

# Medicaid's Crucial Role in Combating the Maternal Mortality and Morbidity Crisis

March 2020

**A Public Health Crisis.** The United States is in the throes of a maternal health crisis. It is the only developed country where the maternal mortality rate has been steadily rising,<sup>1,2</sup> almost doubling from 10.3 deaths per 100,000 live births in 1991 to 17.4 in 2018.<sup>3,4</sup> And for every woman who dies from pregnancy-related causes, another 70 suffer from severe maternal morbidity, complications which come with significant short- and long-term consequences for women's health.<sup>5</sup> The crisis is disproportionately impacting women of color. Black and American Indian/Alaska Native women in the United States are 3.3 and 2.5 times, respectively, more likely to die from pregnancy-related causes than non-Hispanic white women.<sup>6</sup> Disparities between women of color and white women persist regardless of education and socioeconomic status.<sup>7-9</sup> Further, maternal deaths are largely preventable—and their preventability does not vary by race.<sup>10</sup>

**Medicaid's Role.** Medicaid has a pivotal role in improving national health outcomes for pregnant and postpartum women. Nearly half of all U.S. births are financed by Medicaid.<sup>11</sup> 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 (e.g., diabetes)—putting them at higher risk for poor maternal outcomes.<sup>12</sup> Compared with women with private insurance at delivery, those covered by Medicaid are more likely to be Black.<sup>13</sup> In addition, Medicaid frequently leads the way in responding to public health crises. For example, the program played an instrumental role in responding to the lead crisis in Flint, Michigan and the September 11th terrorist attacks in New York City.<sup>14</sup> Also, today Medicaid serves as the primary source of prevention, treatment, and recovery services for people with an opioid use disorder (OUD), covering more than one in three people with OUD.<sup>15</sup>

States have flexibility to shape Medicaid policy related to maternal care, including who is covered, the duration of their coverage, the benefits they receive, and the delivery system through which they receive care. Further, state Medicaid agencies, in partnership with sister agencies, can use their purchasing power and “bully pulpit” to drive broader policy and cultural change to improve maternal health outcomes and the lives and health of mothers and of their children.

This issue brief describes select policy and strategy levers that Medicaid agencies can employ to improve maternal health outcomes and address outcome disparities in five areas: coverage, enrollment, benefits, models of care, and quality improvement. In some cases, the Medicaid agency will be responsible for implementing these policies; in other cases, the Medicaid agency can lead collaboration with other state agencies such as the public health department or the state marketplace.

In all cases, state consultation with communities and consumers affected by these policies will be essential to improve maternal health outcomes. Specifically, Medicaid agencies can directly engage enrollees in their communities, schools, and care settings; go beyond traditional public engagement meetings by hosting events such as radio call-in shows and solicit feedback via random-dial text messages; proactively identify and partner with organizations that are trusted voices for the populations experiencing the poorest outcomes (e.g., Black women and women living in rural communities<sup>16</sup>);<sup>17</sup> and incorporate consumers and advocates in program development and monitoring structures (e.g., working groups and consumer advisory committees).<sup>18</sup>

*Figure 1. Snapshot of Medicaid Strategies to Improve Maternal Health*

### **1. Coverage**

- 1.1. Expand Medicaid
- 1.2. Continue Medicaid/CHIP Coverage for 12 Months Postpartum
- 1.3. Cover Otherwise Ineligible Immigrant Women through CHIP

### **2. Enrollment**

- 2.1. Expedite Enrollment for Pregnant and Postpartum Women

### **3. Benefits**

- 3.1. Cover and Integrate Doula Services
- 3.2. Cover and Expand Access to Home Visiting Services
- 3.3. Cover Enhanced Dental Services for Pregnant and Postpartum Women

### **4. Models of Care**

- 4.1. Leverage Medicaid to Promote a Statewide Maternity Levels of Care Framework
- 4.2. Implement Enhanced Prenatal Care Models
- 4.3. Integrate Maternal Behavioral Health Screenings in Prenatal, Postpartum, and Pediatric Care Services

### **5. Quality Improvement**

- 5.1. Prioritize Engagement in Statewide Maternal Health Quality Improvement Initiatives
- 5.2. Measure, Report, and Assess Maternal Care Measures for Outcomes Disparities

## **Medicaid Strategies to Improve Maternal Health**

### **1. Coverage**

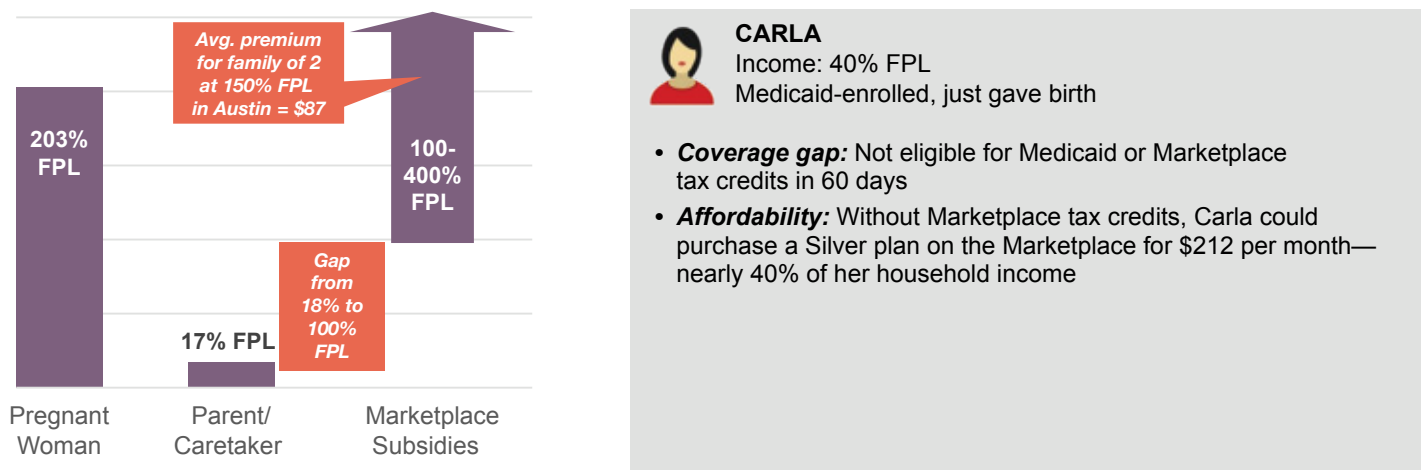
States have a broad array of Medicaid and Children’s Health Insurance Program (CHIP) levers to increase coverage for women broadly, for targeted populations, and at targeted times when women are most likely to experience gaps in coverage and care (e.g., during the postpartum period).

**1.1. Expand Medicaid.** Expanding Medicaid is the most effective strategy to ensure access to care for all women with incomes up to 138 percent of the federal poverty level (FPL). Medicaid expansion ensures continuity of comprehensive (not just pregnancy-related) health coverage before, during, and after pregnancy, and mitigates churn across Medicaid, private coverage, and uninsurance. A growing body of evidence reflects the positive impacts of expanding Medicaid coverage on access to care and health outcomes,<sup>19–21</sup> including a finding that expanding access to Medicaid was associated with 1.6 fewer maternal deaths per 100,000 women compared with states that did not expand Medicaid.<sup>22</sup> These gains are associated with women having coverage prior to pregnancy, which presents the opportunity to address preconception risk factors such as obesity, diabetes, and heart disease, and to begin prenatal care earlier in pregnancy.<sup>23</sup>

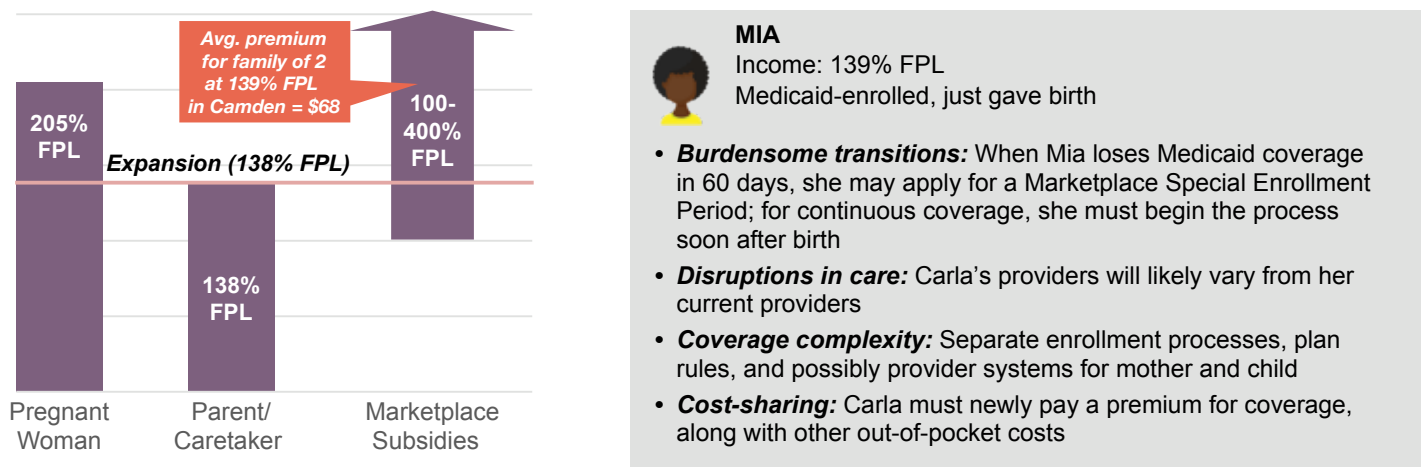
**1.2. Continue Medicaid/CHIP Coverage for 12 Months Postpartum.** In a 2019 report, the Centers for Disease Control and Prevention (CDC) found that nearly 12 percent of pregnancy-related deaths—*not* counting those caused by suicide or overdose—occur 43 to 365 days postpartum. Some states’ analyses of all pregnancy-associated deaths find that 50 percent or more of deaths occur beyond the 60-day postpartum period for which state Medicaid programs are required by federal law to cover women eligible for Medicaid on the basis of their pregnancy.<sup>24–26</sup> In light of these findings, state maternal mortality review committees, the American Medical Association,<sup>27</sup> the American College of Obstetricians and Gynecologists (ACOG),<sup>28</sup> the American Academy of Family Physicians,<sup>29</sup> and numerous consumer advocacy groups<sup>30–32</sup> have recommended that policymakers extend Medicaid coverage from the current standard of 60 days to 12 months postpartum.

Today, postpartum women in *both* expansion and nonexpansion states experience gaps in coverage between when they deliver and three to six months postpartum.<sup>33</sup> Although women in expansion states who lose Medicaid eligibility in the postpartum period are likely eligible for subsidized Marketplace coverage, many do not transition to private coverage because their out-of-pocket costs may be unaffordable or they may be required to change plans or providers. As shown in Figures 2 and 3 below, continuing Medicaid/CHIP coverage for 12 months postpartum would address gaps in coverage and would mitigate disruptions in care during the postpartum period.<sup>34–36</sup>

*Figure 2. Example of Postpartum Coverage Barriers in a Nonexpansion State*



*Figure 3. Example of Postpartum Coverage Barriers in an Expansion State*



Multiple states have submitted to CMS or are developing Section 1115 demonstration waivers requesting authority to continue coverage for up to 12 months postpartum. Illinois' waiver is pending CMS review,<sup>37</sup> New Jersey is poised to submit a similar waiver request (the state public comment period on its draft waiver closed in early February),<sup>38</sup> and a handful of other states are in the process of developing postpartum coverage extension demonstration proposals.<sup>39–42</sup> To date, CMS has not approved any state's proposal to extend postpartum coverage.<sup>43</sup> Notably, multiple federal legislative proposals seek to require or permit states to continue Medicaid/CHIP coverage for 12 months postpartum.<sup>44</sup>

### **1.3. Cover Otherwise Ineligible Immigrant Women through the Children's Health Insurance Program (CHIP).**

States may cover, through two CHIP policies, pregnant and postpartum women who are otherwise ineligible for Medicaid due to their immigration status. For pregnant women who are lawfully present in the United States but are not yet eligible for Medicaid/CHIP due to the five-year waiting period,<sup>45</sup> states have state plan authority under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to cover prenatal, labor and delivery, and postpartum care services.<sup>46,47</sup> This option is often referred to as the "ICHIA option" because it incorporates earlier legislation called the Immigrant Children's Health Improvement Act. Twenty-five states have adopted this option as of January 2019.<sup>48</sup>

Illinois uses a CHIP Health Services Initiative—which allows states to use up to 10 percent of available CHIP administrative funding to pay for public health activities/services—to provide postpartum care services to women otherwise ineligible for Medicaid.<sup>50</sup>

For pregnant women who are undocumented, states may use what is often referred to as the CHIP "unborn child" option to cover prenatal care and labor and delivery, but have less flexibility for covering comprehensive postpartum care. Under this option, states may cover only postpartum care services when 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).<sup>49</sup>

## **2. Enrollment**

**2.1. Expedite Enrollment for Pregnant and Postpartum Women.** Early prenatal care reduces the risk of pregnancy complications and allows for management of existing conditions, making timely enrollment in coverage an important component of improving maternal health. State Medicaid agencies have multiple options for expediting enrollment for pregnant women. For women who are eligible for Medicaid on the basis of their pregnancy,<sup>51</sup> presumptive eligibility is an important tool to increase access to timely prenatal care. Presumptive eligibility policies have been shown to increase by 40 percent the likelihood that pregnant women will enroll in prenatal care and to increase by 30 percent the likelihood of pregnant women obtaining care in the first trimester. States also may prioritize application processing for women who self-identify as pregnant, as states like Hawaii and Rhode Island have done.<sup>52</sup>

**Facilitating Marketplace Enrollment for Postpartum Women:** In some states, as many as 50 percent or more of maternal deaths occur after the 60-day postpartum period, making the postpartum period a high-risk one for maternal mortality and morbidity. As described above, women transitioning from Medicaid to Marketplace coverage will likely face a change in providers, plan coverage, and increased costs—at a time when they are managing the challenges associated with caring for a newborn and their own recovery.

States may consider opportunities to ease the transition for postpartum women losing Medicaid eligibility who are eligible for Marketplace subsidies (i.e., those with incomes at or above 100 percent of the FPL).

For example, states may conduct targeted outreach to women after the birth of their child, alerting them to their Marketplace eligibility and helping them transition coverage. As part of this effort, states can enlist the help of Navigators, managed care organizations (MCOs), and obstetric care providers to connect postpartum women with Marketplace enrollment supports. Finally, state-based Marketplaces might consider creating special enrollment periods designed specifically for pregnant and postpartum women; New York<sup>53</sup> and Maryland<sup>54</sup> have each taken this approach.

### 3. Benefits

States have the flexibility to cover services tailored to improve access to and continuity of care for pregnant and postpartum women enrolled in Medicaid/CHIP. The following are select, evidence-based benefit strategies for improving maternal health.

**3.1. Cover and Integrate Doula Services.** According to the CDC, two of the leading causes of pregnancy-related deaths are missed/delayed diagnoses and not recognizing warning signs of complications.<sup>55</sup> Doulas empower women to communicate their needs and perceptions by providing nonclinical emotional, physical, and informational support before, during, and after birth.<sup>56</sup> Doula care is linked to better outcomes including fewer low-birthweight babies, preterm births, and cesarean sections.<sup>57–59</sup>

Community-based doulas—who are members of the community they serve and share the same background, culture, and/or language as their clients—can help advance health equity. Community-based doulas also often help address social determinants of health by providing more home visits, a wider array of services, and referrals to community-based organizations.

States can cover doula services in Medicaid via state plan authority and, to date, Minnesota and Oregon have taken advantage of this option.<sup>60,61</sup> New York's pilot program, which it plans to expand over time, provides doula services to Medicaid enrollees in Erie County.<sup>62</sup> Also, New Jersey and Virginia recently announced plans to implement programs to cover doula services.<sup>63,64</sup> States seeking to cover doula services can support community-based doulas' integration in Medicaid by partnering with doulas, communities, and beneficiaries in developing their doula program. Key issues for consideration include:

- › **Provider certification requirements.** While various organizations support doula training and certification, there is no national certification standard. In determining a certification standard, states will need to strike a balance between ensuring that doulas meet minimum programmatic requirements and recognizing that doulas are not clinical providers. New York's pilot program requires doulas to attest to completing minimum training criteria such as at least 24 hours of doula training; attendance at classes regarding topics such as breastfeeding, childbirth, and cultural competency; and completion of a doula proficiency exam.<sup>65</sup>
- › **Reimbursement.** Determining, and ensuring doula buy-in to, appropriate reimbursement rates that account for the duration and breadth of services provided by doulas is critical. Minnesota,<sup>66</sup> Oregon,<sup>67</sup> and New York<sup>68</sup> all reimburse doulas on a per-service basis for prenatal visits, labor and delivery, and postpartum visits.
- › **Delivery system integration.** Given that doulas have not historically participated in Medicaid, or health insurance more generally, states will want to ensure that doulas have technical assistance integrating into the delivery system. When implementing its doula pilot program in Erie County, New York provided support to doulas related to their participation in Medicaid by engaging them via webinars, in-person seminars, and establishing a direct line of communication.<sup>69</sup>

**3.2. Cover and Expand Access to Home Visiting Services.** During and after pregnancy, home visiting programs can promote maternal health by connecting mothers to postpartum medical care, mental health and substance use disorder treatment, and community-based resources; reduce mothers' stress levels by providing educational services such as lactation, nutrition, and parenting education; and bring clinical services to mothers in their homes.<sup>70</sup>

Federal public health programs—most significantly, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)<sup>71</sup>—approve and fund a host of evidence-based home visiting models nationally.<sup>72</sup>

Although home visiting itself is not a covered benefit under

Medicaid, more than 20 states use Medicaid to fund some components of home visiting using a variety of authorities including their state plans, Section 1115 demonstrations, and 1915(b) waivers.<sup>73</sup> Among the home visit services that states are able to fund through Medicaid are assessments, referrals, care planning and monitoring, and certain diagnostic, treatment, and prevention services for pregnant women and children delivered via a home visit.

In 2016, CMS issued an informational bulletin outlining the benefits that states may use to cover home visiting services in Medicaid.

Figure 4. Examples of Medicaid Home Visiting Programs for Pregnant and Postpartum Women<sup>74</sup>

| State Example   | Medicaid Authority  | Services Included   |
|---|---|---|
| Colorado<br>(Nurse Family Partnership) <sup>75</sup>  | State plan services: Targeted Case Management   | <ul style="list-style-type: none"> <li>&gt; Regular home visits for first time parents with incomes below 200% FPL until the child is two years old (approximately 75% of these services are covered by Medicaid)</li> <li>&gt; Case management services (needs assessment for mother and/or child, care plan development, referral support, follow-up monitoring)</li> </ul> |
| Michigan<br>(Maternal Infant Health Program) <sup>76</sup>  | State plan services: <ul style="list-style-type: none"> <li>&gt; “Extended services” for pregnant women</li> <li>&gt; Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</li> </ul> | <ul style="list-style-type: none"> <li>&gt; Case management services</li> <li>&gt; Professional visits by registered nurses, social workers, and other licensed professionals (delivered by participating FQHCs, home health centers, home health agencies, and regional health departments, among others)</li> </ul>   |
| Maryland<br>(Home Visiting Pilot Program: Nurse Family Partnership and Healthy Families America) <sup>77,78</sup> | Section 1115 demonstration waiver   | <ul style="list-style-type: none"> <li>&gt; Prenatal and postpartum services including monitoring for pregnancy complications, diet and nutritional education, stress management, mental health and substance use disorder screening and counseling, and breastfeeding support and education</li> </ul>   |

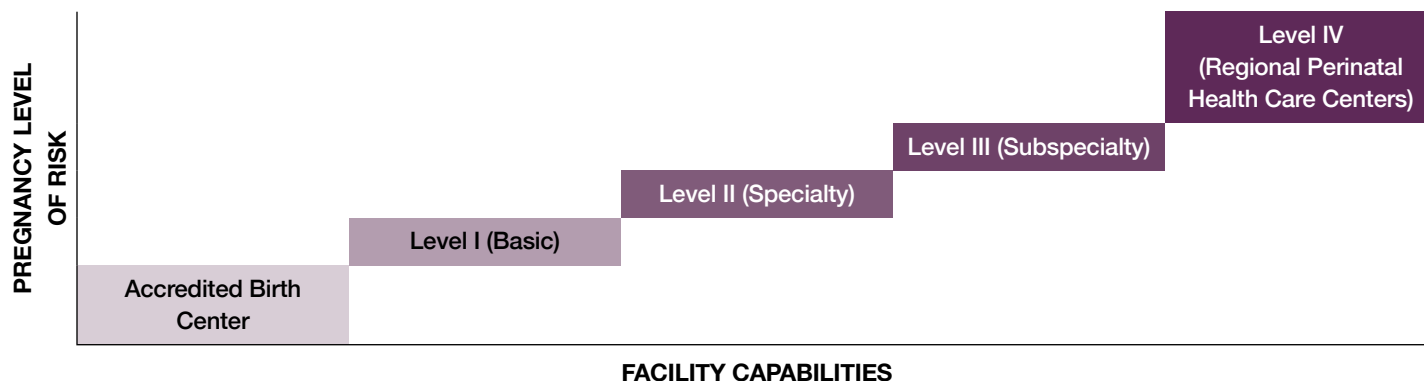
**3.3. Cover Enhanced Dental Services for Pregnant and Postpartum Women.** Pregnant women are especially vulnerable to developing oral health problems that, if left untreated, can lead to serious health complications.<sup>79</sup> Yet women who have lower incomes, are enrolled in Medicaid, or belong to a racial or ethnic minority are half as likely to obtain dental care compared with higher-income, privately insured white women.<sup>80</sup> States have flexibility to determine what, if any, dental benefits are provided to adult Medicaid enrollees through their state plans, and states have used Section 1115 waiver authority to provide different dental benefits to pregnant women than to other adults. For example, Oregon uses Section 1115 waiver authority to provide dental services to most adults, and to provide more robust dental services to pregnant women.<sup>81</sup>

#### 4. Models of Care

State Medicaid agencies can be a critical player in setting parameters for, and can establish incentives to improve, delivery of care to women.

**4.1. Leverage Medicaid to Promote a Statewide Maternity Levels of Care Framework.** In 2019, ACOG issued an updated Levels of Maternity Care framework designed to ensure (1) availability of appropriate care settings across the continuum of pregnancy levels of risk and (2) referral relationships across facilities such that women are treated at the most appropriate level of care for their health risks and needs.<sup>82</sup>

Figure 5. Snapshot of the ACOG Levels of Maternity Care Framework



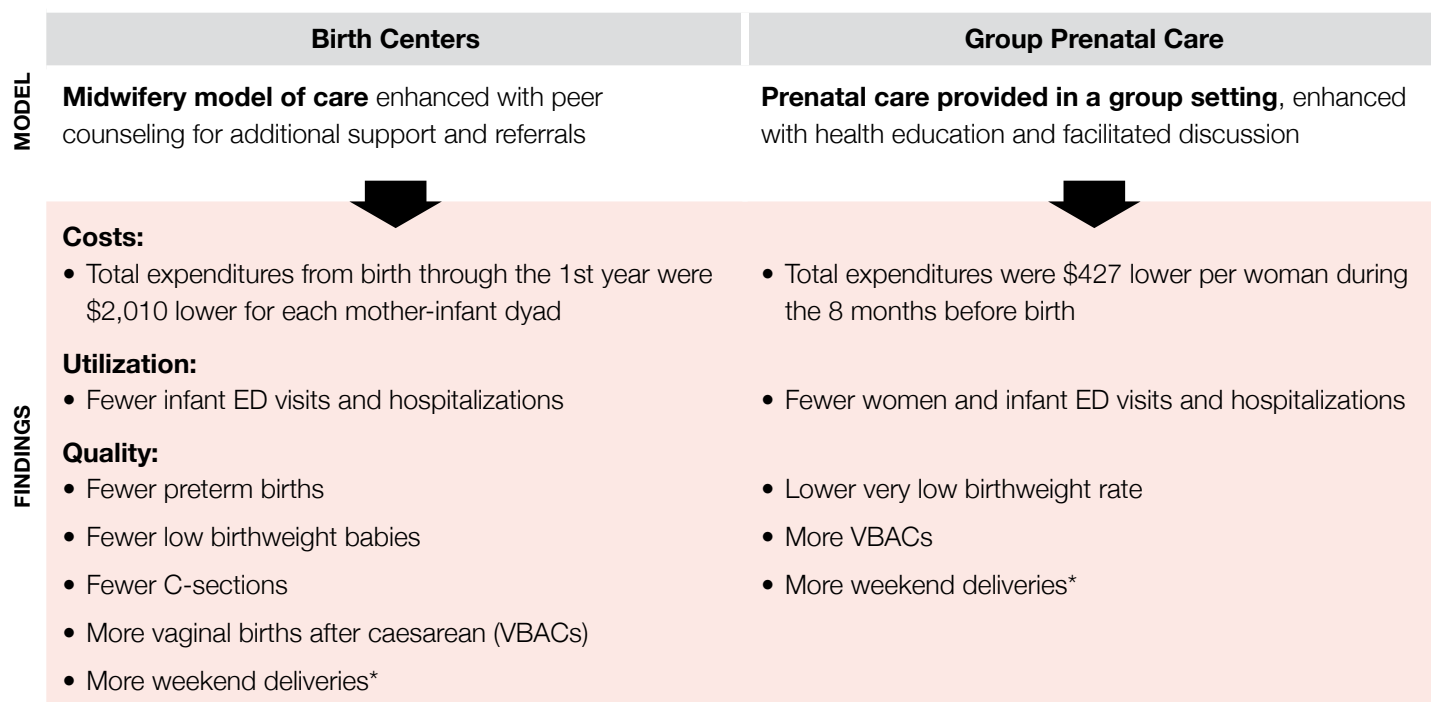


A handful of states have established levels of care designations for all hospitals that provide maternity care.<sup>83</sup> Medicaid agencies can help drive these efforts by linking Medicaid provider enrollment and reimbursement to compliance with levels of care guidelines, as Texas has done. Effective September 2020, Texas will require every hospital to have its level of neonatal and maternal care designated according to the new Levels of Maternity Care guidelines in order to receive Medicaid reimbursement.<sup>84</sup> Each Texas facility must describe the scope of maternity care services available; the maternal population evaluated/treated, transferred, or transported by the facility; and its triage, stabilization, and transfer guidelines. Important to fostering mother-baby dyad care—which is shown to improve outcomes for the mother and baby<sup>85</sup>—is aligning the standards between neonatal and maternal levels of care. Levels of maternal and neonatal care may not match within facilities; however, a pregnant woman should receive care at the facility that best meets her needs as well as her neonate’s needs.<sup>86</sup> Texas’ maternal levels of care designation criteria include triage and assessment standards to ensure that pregnant women identified as high risk of delivering a neonate that requires a higher level of care are transferred to facilities capable of providing those services.

**4.2. Implement Enhanced Prenatal Care Models.** The Center for Medicare and Medicaid Innovation (CMMI), through its Strong Start for Mothers and Newborns initiative, examined the impact of three “enhanced” prenatal care models for Medicaid-enrolled women, including Birth Center Care and Group Prenatal Care.

States may consider strategies to promote these models of care in their Medicaid programs, including through Medicaid payment policy and directing managed care plans to contract with providers of these care models. In November 2018, CMS issued an informational bulletin highlighting the birth center model of care and outlining opportunities for state Medicaid agencies to increase its use and address common barriers to access for birth centers and midwifery models of care in collaboration with other state agencies, including modifying state midwifery scope of practice laws and state certificate of need requirements for birth centers.

*Figure 6. Snapshot of Findings of CMMI Strong Start for Mothers and Newborns Initiative<sup>87</sup>*



\*Indicates lower incidence of planned inductions or C-sections

Note: Findings are relative to other Medicaid participants with similar characteristics

### 4.3. Integrate Maternal Behavioral Health Screenings in Prenatal, Postpartum, and Pediatric Care Services.

For low-income mothers, rates of depressive symptoms are reported to be between 40 and 65 percent,<sup>88</sup> and Medicaid-enrolled pregnant women are more likely to need substance use disorder treatment than pregnant women with all other forms of coverage.<sup>89</sup> Across all models of care, integrating behavioral health screenings for expectant and new moms and connecting them with the appropriate services is critical to improving outcomes.<sup>90</sup>

State Medicaid agencies can drive behavioral health services integration by requiring or incentivizing providers to use standardized screening tools and by providing enhanced payments to providers who address behavioral health needs as part of prenatal care, postpartum care, and well-child visits. For example, North Carolina Pregnancy Medical Home providers receive \$50 for completing its high-risk screening tool at the initial prenatal visit and \$150 for completing each postpartum visit.<sup>94</sup> States also can increase base payment rates—an approach that the majority of states have used to improve access to substance use disorder treatment in response to the ongoing opioid crisis.<sup>95</sup> Provider reimbursement increases can apply to targeted services for pregnant and postpartum women or more broadly to all Medicaid populations.

In large part because postpartum women are more likely to attend visits for their baby than visits for their own health,<sup>96,97</sup> the well-child care schedule provides a crucial opportunity for providers to conduct screenings for behavioral health needs and, as needed, to provide services to the mother or connect her to the right resources. In 2016, CMS issued an informational bulletin on maternal depression screening and treatment, clarifying that states may cover depression screenings for the mother as part of the EPSDT well-child visit. Illinois covers perinatal depression screenings when an approved screening tool is used. If the postpartum depression screening occurs during a well-child visit or an episodic visit for a Medicaid-enrolled infant, providers may bill the service as a “risk assessment” under the infant’s Medicaid identification number. Alternatively, if the mother is enrolled in Medicaid, Illinois Medicaid providers may bill the postpartum depression under her Medicaid identification number.

CMS clarified in its 2016 guidance that, in the event the provider identifies a problem, diagnostic and treatment services exclusively for the mother are covered by Medicaid only if the mother is Medicaid-enrolled. Non-Medicaid-eligible mothers may receive some benefit from services directed at treating the health and well-being of the child (e.g., family therapy services). States interested in promoting providers’ use of the well-child visit to screen postpartum women for behavioral health treatment needs will want to collaborate with delivery system partners to address common provider challenges. Providers may be reluctant to screen patients to whom they are unable to provide comprehensive treatment, and may feel that they lack the appropriate resources or training to address her needs. At minimum, states can equip primary care providers and pediatricians with referral protocols and information about what treatment services are available to women who are identified as needing treatment.<sup>98</sup> States seeking to increase behavioral health screenings and treatment for postpartum women also may consider increasing reimbursement for behavioral health services delivered to postpartum women as part of the EPSDT well-child visit.

## 5. Quality Improvement

Improving the quality of maternity care requires data to monitor outcomes, design interventions, and assess the effectiveness of those interventions over time.

**5.1. Prioritize Engagement in Statewide Maternal Health Quality Improvement Initiatives.** The United States is behind most other developed countries in establishing the infrastructures to collect and assess maternal mortality and morbidity data, and, states’ ability to measure and assess maternal mortality and morbidity vary considerably.<sup>99</sup> Congress in December 2018 passed the Maternal Deaths Act to support states with maternal mortality review

New Jersey requires<sup>91</sup> providers to complete a standardized Perinatal Screening, Risk Assessment and Referral Form<sup>92</sup> during a Medicaid enrollee’s first prenatal care visit. The form includes screenings related to a range of factors impacting maternal health, including social risk factors such as homelessness and transportation problems. Such tools can be used to increase communication and collaboration between prenatal care providers and state and community agencies serving pregnant women.<sup>93</sup>



committees (MMRCs). In states that have—or are establishing—MMRCs or other statewide infrastructures and processes to assess maternal outcomes data, Medicaid agencies can be key partners in these efforts.

An important factor for state Medicaid agencies to keep in mind when assessing opportunities to build upon these efforts is that MMRCs vary in the degree to which they assess disparities in outcomes. Medicaid can contribute to data analysis and reporting efforts, help shape policies and recommendations, and implement recommendations through the Medicaid program—which, in most states, covers more pregnant women than other sources of coverage. State Medicaid agencies also can bolster statewide processes by developing their own distinct procedures for measuring and assessing disparities—particularly among women of color and women living in rural areas, who are known to have poorer outcomes nationally. When developing these initiatives, State Medicaid agencies should aim to include consumer perspectives, including by identifying opportunities to work collaboratively with community-based partner organizations focused on these challenges and the consumer perspective.

The California Maternal Quality Care Collaborative (CMQCC) is a multi-stakeholder organization that uses research, quality improvement toolkits, statewide collaboratives, and its Maternal Data Center to improve outcomes. Since CMQCC's inception, maternal mortality in California has declined by 55 percent. Membership includes the California Department of Health Care Services (which oversees Medicaid), the state's public health department, providers, and consumer advocates. Similarly, Illinois' Medicaid Mortality Review Committee was the driving force behind the state's initiative to extend Medicaid eligibility for postpartum women from 60 days to 12 months.<sup>100</sup>

**5.2. Measure, Report, and Assess Maternal Care Measures for Outcomes Disparities.** A clear starting point for state Medicaid agency data collection and reporting on maternal health is the CMS Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (the “Maternity Core Set”). This measure set includes rates of elective deliveries (prior to 39 weeks' gestation), rates of cesarean section deliveries, live births weighing less than 2,500 grams, measures of timeliness of prenatal care and receipt of postpartum care, and contraceptive care measures.<sup>101</sup> States can build on this set of measures with other priority measures, such as two new Healthcare Effectiveness Data and Information Set (HEDIS) measures for prenatal and postpartum depression screening and follow-up.<sup>102,103</sup> Further, given compelling evidence of disparities in maternal health outcomes, states can use these and other measures to assess outcome disparities. Measuring disparities requires states to assess the quality of existing data, and often improve their demographic data in particular. In 2011, the U.S. Department of Health and Human Services issued implementation guidance on minimum data collection standards for race, ethnicity, sex, primary language, and disability status.<sup>104</sup> State Medicaid agencies can build upon these standards through the collection of more granular ethnicity data, and can partner with stakeholders including health plans, providers, and public health departments to coordinate data collection approaches to ensure accurate reporting of uniformly categorized race and ethnicity data.<sup>105</sup>

## Conclusion

As the source of health coverage and health care for nearly half of all births in the United States, Medicaid is the linchpin in states' efforts to reduce maternal mortality and morbidity, and disparities in maternal outcomes. Potential Medicaid solutions to combating this public health crisis are comprehensive and crosscut nearly all aspects of Medicaid program policy and operations including coverage, enrollment, benefits, delivery of care, and quality. While all strategies will not be workable in all states, and their implementation will depend on state-specific dynamics, the breadth and depth of the tools to improve maternal health outcomes that are at the disposal of state Medicaid agencies is striking.

Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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## Endnotes

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