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What's at Stake

For more than two years, states have maintained coverage of their Medicaid enrollees as a condition of receiving enhanced federal Medicaid funding under the [Families First Coronavirus Response Act](#), resulting in considerable increases in coverage for all Americans, including pregnant and postpartum individuals. From February 2020 to January 2022, Medicaid and Children's Health Insurance Program (CHIP) program enrollment among pregnant individuals [increased](#) by 67% (or 682,000 enrollees)—more than twice the rate of any other eligibility group (with the exception of the adult expansion group, which increased by about 40%). Enrollment growth among individuals in the Medicaid and CHIP pregnancy eligibility groups is expected to continue as a result of the new state option to extend postpartum coverage to 12 months, authorized by the American Rescue Plan Act of 2021 (ARP). When the federal Medicaid continuous coverage requirement expires, which as of this writing is expected to be January 31, 2023 or later, states will redetermine eligibility for nearly all Medicaid enrollees, including roughly [1.7 million](#) people enrolled in a Medicaid or CHIP pregnancy eligibility group.¹ This unprecedented volume of eligibility redeterminations within a condensed period of time will increase the risk of coverage loss among people eligible for Medicaid/CHIP or subsidized Marketplace coverage, including for procedural and administrative reasons.

Large-scale disruptions in coverage and care at the end of the public health emergency (PHE) would jeopardize the health and wellbeing of postpartum individuals and their infants—placing people of color, who are [overrepresented](#) in the Medicaid program, at highest risk of harm. Indeed, a substantial body of research has established health coverage during the intensely vulnerable postpartum period as critical to addressing poor maternal and infant health [outcomes](#) and reducing racial and ethnic [disparities](#) in outcomes. Despite the majority of [maternal deaths](#) being preventable, over 850 individuals died in 2020 in the United States as a result of pregnancy or delivery complications; and Black mothers are nearly three times more likely to die than their White counterparts (accounting for about one-third of all maternal deaths nationally). The potential for loss of Medicaid/CHIP coverage and the compounding effect on people of color comes with even greater risk of harm in the wake of the June 2022 Supreme Court ruling, [Dobbs v. Jackson Women's Health Organization](#). Medicaid is the major source of reproductive healthcare services in the country, including postpartum care, [accounting](#) for 75% of all public expenditures for family planning services and covering close to half of all births. As the need for comprehensive family planning, pregnancy services, and postpartum care increases across the nation, continuity of Medicaid coverage becomes even more crucial.

This issue brief reviews proactive strategies that states can deploy to support postpartum individuals in maintaining health coverage and access to care when the Medicaid continuous coverage guarantee ends and beyond.

Strategies to Protect Coverage and Ensure Access to Care

Expand Medicaid Eligibility Levels, Postpartum Period, and Eligible Populations. States have a variety of Medicaid authorities through which they may expand coverage for pregnant and postpartum people:

- **Expanding Medicaid** under the Affordable Care Act can ensure comprehensive [access to care](#) for all individuals with incomes up to 138% of the federal poverty level (FPL), which is critical for individuals at the end of their postpartum period. A growing body of research continues to demonstrate the positive impacts of providing continued Medicaid coverage before and after pregnancy to mothers who are eligible for the new adult group—including lower [maternal](#) and [infant](#) mortality rates. The enactment of ARP in 2021 made the [fiscal case](#) for

¹ Currently, the federal PHE is in effect through October 12, 2022 per the July 15 [renewal notice](#).

expansion even stronger, by providing states that implement expansion any time after March 11, 2021 with a two-year, five percentage point increase in the federal matching rate for most state Medicaid expenditures. Making this change as soon as possible positions states to provide an affordable health coverage option for a large majority of people who will otherwise lose Medicaid coverage at the end of the PHE.

- States can also **evaluate** and **expand current income eligibility levels** beyond the federally-required minimum (138% of the FPL) for their Medicaid pregnancy eligibility groups to meet the needs of as many residents as possible who would otherwise lose Medicaid at the end of the PHE (and beyond). The District of Columbia, for example, covers pregnant people in Medicaid with incomes up to 324% of the FPL.
- States that have not yet taken up **ARP's state option to implement 12-months continuous postpartum coverage** should consider doing so prior to the end of the PHE.² Extending coverage from 60 days to 12 months reduces the likelihood that individuals will lose coverage for failure to respond to requests for information and/or submit a renewal form—either because they moved or because they cannot or do not respond in a timely way. These same individuals may experience challenges applying for and finding affordable Marketplace coverage, creating gaps in coverage and care. As of August 2022, 21 states (and the District of Columbia) have obtained approval from the Centers for Medicare & Medicaid Services (CMS) to extend 12-month postpartum coverage, and several other states have proposals pending.
- States can also **expand pregnant and postpartum coverage to immigrant populations who lack access to affordable coverage**, including maximizing federal funding available under **CHIPRA 214** and the **CHIP coverage option** for pregnant immigrants and their children (referred to federally as the “unborn child” option). The latter can be paired with a CHIP Health Services Initiative to offer 12-month postpartum coverage (as **Illinois** has done). States can deploy **state-funded** Medicaid/CHIP-based or comparable coverage programs to address the remaining gaps in insurance for uninsured immigrants.

In addition to expanding coverage through the above listed strategies, states can take several steps in planning for PHE unwinding to maximize coverage for people who are enrolled today in the pregnancy eligibility group.

Strategically Sequence Redeterminations. States may consider staging redeterminations post-PHE to support coverage continuity and help postpartum people maintain access to essential healthcare services.³ For example:

- States that are planning to implement **ARP's state option** can time renewals of people in the pregnancy eligibility group to dovetail with the implementation of expanded postpartum coverage.
- All states can sequence redeterminations of people in the pregnancy eligibility group later to keep high-risk postpartum people enrolled in coverage for as long as possible.

For additional information on staging redeterminations, see these State Health and Value Strategies (SHVS) expert perspectives, *Ensuring Continuity of Coverage and Care for High Need Enrollees When the Medicaid Continuous Coverage Ends: Medicaid Strategies* and *State Strategies for Sequencing Enrollee Communications When Medicaid Continuous Coverage Ends*.

² Under the ARP state option, states may extend continuous postpartum coverage for a 12-month period, effective on or after April 1, 2022. States may also extend postpartum coverage through a section 1115 demonstration. Under 1115 authority, states have more flexibility than is provided under ARP (e.g., states may request that the duration of the extended postpartum coverage period be more or less than 12 months, states may select the implementation date, and benefits can be more or less robust).

³ Per CMS State Health Official Letter # 22-001, states are expected to adopt a “**risk-based approach**” when prioritizing pending eligibility and enrollment actions.

Conduct Enhanced Outreach and Targeted Communications. States can target outreach and tailor their communications to help postpartum people maintain coverage. For example, states can:

- Develop specialized outreach processes where eligibility workers follow-up by telephone if an individual has not responded to a request for information.
- Provide longer timeframes for postpartum people to respond to requests for information to complete renewal processes or transition to new sources of coverage.
- Offer enhanced renewal assistance through state or county eligibility offices, managed care plans, and Navigators/assisters.
- Work with **community partners** (e.g., community health workers, faith-based organizations) that have strong relationships with pregnant and postpartum enrollees and can serve as trusted messengers to communicate information in culturally and linguistically appropriate ways about updating contact information and forthcoming actions individuals need to take to keep coverage.

Redetermine Eligibility for Other Medicaid Eligibility Categories and Ensure Seamless Transitions to Marketplace Coverage. Federal regulations require that, upon the end of the PHE, all individuals must have their eligibility redetermined to see if they are eligible for another Medicaid or CHIP eligibility group.⁴ States should only conduct a **redetermination** of eligibility for individuals in the pregnancy eligibility group at the expected end of their continuous postpartum period (whether 60 days or 12 months). If a postpartum individual is not eligible for another Medicaid/CHIP eligibility group upon redetermination, states are required to seamlessly transition their eligibility information to the federally-facilitated Marketplace or State-Based Marketplace (SBM). State Medicaid agencies can flag for their SBMs these individuals as requiring specialized Marketplace and Navigator/assister support. This process could include data sharing between Medicaid and the Marketplace to map individuals to qualified health plans, networks, and specialized providers (e.g., OB/GYNs, certified nurse midwives, community health workers) that meet

For more information on ways SBMs can help mitigate disruptions to coverage and care, see this SHVS expert perspective, *Ensuring Continuity of Care for Individuals Transitioning from Medicaid to Marketplace: Post-PHE Considerations for States*.

their specific needs. CMS has **clarified** that state Medicaid/CHIP agencies are permitted to transfer accounts to the SBM for individuals whose eligibility has been denied for procedural reasons (e.g., failure to respond to requests for information and/or submit a renewal form). CMS also encourages state agencies to (1) exchange information about individuals who have been procedurally terminated, and (2) develop joint messaging and outreach urging individuals to take action to enroll in coverage.

Mitigate Procedural Denials.⁵ To minimize the number of postpartum people who are denied for procedural reasons, states can leverage the host of policy and operational strategies established by CMS that apply to Medicaid and CHIP enrollees broadly. Foundational to preserving coverage post-PHE is ensuring states have updated contact information, increasing the percentage of redeterminations that states are able to process *ex-parte* (i.e., based entirely on available data sources), and conducting enhanced outreach through multiple modalities (e.g., text, telephone, email, via an online account).

⁴ 42 C.F.R. 435.916(f); 42 C.F.R. 435.930(b); and 42 C.F.R. 457.350(b).

⁵ Procedural denials occur when potentially eligible individuals fail to respond to a state Medicaid/CHIP agency's request for additional information as part of the redetermination process.

Conclusion

The country has made major strides in addressing disparate pregnancy and postpartum health access by closing gaps in Medicaid and CHIP coverage, and there is more work to do to eliminate the stark racial and ethnic disparities in maternal and infant health outcomes. The looming end of the federal PHE is a seismic health coverage event that threatens continued progress in coverage and access to care for pregnant/postpartum individuals and their infants, especially for people of color. Given these high stakes, it will be essential for federal and state policymakers to use all levers at their disposal to ensure continuity of coverage and care for pregnant and postpartum people at the end of the PHE. With the extension of the PHE to at least January 2023, and perhaps longer, states have time to effectuate these strategies and an opportunity to positively impact the lifelong health and wellbeing of postpartum people, their infants, and families.

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