The State of Postpartum Care Data Report

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Executive Summary

The current health care system overwhelmingly focuses on pregnancy, often neglecting the critical postpartum period. This leaves many women without adequate support, resources, and care during a vulnerable time. Through community listening sessions, interviews with 60 women of color, and analysis of state-level data, United States of Care has identified four key areas for postpartum care transformation:

1. **Mental Health Support:** Destigmatizing and addressing postpartum mental illness through accessible, culturally responsive support and care.
2. **Access to Information:** Providing consistent access to postpartum information and resources from perinatal health workers, regardless of location or socioeconomic status.
3. **Postpartum Health Coverage:** Expanding state and employer-level coverage to ensure access to appropriate care and recovery resources throughout the postpartum period.
4. **Pregnancy Loss Support:** Offering comprehensive support and resources for women navigating pregnancy loss, including bereavement leave, mental health services, and lactation education.

Key Takeaways

#1 - **Need for Better Data.**The availability of postpartum data at the state level is inconsistent at best and is generally not available in many instances as it relates to postpartum mental health or mental health outcomes.

#2 - **Focus on the South.** The South remains consistently worse than other geographic regions across the country because it has higher rates of postpartum depression, fetal mortality, and fewer perinatal health workers compared to other regions in the U.S.

#3 - **Employers must do better.** Most states have extended postpartum coverage for Medicaid recipients to one year, however, that does not have an impact on the millions of women that are insured through their employers. There's a lack of comprehensive data on employer-provided coverage and key state-level metrics like postpartum mortality rates.

#4 - **Sustain and enhance Medicaid.** Medicaid expansion is a powerful tool for improving access to postpartum care. Maintaining access to this successful program, while also considering policy changes to increase reimbursement for perinatal providers, requiring coverage for essential services (doulas, lactation consultants), and expanding Medicaid access in all states is crucial.

Data Gaps and Limitations: Inconsistent data availability across states highlights a lack of prioritization for postpartum health. Additionally, limited employer coverage data hinders efforts to improve postpartum benefits for non-Medicaid patients. In order to bridge these gaps, further research is needed to explore population-specific needs and address data limitations related to self-reported symptoms, access challenges, and pregnancy loss reporting.

Call to Action: The landscape of reproductive health in the US is rapidly evolving, demanding a renewed focus on comprehensive postpartum care. To ensure the well-being of families, we must prioritize the health of mothers with the same urgency as we do newborns. These findings highlight the critical need for a multifaceted approach to postpartum care, including addressing policy shortcomings, expanding access to perinatal health workers, and improving data collection. By taking action in these areas, we can create a system that truly supports mothers and strengthens families across the nation.

Overview

Today's clinical, research, and policy efforts are centered primarily on the pregnancy experience; however, we believe that care is needed long after birth to holistically improve health outcomes for women. We must care just as much about the health of new mothers as we do newborns if we want to build healthy families. Since early 2023, United States of Care has aimed to better understand the experiences and challenges of people from early pregnancy through the first-year as a new parent. Coupled with existing research, we conducted a series of community listening sessions, one-on-one interviews, and interviews with 60 women of color across the country to capture their experiences with their journey to motherhood and particularly during the postpartum period. Identifying gaps in existing research along with gathering the lived experiences of the women we spoke to helped us to identify four collective themes that define the often-neglected postpartum experience. Four areas that are not just points of concern, but the foundation for a transformative movement in maternal health.

(1) Mental Health Support – We need to better understand and destigmatize postpartum mental illnesses while providing accessible culturally responsive support, resources, and care offerings.

(2) Access to Information – There is a need for more postpartum information from perinatal health workers such as providers, midwives, doulas, lactation consultants, and/or community health workers throughout the postpartum period, regardless of geography or socio-economic status.

(3) Postpartum Health Coverage – More coverage at the state and employer levels is needed to ensure opportunities and resources for appropriate care and recovery are made available throughout the postpartum care period.

(4) Pregnancy Loss Support – More support and resources are needed for women to navigate unexpected pregnancy loss as they are in need of some of the same postpartum coverage and support services if they had a baby (e.g., bereavement leave, mental health support, lactation education, etc.).

To improve postpartum support and outcomes, we identified specific areas where women experience the greatest gaps and where the data that has been collected at the state level for various postpartum support services and coverage indicates poor outcomes. To this end, we

partnered with ZS Associates to identify metrics that aligned with the four postpartum focus areas: (1) maternal mental health, (2) access to postpartum information through perinatal health workers, (3) coverage of postpartum services and benefits, and (4) late stage pregnancy loss, all identified from our listening research. We then identified a total of 16 state level population metrics from public and private databases and looked across states to highlight both the bright spots and opportunities where more support is needed with respect to the postpartum journey.

What We Are Seeing

Maternal Mental Health and Screening Data

The South[1] has the highest average rates of self-reported postpartum depression symptoms (15%) compared to other U.S. regions. This average is 40% higher compared to the Northeast (11%), and 20% higher compared to the Midwest (12%) — which suggests that there are disparities in the prevalence of postpartum depression across geographic regions (see Figure A below). While some states do have better postpartum depression screening rates, all states can improve their screening practices and report screening rates consistently year over year. In particular, there is an urgent need for wider adoption of prenatal screening of depression symptoms. Across states, ***higher rates of prenatal and postpartum depression screening at health provider visits are associated with lower rates of postpartum depression symptoms***. This suggests that ***depression screening during health visits may help to reduce the rate of postpartum depression***. If left untreated, postpartum depression (PPD) can have lasting adverse impacts on their child's health and outcomes. For example, children with mothers of PPD have increased risk of behavioral problems in early childhood, lower academic performance in adolescence, and increased risk of depression in adulthood (Netsi et al. 2018). Recently, the American College of Obstetricians and Gynecologists (ACOG) recommended that patients be screened for anxiety and depression at least once during the perinatal period and again during their comprehensive postpartum visit. The South has significantly lower screening rates reported than all other regions (Figure B), and on average, over a quarter of women in the

[1] South: Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia

Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin

Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

South were not screened for depression prenatally. However, data for many states across the country is missing, therefore, more comprehensive data collection and reporting requirements should be established to accurately assess the prevalence of postpartum depression and inform areas for intervention. Increasing postpartum depression screening can help identify at-risk women early on, allowing for more timely and effective intervention and treatment. Additionally, providing community-based programs, such as postpartum support groups, can offer additional resources and support for new parents. By addressing these issues, we can work towards improving the mental health of new mothers and reducing the burden of postpartum depression.

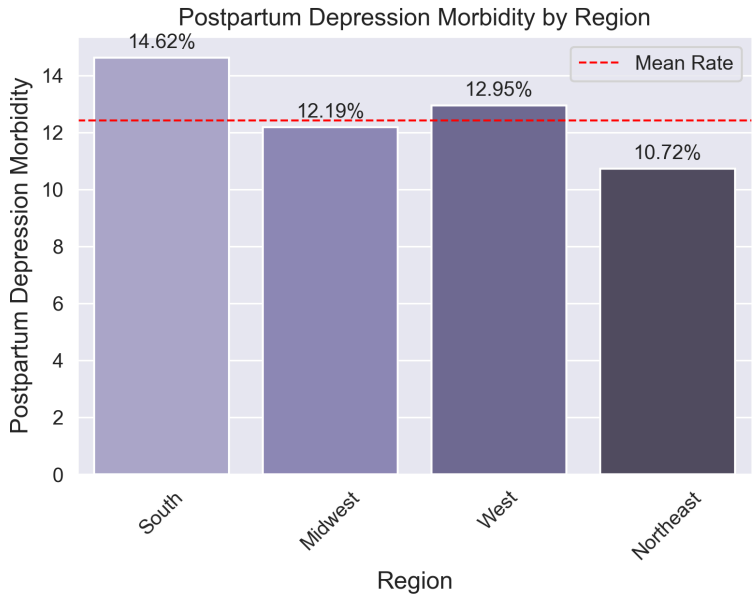

Figure A. Postpartum depression (PPD) self-report symptom morbidity across U.S. regions in 2022. Dashed line indicates the average nationwide morbidity rate.

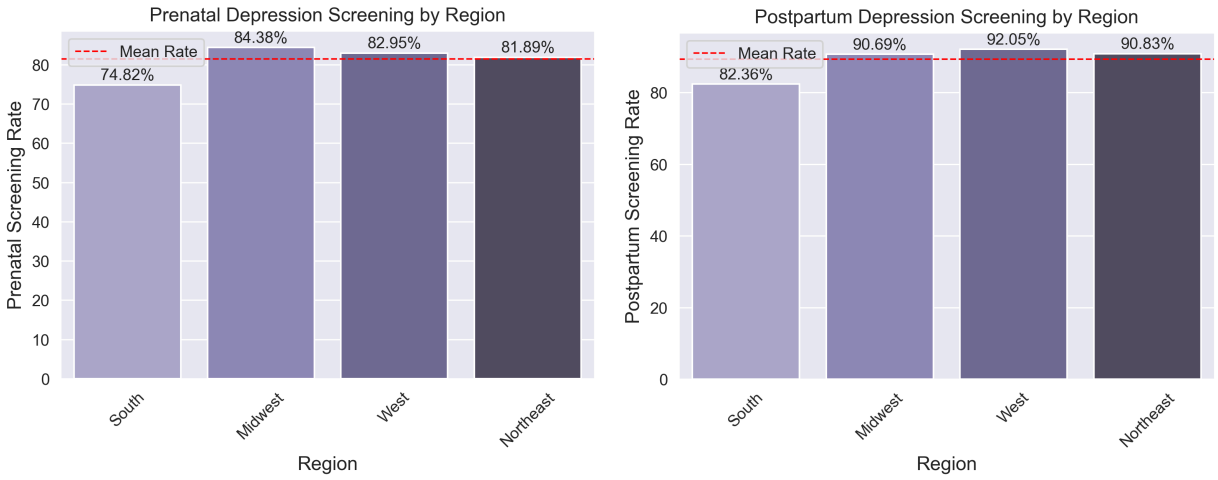

Figure B. (Left) Average rates of prenatal screening for depression across U.S. regions in 2018. (Right) Average rates of postpartum screening for postpartum depression (PPD) across U.S. regions in 2018. Dashed line indicates average nationwide screening rates.

Access to Postpartum Information via Perinatal Health Workers

Across states, the number of perinatal health workers (OB/GYNs, nurses, doulas, midwives, lactation consultants) per 10,000 women varies widely. For example, Vermont (27 per 10,000), Connecticut (24 per 10,000), and Alaska (23 per 10,000) have a high number of perinatal health workers per capita compared to states such as Arkansas, Nevada, and Oklahoma (11 per 10,000 respectively). Women living in the South and Midwest are much more likely to live in a county within a maternity care desert than women living in the West and Northeast. While the percentage of women living in maternity care deserts in the Northeast is less than 1%, the rate in the South is almost 8% (Figure C). This means that ***for every woman in a maternity care desert in the Northeast, there are more than 50 women facing the same barriers in the South***. The South and Midwest also have fewer perinatal health workers compared to other regions in the country and may contribute to some of the largest disparities in maternal health outcomes. Having a higher number of perinatal health workers available leads to improved maternal and child health outcomes and can improve access to postpartum care, breastfeeding support, and mental health services. By understanding the factors affecting the availability of perinatal health workers, policymakers and healthcare providers can work towards improving access to quality maternal and child health services.

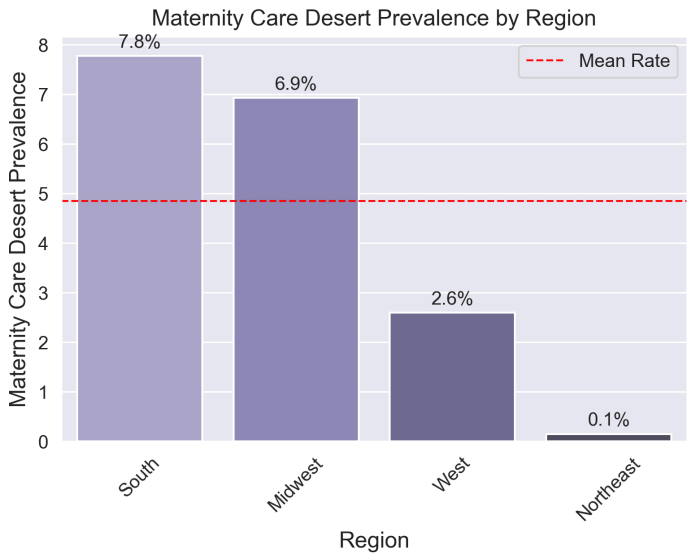

Figure C. Percentage of women living in a maternity care desert (2021-2022) in each region. Dashed line indicates the national percentage of women living in a maternity care desert.

Coverage of Postpartum Services and Benefits

Postpartum coverage varies widely across states and the services or benefits women have access to varies widely depending on the type of coverage they are enrolled in. For example, most states have extended Medicaid coverage to 12 months postpartum and cover additional services like doula care and lactation consulting, but in the remaining few states that have not pursued this policy, coverage and access to these benefits are limited. Further, states that have expanded Medicaid to higher income populations, also tend to have better postpartum coverage, including longer coverage durations and coverage for services related to postpartum care suggesting that Medicaid expansion is a powerful tool to improve access to care for new mothers. For instance, states that have expanded Medicaid have a three times higher rate of coverage for doula reimbursement and a 25% higher rate of coverage for outpatient lactation consultant reimbursement. **Since seven out of the ten states that have not adopted medicaid expansion are in the South, these gaps in coverage disproportionately affect maternal health care and outcomes for mothers living in the Southern region** including increased postpartum depression morbidity, mortality, and late stage pregnancy loss**.** We also see that the southern states with the least amount of coverage for postpartum services, corresponds with where the highest rates of maternal deaths are occurring in the country. While some states are making progress in covering doula care and home visits in their Medicaid programs, many still do not require coverage for these services in their marketplace plans. Similarly, there

is a lot less known about the coverage of these services under private insurance, leaving a very wide gap in coverage of postpartum services and benefits for those not on Medicaid. This limited access to essential support services for new mothers, particularly those in underserved communities, greatly impacts health outcomes of new moms. Notably, women who received doula care from 2014-2020 had 52.9% lower odds of cesarean delivery and 57.5% lower odds of postpartum depression/postpartum anxiety (Falconi et al. 2021). State-level coverage policies play a crucial role in determining access to critical postpartum services and benefits. Policymakers can implement policies to improve postpartum coverage by expanding Medicaid in the states that haven't yet, increasing reimbursement rates for perinatal providers, and requiring private insurers to cover certain services, like doulas, perinatal health workers, and various breast pumps.

Late Stage Pregnancy Loss

When it comes to the loss of pregnancy in later stages of pregnancy, we heard from women that services that would have otherwise been extended to them if they had their baby were rarely provided after the loss of their pregnancy. They shared that they often sought out information for support, mental health services, resources on what to do about producing milk and were largely unsuccessful in getting the support they needed, in addition to not having adequate amounts of maternity bereavement leave. From the little data that is available on late stage pregnancy loss, we observe a wide variability in fetal mortality rates across the country. For example, Mississippi (9.9 per 1,000 live births and fetal deaths) and Nevada (7.8 per 1,000) reported higher rates compared to other states such as New Hampshire (3.7 per 1,000) and Maine (3.5 per 1,000). Regional differences are also evident. In 2023, Southern states had an average fetal mortality rate of 6.05 per 1,000 live births and fetal deaths, compared to 5.25 in other states. Notably, we found that **Southern states have almost 3x the likelihood of the state-wide fetal mortality rate being above the national average compared to other U.S. regions.** This means that ***Southern states are at risk of having higher rates of fetal mortality than other U.S. states.*** This analysis is based on provisional 2023 data from the Centers for Disease Control and Prevention (CDC), covering 99.7% of expected cases. Factors such as socioeconomic disparities, access to health care, availability of prenatal care, quality of care, and health care provider practices, might contribute to these regional differences. Further, states with higher rates of women living in maternity care deserts tend to have higher rates of fetal mortality (Figure D). From 2022 data, we saw that higher rates of self-reported post-partum depression symptoms were associated with significantly higher fetal mortality rates, suggesting that maternal mental health may also impact rates of fetal mortality (Figure E). By understanding the factors contributing to these disparities, policymakers and health care

providers can work towards reducing fetal mortality rates and improving maternal and infant health outcomes.

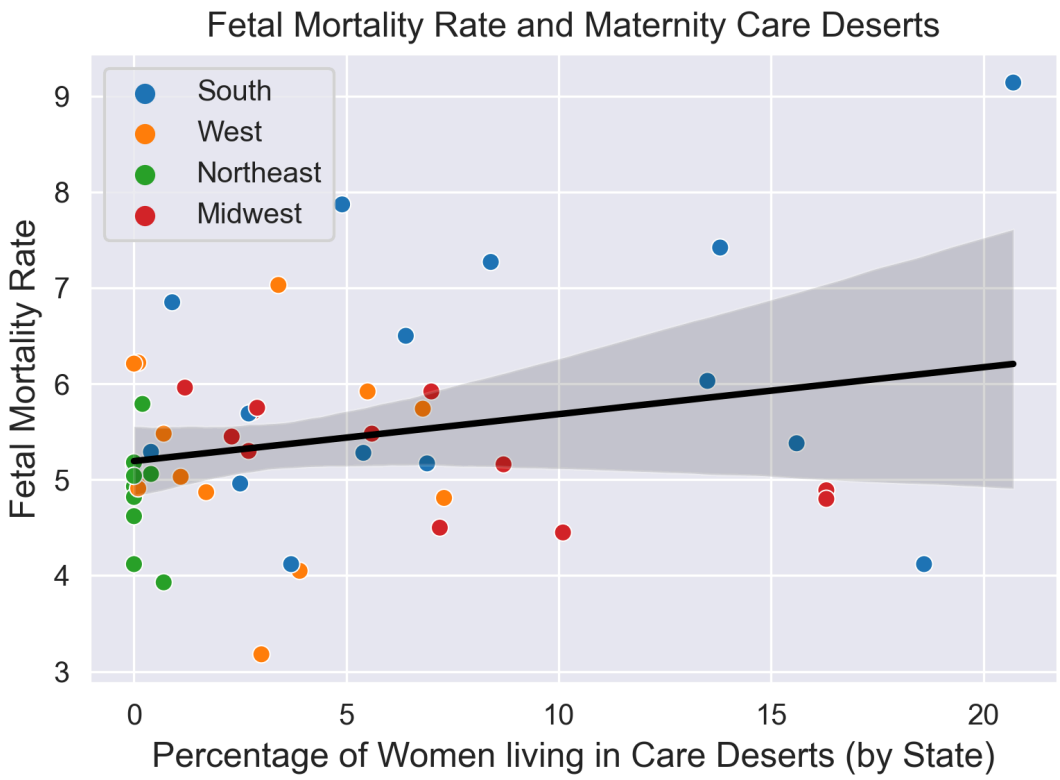

Figure D. Relationship between state-wide fetal mortality rates (2022) and percentage of women living in a maternity care desert (2021-2022) by region (N=50 states reporting).

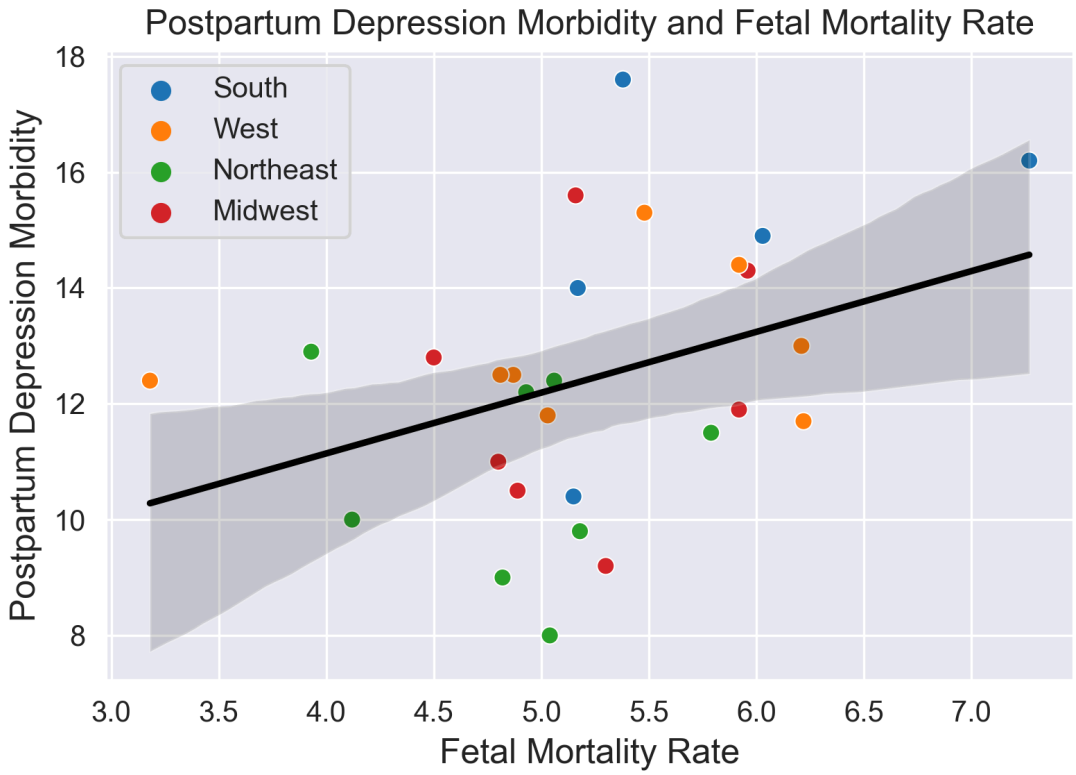

Figure E. Relationship between postpartum depression morbidity rates (2022) and fetal mortality rates (2022) by region (N=29 states reporting depression morbidity).

Data Gaps

A notable gap in data and research literature persists as it relates to postpartum health in the United States, including the metrics we investigated, and while we made sizable efforts to optimize the data quality and source data from reputable state-level databases, several major gaps were still encountered across states:

- **Employment Data:** Lack of employer coverage data for postpartum care persists as a glaring chasm in research literature and public-facing reports. While over 50% of women and birthing people obtain health coverage from their employers, many transformational improvements are happening to support women on Medicaid because these data are more readily available whereas it is more difficult to capture employer coverage improvements through publicly available data. Although patient-centric efforts to improve postpartum coverage under Medicaid is still necessary, our community-based listening has revealed the affordability burden for postpartum care faced by people covered by private insurance. Now more than ever, it is important to

establish congruence in benefit design across coverage types. The availability of employer coverage information is imperative for tracking the extent of this issue. (*Key employer data gaps: maternity leave by employer, lactation benefits by employer*)

- **Availability of State-Level Data:** Data was not consistently available between states across the four focus areas above, and several postpartum metrics were not able to be captured sufficiently via publicly accessible data or state health department databases. It is important to note that gaps in postpartum data availability could indicate a lack of state-level prioritization as it pertains to postpartum health. To maintain trust and partnership among vested stakeholders, state-level health departments or other regulatory entities should continue striving towards improving data transparency across a variety of postpartum care metrics (*Key state-level data gaps: postpartum mortality rates, postpartum depression screening & diagnostic rates, OBGYN appointment attendance*)

- **Population-Specific Context**: It is also important to note that metrics across the four focus areas were initially developed in alignment with key trends and listening work conducted by USofCare that centered Black women's postpartum experiences. Although the current metrics used for indexing include various racial and ethnic groups, it would be worthwhile to explore some ethnicity specific metrics (e.g., availability of bilingual doulas, multilingual mental health resources, etc.) that are not captured in this research phase. Additionally, it would be worthwhile to explore the existing metrics by specific race and ethnicity to understand the postpartum landscape for women of color more deeply.

Summary

As you explore the interactive map, we encourage you to think about how this data can be used to help support women in your state, region, or nationally and consider other metrics that are important to capture during this critical period. Continuing to build out these and other data sources is essential to:

- Better visualizing the postpartum **landscape** by state
- Understanding opportunities to improve postpartum care
- Regionally assessing **postpartum data availability**
- Geographically planning **programs and interventions**
- Improving **coverage** for postpartum **benefits and services**

It is important to note that while we have an understanding of state-level performance, one thing is clear: states need to do a better job of collecting data. We cannot fix what we do not measure or understand. This is true across areas where women's health is not studied in depth, and the lack of data stifles investments into effective interventions and meaningful policy change.

Appendix 1: Sources and Data Limitations

Map 1: Postpartum Mental Health

Postpartum depression (PPD) illness (self-reported) Data from PRAMS survey 2022, N = 30,706 (for the question); Data type - Self-reported PPD symptoms; 29 states reporting (* PRAMS sites aggregated for 2022: Alabama, Arizona, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York City, New York State, North Dakota, Northern Mariana Islands, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming that met the required 50% response rate threshold for inclusion.)

The data contains percentage of women who were asked about depression by their HCPs during Prenatal visit Data from PRAMS survey 2018, N = 32,619

The data contains percentage of women who were asked about depression by their HCPs during Postpartum visit Data from PRAMS survey 2018, N = 29,187

Data Limitations: Data reported for postpartum depression symptoms is self-reported and not diagnosed by a physician which means that actual diagnosis of postpartum depression, if screened, might be higher than reported here. Additionally, PRAMS data for self-reported postpartum depression symptoms has fewer states reporting (N=29 in 2022) compared to previous years (N=34 in 2021).

Map 2: Access to Postpartum Information via Perinatal Health Workers

CDC Wonder, 2022 Population defined as women of all races and ethnicities between 15-49.
Disclaimer: materials Developed by CDC ATSDR and/or HHS and the use of these data including any links to the materials on the CDC, ATSDR or HHS websites, does not imply endorsement by CDC, ATSDR, HHS or the United States Government of you, your company, product, facility, service or enterprise. Material is otherwise available on the agency website for no charge.

Area Health Resources Files 2022-2023, Data type- No. of HCPs across specialities, per state; Data was calculated by the Sum of number of HCPs (including M.D.s specializing in Obstetrics and Gynecology, Nurses and Nurse Midwives with National Provider Identifier (NPI),Physicians practicing in Obstetrics and Gynecology and Physicians) specializing in Neonatal-Perinatal Medicine

DoulaMatch.net; data was compiled from the reported number of Postpartum doulas for each state

International Board of Lactation Consultant Examiners (IBLCE 2024); data was compiled from the reported number of Internationally Board certified Lactation Consultants in the U.S. & Territories

Data Limitations**:** The relationship between the number of perinatal health workers and maternity care access is not straightforward. Contrasting this data with other critical metrics such as maternity care deserts and reimbursement for perinatal health workers (if any) will be important to understand its significance on women and birthing people.

Map 3: Coverage of Postpartum Services and Benefits

KFF Status of State Medicaid Expansion decisions; data compiled from the reported current scenario of states implementing/ not implementing Medicaid expansion to cover individuals with incomes up to 138% of the Federal Poverty Level as of May 8, 2024.

KFF Medicaid Postpartum Coverage Extension Tracker; data compiled from the reported current scenario of states considering/ implementing Section 1115 waivers to extend Medicaid Postpartum care coverage to 12 months as of August 1, 2024.

National Health Law Program 2024; data compiled from the reported Current scenario of postpartum doula coverage reimbursement under Medicaid as of map publication date.

National Health Law Program 2024; data compiled from the reported Current scenario of states considering expansion of private coverage of doula care as of map publication date.

KFF Medicaid Coverage of Pregnancy-Related Services 2021; data compiled from the reported Current scenario of coverage for Lactation Consultation - Inpatient

KFF Medicaid Coverage of Pregnancy-Related Services 2021; data compiled directly from the reported Current scenario of coverage for Lactation Consultation - Outpatient

KFF Medicaid Coverage of Pregnancy-Related Services 2021; data compiled directly from the Current scenario of coverage for Lactation Consultation Home Visit through Medicaid

Wisconsin's *BadgerCare Plus* program has expanded maternal Medicaid eligibility from 138% to 306% of the Federal Poverty Level (giving it the highest eligibility threshold in the US). However, Wisconsin has not adopted the Section 1115[2] waiver to postpartum care coverage from 60 days to 12 months. Winson's proposed Senate Bill 110 would adopt the Section 1115[2] waiver but is currently awaiting further review.

Data Limitations: While postpartum care coverage is essential, it does not guarantee access, as barriers such as provider availability (see map 2 on Access to Postpartum Care Information), transportation,

childcare, and culturally responsive care still limit the ability of many women to receive the services they need.

Map 4: Late Stage Pregnancy Loss

National Vital Statistics Reports 2023, provisional data compiled from the reported Fetal Mortality rate at 20 weeks of gestation or more (number of fetal deaths per 1000 live births and fetal deaths)

Data Limitations: Some research does not clearly differentiate between "still birth rate" and "fetal mortality rate". In the case where a pregnancy spontaneously ends, many states still do not use the updated death reports which include fetal death as a cause. Moreover, they also do not specify the cause of the fetal death to understand the origins and create interventions for improvement. Nearly 1/3 of updated death reports still lack an informative cause (due to clerical error). https://www.cdc.gov/mmwr/volumes/69/wr/mm6937a1.htm.