Maternal and Child Health Medicaid Policy Landscape & State Trends

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In the United States, maternal deaths and pregnancy-related complications occur at shocking rates. The number of maternal deaths each year in the U.S. ranges from 650 to 750, and severe maternal morbidity — unexpected outcomes from giving birth that result in significant health consequences such as heart attacks, eclampsia, and embolisms — affects between 50,000 to 60,000 people giving birth each year. Furthermore, significant disparities exist by race and ethnicity and across socioeconomic status. Black and American Indian and Alaska Native people experienced 41 and 30 pregnancy-related deaths per 100,000 live births, respectively. White people, in comparison, experienced 13 pregnancy-related deaths per 100,000 live births.

These statistics illustrate the maternal health crisis in the U.S., but strategic policy efforts have the potential to effect real change. Ensuring access to health insurance coverage, in particular, is a critical policy lever for improving maternal and child health outcomes. Given that almost 50% of U.S. women of reproductive age report skipping or delaying care due to cost, affordability of coverage poses a significant barrier to accessing quality care.

We know through our listening research that people want personalized care that meets their needs and treats them as a whole person, including providing better maternal and newborn care. Overall, 75% of respondents in our national survey supported commonsense solutions that include expanding postpartum in-home visits and increasing coverage for models of care — such as doula services,[1] birthing centers, and home births that have often only been accessible to those paying for care out of pocket.

We know solutions such as these are critical for ensuring all birthing people and their children are able to receive access to the personalized care they need, when and how they need it, especially as we face the anticipated increased strain on our already stretched health care system under the recent Supreme Court ruling in *Dobbs v. Jackson Women's Health*

[1] We use the term "doula" to reflect the terminology used in state Medicaid programs.

Organization, which overturned *Roe v. Wade*. Some states have taken action to expand access to various birthing support services, but more work is needed.

This brief presents our research on maternal health policy within Medicaid programs across all 50 states and DC; we focused specifically on Medicaid because it covers 45% of all births in the U.S.–playing such an important role in providing care to pregnant people. In the information that follows, we share our findings, outline key trends and critical gaps, and highlight innovative models. We focus on four key policy areas within Medicaid: doula reimbursement, midwifery reimbursement and licensure, coverage for freestanding birth centers and home births, and coverage for prenatal and postpartum care, including Medicaid postpartum coverage expansion.

The maternal health landscape is complex, and there are many potential policy solutions to address the maternal health crisis in the U.S. The four policy areas that we address in this brief are just a few pieces of the maternal health puzzle, and USofCare chose to focus on this set of policies specifically due to 1) their relationship to health equity, 2) their potential impact on health outcomes, and 3) their timelines regarding the COVID-19 pandemic and their focus on meeting people where they are with their care needs:

1. **Health equity.** Given that the maternal health crisis in the U.S. disproportionately impacts people of color and low-income people, policy solutions must center on health equity and specifically address disparities in order to effectively move the needle. Community-based models of maternal health care include access to doulas, midwives, community births, and perinatal care services, all of which have potential to advance health equity. Additionally, the delivery of culturally competent care, a diverse healthcare workforce, and a model of care that links payment to quality would decrease disparities in maternal and child health.
2. **Potential impact on health outcomes.** Research shows that using doulas and midwives leads to vastly improved health outcomes for pregnant people: the use of a doula is associated with positive outcomes, including fewer maternal and infant complications, fewer cesarean sections, and less postpartum depression, and the use of a midwife is associated with outcomes such as higher rates of vaginal birth, fewer obstetric interventions, and higher rates of breastfeeding.
3. **The COVID-19 pandemic.** The pandemic elevated interest among pregnant people to have options to personalize their care, particularly regarding giving birth outside of the hospital in a community-based setting, either at home or in a freestanding birth center.

Many hospitals also limited the number of people–including doulas–who could be in the room during a delivery due to the pandemic, depriving pregnant people of critical support. In addition, the pandemic highlighted long-standing issues related to maternal health, leading many states to take action.

When these four policy areas are fit together with intentionality and with health equity at the center, they can increase access to care and improve health outcomes for all birthing people, regardless of health status, social need, or income.

A CHANGING LANDSCAPE:
Barriers and Advancements in State Maternal Health Policy

Doula Care: Reimbursement and Access

Doula care has been shown to improve health outcomes and advance health equity, and is cost effective. People who have access to doulas experience better maternal and child health outcomes, such as being less likely to have birth complications and more likely to have higher birth weight babies, to be able to breastfeed, and to report higher levels of satisfaction with care. Doulas, particularly community-based doulas, have been shown to be especially beneficial for people of color and low-income people and offer more culturally competent care. Potential cost savings associated with doula support are estimated to average $1,000 per birth for Medicaid beneficiaries.

In recent months, an increasing amount of attention has been directed towards expanding access to doula care, including through Medicaid. As of May, very few state Medicaid programs actively reimburse for doula care, but, in a testament to recent progress in this space, many states are in the process of implementing new programs and policies that will soon reimburse for doula care. This includes Massachusetts, which has pending legislation to reimburse for doula care through Medicaid, and Rhode Island, which will require both Medicaid and private insurance to reimburse for doula care. However, while coverage for doula services is expanding, the reimbursement rates themselves have varied widely. There has been some recent state momentum to address reimbursement. For example, in Oregon, doulas were reimbursed $350 through Medicaid for two prenatal and two postpartum visits, labor, and delivery. As of June 2022, Oregon has expressed its intent to submit a request to the federal

government to increase the rate to $1,500. Rhode Island's Medicaid program reimburses doulas up to $1,500 per pregnancy for up to three prenatal visits, labor and delivery, and and three postpartum visits. California's Medicaid program increased its proposed reimbursement for doulas from a flat rate of $450 per birth (including all prenatal visits, labor and delivery, and postnatal visits) to up to $1,154 per birth.

For states that are taking action to pass doula Medicaid reimbursement legislation, some states have first passed legislation that defines and standardizes the scope of practice for doulas and/or develops a doula registry For example, the Connecticut legislature passed SB1 in June 2021, which outlines a definition for doulas in state statute, and the Connecticut Department of Public Health convened a doula scope of practice working group in early 2022 with the aim of garnering support for legislation that would reimburse for doula care through Medicaid. Other states are first starting pilot programs for doula reimbursement before making them more broadly applicable, including Georgia, which is running a pilot program to cover doula care under two Medicaid Managed Care plans.

There has also been interest and focus on doula care at the federal level. For example, the Biden Administration continues to commit to expanding maternal health initiatives, including an announcement on April 1, 2022 from the Health Resources and Services Administration (HRSA) that $4.5 million in grant funding will be made available for hiring, training, certifying, and compensating community-based doulas under the Healthy Start Initiative, increasing the total number of community-based doula programs under the initiative from 25 to around 50 nationwide. There has been congressional activity regarding doula care, including the passage of H.R.959, the Black Maternal Health Momnibus Act of 2021, that seeks to end the Black maternal health crisis through a number of avenues, including expanding access to doula care.

Midwife Care: Reimbursement and Licensure

Another key service for improving maternal health outcomes is access to midwifery care. Similar to the outcomes associated with doula care, midwife-led care has also been shown to improve health outcomes and can generate health care cost savings. For example, people who use a midwife have higher rates of vaginal birth, fewer obstetric interventions, and higher rates of breastfeeding, and cost effectiveness modeling indicates that increasing the percentage of pregnancies with a midwife present from roughly 9% to 15% would generate $1 billion in cost savings by 2023.

Despite the demonstrated benefits of midwife care, there are a number of barriers that midwives face in trying to offer care, especially to the most vulnerable populations. For example, Certified Nurse Midwives (CNMs) are reimbursed by Medicaid in every state. However, many states' Medicaid programs reimburse CNMs at only a fraction of the rate physicians receive for the same services, with some states reimbursing CNMs as little as 75% of the physician rate. Low reimbursement rates for Medicaid patients can create a disincentive for CNMs to accept Medicaid patients, thereby limiting the access that people enrolled in Medicaid have to midwife care. Additionally, hospitals may be disincentivized to employ midwives because of low reimbursement. In comparison, the Affordable Care Act included a provision that, as of 2011, Medicare payment for CNM services is reimbursed at 100 percent of the Medicare rate under the Physician Fee Schedule.

While CNMs are reimbursed by Medicaid in every state, other types of midwives are not. Only 18 states reimburse direct-entry midwives, which are midwives who are not trained in nursing. These include Certified Midwives (CMs) and Certified Professional Midwives (CPMs), whose scope of practice and licensing process vary widely from state to state. Many states lack licensure programs for these direct-entry midwives, which makes it challenging for them to be reimbursable providers.

Regarding equity implications, there is potential for future advancement: there is limited evidence that midwife care currently mitigates racial disparities in maternal health outcomes, in part because 90% of the nurse midwifery workforce is white. However, midwives have closed gaps in access for those in rural communities in which hospital closures have been prevalent. Additionally, rural counties that are more likely to lose obstetric care services have higher populations of Black patients and have "less generous" Medicaid programs. Developing policies aimed toward creating a more diverse and representative midwifery workforce could also advance health equity.

Community Births: Coverage and Access

The COVID-19 pandemic fueled a rise in birthing people pursuing both home births and deliveries at birthing centers, particularly among Black birthing people: home births among non-Hispanic Black people increased 36% from 2019 to 2020, compared to 30% and 21% for Hispanic people and white people, respectively. There is also evidence for health and cost

benefits of community births, making access to home births and birth centers a critical policy issue. For example, among Medicaid beneficiaries, those who gave birth in birthing centers had lower birth costs, fewer infant emergency room visits, and fewer cesarean sections and preterm births compared to those who participated in other maternal care models. Community births offer a personalized care experience, which aligns with one of the themes we heard from people through our listening research that they want a health care system that is personalized, treats them as a whole person and meets their specific needs. Non-hospital births–particularly in birth centers owned, led, and staffed by people of color–also create opportunities for birthing people to engage with a more culturally sensitive care team, who understands and identifies the the needs of birthing peoples' communities and the societal factors that impacts their communities, and prioritizes person-centered care.

While people across the U.S. are signaling an increasing interest in non-hospital births, there are still significant barriers to people accessing and affording both home births and birth center births. According to a federal mandate, the facility fee and professional fee for birth center deliveries must be covered under Medicaid, but only 38 states and D.C. provide this coverage. There are also restrictions and barriers that make it challenging for people enrolled in Medicaid to access birth center services. In particular, birth centers face challenges such as difficulty contracting with Medicaid managed care organizations, getting reimbursement through value-based care models, and obtaining sustainable Medicaid reimbursement rates. There is also limited Medicaid coverage for home births: as of 2017, only 21 of the 41 states that responded to a national survey reported covering home births under Medicaid. These data may have changed since the onset of the pandemic, but they underscore that more progress needs to be made.

Prenatal and Postpartum Care: Coverage and Access

Prenatal and postpartum care facilitate healthy pregnancies and improved maternal and infant outcomes after birth. Having insurance coverage for these services is associated with fewer barriers to accessing care and in turn, better health outcomes. With almost half of all births in the U.S. covered under Medicaid–and two-thirds of births among people of color covered by Medicaid–prenatal and postpartum care coverage by Medicaid plays a key role in mitigating health disparities. While certain prenatal and postpartum care services are covered under Medicaid, there remain challenges regarding comprehensive coverage of critical services.

There are two main ways in which Medicaid coverage of prenatal and postpartum care varies across states. First, each state Medicaid program covers different perinatal support services and education, such as genetic counseling, home visits, parenting education, and breastfeeding education. For example, only 14 out of the 41 states that responded to a national survey covered childbirth education classes, 27 out of 41 cover breastfeeding education, and 30 out of 41 cover prenatal and postpartum home visits.

Second, the length of time that people have Medicaid coverage after giving birth varies across states. Postpartum coverage is an important factor in reducing maternal morbidity and mortality: one-third of pregnancy-related deaths occur in the postpartum period, and postpartum care for up to a year after birth can improve mental health outcomes and the management of chronic conditions. States are federally mandated to cover people under Medicaid for 60 days postpartum, but many people experience a gap in coverage after the 60-day mark, particularly in states that have not expanded Medicaid under the Affordable Care Act. However, under a provision outlined in the American Rescue Plan Act of 2021, states can expand postpartum coverage for up to 12 months postpartum using a State Plan Amendment. As of June 2022, 16 states have already implemented a 12-month extension, 15 states and D.C. are planning to implement a 12-month extension, 3 states have approved or proposed a limited coverage extension, and 3 states have pending legislation to extend coverage through either a state plan amendment (SPA) or 1115 Waiver. In sum, 37 states and D.C. have taken some action to extend postpartum coverage.

GAPS & HIGHLIGHTS

While considerable progress has been made on improving maternal and child health in state Medicaid programs throughout the country, state progress is varied and gaps and outliers still remain. For example, only 18 states reimburse *both* CNMs and direct-entry midwives, **which limits peoples' options for accessing the right personalized care for their pregnancy.** Further, some states have enacted policies that only partially address their perinatal and postpartum support needs, leaving other policies unchanged and misaligned with the overall goal of improving maternal health. For example, while Montana has the highest rate of at-home births in the country, Medicaid does not reimburse providers for at-home birth care. Montana does, however, reimburse providers through Medicaid for birth-center births. In Hawaii, CNMs are only reimbursed at 75% of what physicians receive for the same services–one of the lowest rates in the country–despite the state implementing other inclusive policies, such as

establishing a certification program for community health workers, which includes doulas. In addition, states should prioritize policy enactment, implementation, and monitoring in order to reach their aims of improving maternal health. For example, Oregon established a doula certification program to facilitate Medicaid reimbursement, but uptake rates have been low due to system limitations with reimbursement and inadequate reimbursement rates. By creating mechanisms to continually monitor implementation, states can assess whether their residents' needs are truly being met and can take action when needed.

While there is much work to be done to fill these gaps in the maternal health puzzle, a few states have emerged as leaders. In 2021, Colorado passed a package of legislation–called Colorado's Momnibus–that takes a comprehensive approach to maternal health and birth equity: the legislation expands postpartum healthcare coverage from 60 days to 12 months, mandates the coordination of care and transfers between birthing centers and hospitals, and continues the state's direct-entry midwifery program. Maine and Rhode Island also made major strides toward maternal health equity and options for birthing people. In Maine, Medicaid reimburses CNMs at 100% of the physician reimbursement rate for the same services, and recently passed legislation requiring commercial plans to cover midwifery services for both CMs and CNMs. Rhode Island was the first state to pass legislation that requires both private insurance and Medicaid to cover doula services, which went into effect July 2022. Doulas in Rhode Island will be reimbursed up to $1,500, the highest reimbursement rate in the country, for three prenatal and three postpartum visits, labor, and delivery. These states are filling gaps in the fragmented maternal health puzzle by expanding care options, increasing coordination between providers, and reimbursing providers at sustainable rates, which all result in expanded access for birthing people.

CONCLUSION

Across the country, maternal health is finally being recognized as an integral aspect of our healthcare system. On a monthly basis, new states join the list of legislatures allowing doulas to be reimbursed by Medicaid, or the list of those expanding Medicaid to 12 months of postpartum care. Despite these near daily changes and advances to the maternal health landscape, there are still many missing pieces to the puzzle that states can address to improve maternal health outcomes. States can look to expand who can provide care by addressing variation in licensure and reimbursement rates for various types of providers. They can increase the personalized care options of where to give birth by expanding Medicaid coverage to

at-home births and birth centers. Finally, states can expand prenatal and postpartum Medicaid coverage to help birthing people better access these essential services. Through listening to everyday people and health experts across the country, United States of Care is deepening our understanding of the policy mechanisms that take a comprehensive approach to maternal health with the goal of improving maternal health outcomes and providing all birthing people with the quality care they need and deserve. In the coming months, we plan to leverage the insights of key partners who are leaders in maternal health, providers, and community organizations to understand the barriers providers and communities face in trying to offer high-quality, inclusive maternal and newborn care and identify potential policy solutions at the state and federal level that USofCare can champion in the coming years.

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