births and $74.9 million in associated Medicaid cost savings from the program over one demonstration year. Cost savings were based on the estimated cost of maternity care, including the infant's first year of life.[110] While Texas's 12-month postpartum coverage extension bill ultimately did not pass, its fiscal note estimated $198.6 million in savings associated with averted births by fiscal year 2024.[111]

- **How long should the postpartum coverage extension be?** Given the broad consensus among experts, states should strive to extend Medicaid coverage to 12 months postpartum. However, 12 months may be difficult in some states due to budget constraints. For example, New Jersey passed a six-month extension after first considering a 12-month extension.[112]
- **What benefits would a postpartum coverage extension include?** States should offer full benefit coverage for pregnant and postpartum women in order to properly treat chronic conditions, address the whole person, and avoid the administrative burden of limiting benefits. For example, New Jersey and Illinois are proposing to provide full Medicaid benefits in its postpartum coverage extension. However, some states, such as Missouri, are considering more narrow benefits for cost reasons. Services under Missouri's postpartum coverage extension would be limited to SUD treatment, mental health services related to the SUD treatment, and transportation to and from the SUD treatment.[113]
- **What population would a postpartum coverage extension apply to?** To be most effective, the extension of the Medicaid postpartum coverage period should apply to all postpartum women enrolled in the program, regardless of eligibility group. Most states that have moved forward are doing so. For example, Illinois is proposing to extend the Medicaid postpartum coverage period to 12 months for all women qualifying for Medicaid on the basis of their pregnancy. This approach ensures that all women have the same assurance of coverage after they give birth. As a way to limit costs and prioritize coverage in a state that is resistant to expansions of public coverage, Missouri's proposal would only extend the postpartum coverage period to women with a SUD diagnosis.[114] While Missouri's annual state cost estimate for its postpartum coverage extension went from $42.8 million for full Medicaid benefits for all postpartum women to $1.9 million in state general funds for targeted SUD benefits for women with a SUD diagnosis, Missouri estimates that out of an annual 28,762 Medicaid births, only 684 women will be eligible for the postpartum coverage extension each year.[115, 116, 117]
- **Can a postpartum coverage extension apply to pregnant women covered under CHIP?** States that provide CHIP coverage to low-income pregnant women with incomes too high to be eligible for Medicaid coverage can choose to include this population in a postpartum coverage extension. Six states currently provide CHIP coverage to low-income pregnant women.[118] For example, New Jersey is proposing to cover its Medicaid and CHIP pregnant women populations under its six-month postpartum coverage extension.[119] However, states that use CHIP funds to cover prenatal services and labor and delivery only, often referred to as the "unborn child" option, cannot extend the postpartum coverage extension to this population because they currently do not receive any postpartum coverage.

Effectuating the Medicaid Postpartum Coverage Extension

Below are answers to key questions about states seeking federal matching funds to adopt a Medicaid postpartum coverage extension. If states are funding their postpartum coverage extensions with state-only dollars, they do not need federal authority.

- **Does a state need federal approval before implementing a Medicaid postpartum coverage extension?** Yes. In order to receive federal Medicaid matching funds for a Medicaid postpartum coverage extension, a state will need to propose or amend a Section 1115 waiver. Illinois, Missouri, and New Jersey have sought Section 1115 waiver approval for a Medicaid postpartum coverage extension, and other states can use their waiver applications as a prototype.[120, 121, 122] To date CMS has not yet acted on these requests, and the COVID-19 pandemic will likely delay CMS action on these waiver applications.[123]

- **Does my state need to pass legislation to submit a Section 1115 waiver?** Some states require legislative authority before a governor can submit a Section 1115 waiver application while other states do not require state legislature approval. Regardless, a state will need to have state funding authorized in its Medicaid budget to cover the state share of the postpartum coverage extension. State funding does not need to be secured before a state seeks a waiver, although CMS may ask about the expected sources of state funding.

- **What federal match can a state expect to receive for extending Medicaid postpartum coverage?** If a state receives federal approval from CMS to implement a postpartum coverage extension, the state would receive federal matching funds for the postpartum coverage extension at the state's regular Federal Medical Assistance Percentage (FMAP), and the state would be responsible for the state share.[124]

- **Can a state submit a State Plan Amendment (SPA) instead of a Section 1115 waiver for a Medicaid postpartum coverage extension?** No. At present, there is not an option to receive federal approval for a postpartum coverage extension in Medicaid or CHIP through a SPA. Federal legislation is pending that would create that option.

- **What does it mean that an 1115 waiver needs to be budget neutral, and what are the different ways states can approach budget neutrality in their waiver applications?** Section 1115 waivers are required to be budget neutral, meaning that the changes proposed in the 1115 waiver cannot cost more to the federal government than the state's Medicaid program would have cost absent the waiver. The state can meet the requirements in a few different ways. The state can offset the cost if it has accrued budget neutrality savings through a previously approved waiver or if the new waiver request includes features that will reduce federal Medicaid spending, offsetting the new cost.[125, 126] Alternatively, CMS could consider the new expenditures as "hypotheticals" or "passthroughs" on the basis the waiver, essentially substitutes for other Medicaid spending a state could have done without the waiver. Under this approach, which is the most advantageous way for a state to proceed, these calculations are not required.

  Since CMS has not acted on any of the postpartum extension waivers to date, it is not clear how they will approach budget neutrality. States that have already submitted waiver requests to CMS have approached budget neutrality in two ways. Illinois and Missouri treated the new expenditures for the postpartum coverage extension as "passthrough" expenditures under the waiver, citing that approach is in accordance with recent CMS guidance.[127, 128, 129, 130] New Jersey, however, is not treating the expenditures as passthrough and has submitted its data to CMS showing overall its waiver (considering other components) is budget neutral to the federal government.[131, 132]

Advocacy Tips

Finding the right framing and identifying a catalyst to build support for addressing the maternal health crisis will be critical to garnering support to extend Medicaid postpartum coverage at the state level. Circumstances will of course be different in every state. Below are tips gleaned from efforts in various states.

- **Identify a catalyst for change to support the Medicaid postpartum coverage extension.** A catalyst could be an event or report that people then rally around or a leader who can help galvanize support. For example, Illinois's Maternal Morbidity and Mortality Report in October 2018, which found that 93 women died within one year of pregnancy in 2015 and recommended extending the Medicaid postpartum coverage period to 12 months, garnered significant press coverage and helped create public support.[143] New Jersey's First Lady Tammy Murphy created a statewide awareness campaign designed to reduce infant and maternal mortality and morbidity and ensure equitable maternal and infant care among women and children of all races and ethnicities. The campaign has supported the postpartum coverage extension.[144]
- **Frame the policy to fit the context of a state's coverage landscape, particularly whether the state has expanded Medicaid.** In expansion states, the postpartum coverage extension can be framed as an essential step to ensuring ongoing postpartum coverage for the pregnant women Medicaid now covers. In some non-expansion states, depending on a state's particular circumstances, the framing could focus on "continuing coverage" for women to address the maternal health crisis versus "expanding coverage". Advocates can focus the arguments on how this policy is a targeted and simple approach to addressing the maternal health crisis.
- **Secure bipartisan sponsorship and key committee leadership support in the state legislature.** Identifying bipartisan sponsors and garnering committee support for a postpartum coverage extension bill will improve the chances of the bill successfully passing.
- **Frame the postpartum coverage extension as a first in order approach for addressing the maternal health crisis.** Extending the Medicaid postpartum coverage period is foundational to other approaches.
- **Advocate for more research on the long-term cost savings from a postpartum coverage extension.** It is imperative to accelerate the research agenda on improved long-term health outcomes from continuous postpartum coverage and the subsequent cost savings to support the postpartum coverage extension policy efforts.

Conclusion

Given the maternal health crisis across the U.S., states face an imperative to act. With nearly half of all U.S. births covered by Medicaid, states have an opportunity and responsibility to improve maternal health and address disparities in health outcomes. Extending the Medicaid postpartum coverage period from the current 60 days to a full 12 months is the simplest and most targeted way to address coverage loss and continuity of care for postpartum women in both expansion and non-expansion states. Currently, three states have pending Section 1115 waivers at CMS for authority to receive federal matching funds for a postpartum coverage extension, and many other states are considering taking this step. While a Medicaid postpartum coverage extension will not single-handedly solve the maternal health crisis, it is foundational to most other efforts because it provides vital coverage and continuity of care to postpartum women during an extremely vulnerable time.

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- *National Association of Nurse Practitioners in Women's Health*
- *Preeclampsia Foundation*
- *Washington University in St. Louis*

Appendix 1. More than 60 national organizations support extending the Medicaid postpartum coverage to 12 months

2020 Mom / Mom Congress
AFE Foundation
AIDS Alliance for Women, Infants, Children, Youth & Families
America's Essential Hospitals
America's Health Insurance Plans
American Academy of Family Physicians
American Academy of Pediatrics
American Association of Birth Centers
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American College of Physicians
American Hospital Association
American Medical Association
American Nurses Association
American Osteopathic Association
American Psychiatric Association
American Public Health Association
Anthem, Inc.
APS Foundation of America, Inc
Association for Community Affiliated Plans
Association of Maternal & Child Health Programs
Association of Women's Health, Obstetric and Neonatal Nurses
Black Mammas Matter Alliance
Black Woman's Health Imperative
Blue Cross Blue Shield Association
Center for Law and Social Policy
Center for Reproductive Rights
Coalition for Disability Health Equity
Community Catalyst Women's Health Program
Every Mother Counts
Expecting Health
Families USA
First Focus Campaign for Children
Guttmacher Institute
Hyperemesis Education & Research Foundation
March for Moms
March of Dimes
Medicaid Health Plans of America
MomsRising
NAACP
National Accreta Foundation
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Birth Equity Collaborative
National Family Planning & Reproductive Health Association
National Health Law Program
National Partnership for Women & Families,
National Perinatal Task Force
National WIC Association
National Women's Health Network
Nurse-Family Partnership
PCOS Challenge: The National Polycystic Ovary Syndrome Association
Physician Assistant Education Association
Preeclampsia Foundation
Save The Mommies Inc
Sepsis Alliance
Shades Of Blue Project
Society for Maternal-Fetal Medicine
The Catholic Health Association of the United States
The PPROM Foundation
The Shane Foundation
WomenHeart
Young Invincibles

Appendix 2. Medicaid and CHIP Income Eligibility Limits for Pregnant Women and Parents/Caretaker Relatives as a Percent of the Federal Poverty Level, as of January 2020

	Pregnant Women		Parents/ Caretaker Relatives (in a family of three)
	Medicaid	CHIP	Medicaid
US Median	200%	262%	138%
Alabama	146%	n/a	18%
Alaska	205%	n/a	138%
Arizona	161%	n/a	138%
Arkansas	214%	n/a	138%
California	213%	n/a	138%
Colorado	200%	265%	138%
Connecticut	263%	n/a	160%
Delaware	217%	n/a	138%
District of Columbia	324%	n/a	221%
Florida	196%	n/a	31%
Georgia	225%	n/a	35%
Hawaii	196%	n/a	138%
Idaho	138%	n/a	138%
Illinois	213%	n/a	138%
Indiana	218%	n/a	138%
Iowa	380%	n/a	138%
Kansas	171%	n/a	38%
Kentucky	200%	n/a	138%
Louisiana	138%	n/a	138%
Maine	214%	n/a	138%
Maryland	264%	n/a	138%
Massachusetts	205%	n/a	138%
Michigan	200%	n/a	138%
Minnesota	283%	n/a	138%
Mississippi	199%	n/a	26%

	Pregnant Women		Parents/ Caretaker Relatives (in a family of three)
	Medicaid	CHIP	Medicaid
Missouri	201%	305%	21%
Montana	162%	n/a	138%
Nebraska	199%	n/a	63%
Nevada	165%	n/a	138%
New Hampshire	201%	n/a	138%
New Jersey	199%	205%	138%
New Mexico	255%	n/a	138%
New York	223%	n/a	138%
North Carolina	201%	n/a	41%
North Dakota	162%	n/a	138%
Ohio	205%	n/a	138%
Oklahoma	138%	n/a	41%
Oregon	190%	n/a	138%
Pennsylvania	220%	n/a	138%
Rhode Island	195%	258%	138%
South Carolina	199%	n/a	67%
South Dakota	138%	n/a	48%
Tennessee	200%	n/a	94%
Texas	203%	n/a	17%
Utah	144%	n/a	138%
Vermont	213%	n/a	138%
Virginia	148%	205%	138%
Washington	198%	n/a	138%
West Virginia	190%	305%	138%
Wisconsin	306%	n/a	100%
Wyoming	159%	n/a	53%

Note: Medicaid/CHIP income eligibility limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include 5% FPL disregard.

Source: Kaiser Family Foundation. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey. San Francisco, CA: Kaiser Family Foundation; March 2020. https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey-tables/ Accessed April 3, 2020.

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