# State Strategies to Improve Maternal Health and Promote Health Equity Compendium

*Prepared by Manatt Health*

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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## Context

Despite new data from the Centers for Disease Control and Prevention (CDC) establishing four out of five pregnancy-related deaths as preventable, more than 860 individuals died in 2020 in the United States as a result of complications while pregnant, during delivery, or within the first year after delivery. Among the leading causes of maternal mortality are behavioral health conditions (including deaths from suicide and overdose), hemorrhage, and cardiac and coronary conditions. The CDC data also exposed stark disparities, with pregnancy-related deaths disproportionally occurring among American Indian and Alaska Native and Black mothers.[1] Similarly, rates of maternal morbidity (or unexpected outcomes of labor and delivery resulting in significant consequences to a mother's health) in the United States are increasing and disproportionately impacting mothers of color. These findings, along with the fact that more than half of pregnancy-related deaths occur between one week and one year after delivery, underscore the need for comprehensive pregnancy and postpartum care.

Given the outsized role of Medicaid in maternal health—accounting for 75% of all public expenditures for family planning services and covering close to half of all births nationally—state policymakers have both a moral imperative and major opportunity to improve and protect the health and well-being of their pregnant/postpartum residents and their infants and families. The need to take action has grown more urgent with the looming end of the federal public health emergency threating access to coverage and care for the roughly 1.7 million people currently enrolled in the Medicaid or Children's Health Insurance Program (CHIP) pregnant eligibility group, of which people of color are overrepresented and therefore at higher risk for harm. Given these high stakes, states are considering the various levers at their disposal to ensure continuity of coverage and care for pregnant and postpartum people at the end of the Medicaid continuous coverage guarantee—but also to improve maternal health outcomes and center health equity more broadly.

## Compendium Overview

The following compendium provides information on strategies to improve maternal health outcomes and synthesizes research about the national state-of-play, including state examples, across four domains: maternal health models, quality improvement, workforce and benefits, and eligibility and enrollment/coverage expansion. This resource builds on a September 2022 maternal health roundtable convened by State Health and Value Strategies (SHVS) and Manatt Health with California, Louisiana, Maryland, Minnesota, and Tennessee. As such, the five participating states are heavily represented in our discussion of the types of programs, care delivery models, and activities that states can deploy to improve maternal health outcomes and advance health equity. We also describe other leading state efforts and promising practices.

While this compendium is intended to serve as an accessible source of information for state Medicaid/CHIP agencies (as well as their partners) interested in exploring or already implementing strategies to address the maternal health crisis, it is important to acknowledge that the strategies listed herein are (1) not exhaustive, but rather based on research into discrete state models and input from the roundtable; and (2) not applicable in all states, given state-specific characteristics and considerations.

As a reminder, the SHVS technical assistance team is available to provide technical assistance for states related to maternal health. SHVS has published several resources related to improving maternal health outcomes, including:

- An issue brief on the American Rescue Plan Act's (ARP's) option to extend postpartum coverage;
- An issue brief focused specifically on actions Medicaid agencies can pursue through their managed care programs or directly with provider organizations to promote health equity and improve birth-related health outcomes; and
- An issue brief that outlines strategies states can deploy to help postpartum individuals maintain health coverage and access to care when the Medicaid continuous coverage guarantee ends and beyond.

| Strategy | Overview | National State-of-Play and State Examples |
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| ***Maternal Health Models*** | | |
| Care Delivery Models and Programs | State Medicaid/CHIP agencies are adopting maternity care delivery models and programs aimed at improving maternal health outcomes, for example:<br>• Pregnancy Medical Homes (PMHs): A care delivery model that addresses clinical, behavioral, and social aspects of prenatal, perinatal, and postpartum care.<br>• Group Prenatal Care: Prenatal care provided in a group setting, enhanced with health education and facilitated discussion.<br>• Maternal Opioid Misuse (MOM) Model: A Center for Medicare & Medicaid (CMMI) model that addresses fragmentation in the care of pregnant and postpartum Medicaid enrollees with opioid use disorder (OUD) through state-driven transformation of the delivery system. | • **North Carolina's** PMH model, launched by the Medicaid agency in partnership with a primary care case management entity, seeks to improve birth outcomes and maternity care for Medicaid enrollees by standardizing care for specific conditions, including obesity, hypertensive disorders, substance use disorder (SUD), and progesterone treatment. Care managers support pregnant people by telephone, during prenatal office visits, at home, or in the community and help with medication management, transportation, and referrals to childbirth and breastfeeding classes. States such as **Texas and Wisconsin** also have implemented PMHs.<br>• **Maryland and New Jersey** Medicaid participate in a group prenatal care model, the Centering Pregnancy Model, in which facilitators lead a cohort of eight to 10 individuals of similar gestational ages through interactive group discussion sessions that cover medical and non-medical aspects of pregnancy—e.g., nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care.<br>• CMMI is supporting awardees in several states—including **Colorado, Indiana, Maine, Maryland, New Hampshire, Tennessee, Texas, and West Virginia**—with implementation of the MOM Model in Medicaid. **Tennessee's** model provides prenatal mental health, infectious disease and substance use disorder treatment services for pregnant people, in-hospital supports, and targeted discharge services (e.g. relapse prevention, substance use disorder treatment, nurse home visiting). **Maryland** launched its model in 2020 and works with managed care organizations (MCOs) and stakeholders to improve case management practices, bolster health information technology, and strengthen provider capacity throughout the state.<br>*For more information on state care delivery models, see this Commonwealth Fund resource and this Medicaid and CHIP Payment and Access Commission (MACPAC) inventory.* |

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| Payment Models | States also utilize payment models in Medicaid and CHIP to increase access to pregnancy-related and postpartum care, and to incentivize providers to improve maternal health outcomes. For example:<br>• Maternity Payment Bundle: A comprehensive payment for all of the services provided during an episode of pregnancy-related care. Providers may be financially rewarded or accountable depending on if costs are lower or higher than the bundled payment rate or a predetermined threshold.<br>• Episodes of Care: A payment model that creates payment incentives to manage costs and quality across a set of services, focusing on the provider with the greatest role in delivering these services.<br>• Blended Payments: A payment model that combines cesarean and vaginal birth reimbursement rates into a combined case rate for hospitals.<br>• Pay-for-Performance (P4P): A provider incentive to meet certain quality goals. If providers perform well on a given set of measures, they receive a financial reward. Payments are calculated retrospectively based on past performance and may include downside risk if thresholds are not met.<br>• Reduced or Non-Payment Policies: A strategy where states reduce payments or do not cover procedures, such as early elective deliveries, elective inductions, or cesarean sections that are not medically indicated. | • **Colorado** has a voluntary Maternity Bundled Payment program that holds participating Medicaid providers accountable for the cost and quality of care for the entire perinatal episode.<br>• **Tennessee's** Perinatal Episodes of Care Payment Model subjects accountable providers (i.e., the individual or group practice performing a delivery) to gainsharing and risk-sharing payments based on cost and quality. The model is applied retrospectively, and providers receive fee-for-service (FFS) payments from the MCO for perinatal services delivered throughout the enrollee's pregnancy, delivery, and postpartum period. Tennessee also offers a blended payment—or single payment for delivery, regardless of whether it was cesarean or vaginal.<br>• **California** offers several P4P programs, including the Comprehensive Perinatal Services Program, Public Hospital Redesign and Incentives in Medi-Cal program, and incentive payments for meeting quality measure goals.<br>• Under the Medicaid Quality Incentive Program, **Washington** hospitals may earn a 1% incentive payment. The program has maternal-related measures, including to reduce early elective deliveries. The incentive is paid by Washington State Health Care Authority.<br>• In **Louisiana**, Medicaid will not reimburse for induced deliveries and cesarean sections if performed before 39 weeks' gestation, except when these procedures are indicated by a documented medical condition.<br>• **Minnesota's** Integrated Health Partnerships accountable care organization payment model provides MCOs population-based payment for care coordination and requires them to implement interventions to address healthcare disparities, including those related to maternal health. Minnesota also has in place reduced/non-payment policies.<br><br>*For more information on state payment models, see this Commonwealth Fund resource and this MACPAC inventory.* |

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| ***Quality Improvement*** | | |
| Maternal Mortality Review Committees | States may establish Maternal Mortality Review Committees, which may be funded by the CDC and Title V Maternal and Child Health (MCH) Services Block Grants, or have a state statutory requirement to investigate pregnancy-related deaths and guide decisions and policymaking to prevent future deaths.<br><br>Notably, the new CDC data showing that more than 80% of pregnancy-related deaths in the United States are preventable was collected from Maternal Mortality Review Committees in 36 states between 2017 and 2019. | • Nearly all states have Maternal Mortality Review Committees.<br>  • The majority of committees review deaths that occur up to one year postpartum and must follow data and confidentiality protocols, and adhere to reporting requirements.<br>  • Almost one-third of states are required to determine if a pregnancy-related death was preventable.<br>  • 10 states consider racial disparities and equity in conducting their reviews.<br>  • Most states require multidisciplinary committee membership, such as representation of behavioral health, doulas, nurses, Tribes, and patients or family members affected by a death.<br>• The **Louisiana** Pregnancy-Associated Morality Review reviews all pregnancy-associated deaths and develops recommendations.<br>• **North Carolina's** Maternal Mortality Review Committee is composed of an interdisciplinary team with statewide representatives. The committee instituted an enhanced linkage process that includes computerized datasets: death, birth and fetal death certificate files, and the statewide computerized hospital discharge database.<br>• **Maryland**, **Minnesota**, and **Tennessee** also have Maternal Mortality Review Committees, and emphasize the importance of having patients or family members affected by a death and/or served by the program represented on the committee. **Maryland** also has a multi-pronged initiative, the Maternal Health Innovation Program, that involves statewide population and hospital-based identification and review of factors that lead to maternal morbidity and mortality; and the state has implemented a Severe Maternal Morbidity indicator. |

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| Quality Improvement Initiatives | States have established various quality improvement initiatives aimed at addressing maternal and infant health outcomes, such as:<br>• Medicaid/CHIP quality measures.<br>• Medicaid/CHIP performance improvement projects (PIPs) in Medicaid managed care (MMC) (e.g., to increase early initiation of or improve prenatal care, increase rates of postpartum visits, screen for maternal depression, improve referrals for SUD).<br>• CDC Perinatal Quality Collaborative (PQC): State or multistate networks of teams working to improve the quality of care for mothers and infants by providing opportunities for collaborative learning, rapid response data, and quality improvement to achieve systems-level change.<br>• Designations (e.g., "Birthing Friendly") to incentivize providers.[2] | • About half of states monitor or report state-level metrics related to maternal health (e.g., the CMS measures for Medicaid/CHIP). Most states also require MCOs to report maternity-related quality measures to the state.<br>• **Maryland's** MCOs implement PIPs focused on providing education and case management for pregnant and postpartum members. **Tennessee** similarly requires its MCOs to implement PIPs related to child or perinatal health. **Minnesota's** 2021 to 2023 PIP topic is Healthy Start for Mothers and Their Children (for the Families and Children contract).<br>• **Louisiana's** PQC provides support to hospitals for continuous quality improvement on perinatal outcomes, including work focused on: breastfeeding and infant nutrition; reducing maternal mortality through the Safe Births initiative; and improving the identification, care, and treatment of birthing persons and newborns affected by SUD. Also through the PQC, Louisiana updated their maternal health standards of care to more closely align with federal guidelines. Further, Louisiana recognizes hospitals that have committed to practices that improve quality and outcomes for individuals giving birth through the "Birth Ready Designation." To achieve the designation, facilities must meet criteria, including promoting patient partnership and addressing health disparities and equity. **Minnesota's** PQC seeks to improve perinatal and infant health outcomes with an emphasis on improving health equity for all birthing people. |

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| ***Workforce and Benefits*** | | |
| Reimbursement of Providers Shown to Improve Birth Outcomes | States are taking steps to improve outcomes by providing sustainable and equitable Medicaid reimbursement for diverse provider types, including:<br>• Community-Based Doulas (and Other Peer-Support Providers and Community Health Workers): Trusted individuals, often from local communities, trained to act as patient advocates and provide psychosocial, emotional, and educational support during pregnancy, childbirth, and the postpartum period.<br>• Licensed Midwives: Practitioners that provide reproductive healthcare and attend births in multiple settings (e.g., at home, a birth center, the hospital). They help people identify their labor preferences and the appropriate site of delivery. Licensed midwives are an optional Medicaid benefit that allows coverage of midwives who are not registered professional nurses, but are otherwise licensed by the state to furnish midwifery services. (Note that nurse-midwife services are a mandatory benefit described at 42 CFR 440.165.)<br>• Freestanding Birth Centers: Midwifery-led stand-alone facilities that provide prenatal and labor and delivery care. Section 2301 of the Affordable Care Act requires states that recognize freestanding birth centers in their state to provide coverage/reimbursement for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center, to the extent the state licenses or otherwise recognizes such providers under state law.[3] | • Many states, such as **Maryland** and **Minnesota**, have approved state plan amendments (SPAs) in place to cover doula services in Medicaid; others are actively working through the implementation process. **Louisiana** established the Louisiana Doula Registry Board (under the Louisiana Department of Health) that will create a registry for doulas seeking reimbursement. **California's** doula benefit will begin in January 2023 (originally the state proposed $450 per birth but revised the budget to provide $1,094 per birth).<br>• Trauma-informed peer support providers in **Ohio** help individuals through pregnancy and motherhood. **California**, **Maryland**, and **Tennessee** also utilize community health workers.<br>• States such as **California**, **Louisiana**, and **Minnesota** provide Medicaid reimbursement for licensed midwives.<br>• As of 2020, approximately two-thirds of states offered Medicaid coverage for freestanding birth centers.<br><br>Beyond Medicaid reimbursement, states are providing funding to build the obstetric care workforce, particularly in rural areas that have limited obstetric care capacity, for example:<br>• **California's** 2022-2023 budget includes $1.5 billion in investments over the next three years to strengthen and expand the healthcare workforce (to include certified nurse midwives and other primary care/reproductive health workers).<br>• **Minnesota's** 2022-2023 budget includes a funding expansion for community health workers and other maternal health investments (Healthy Beginnings, Healthy Families).<br>• **Montana** deployed $9.6 million in grants to fund the Montana Obstetric and Maternal Support Program, which aims to improve maternal health in rural areas through telehealth innovations.<br>• The Health Resource Services Administration (HRSA) awarded **Iowa** $10 million over five years to execute innovative strategies to address maternal health. The state utilized funding to address workforce shortages and expand telemedicine initiatives to increase access to maternal fetal medicine specialists and mental health professionals. |

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| Enhanced Services | States are covering evidence-based services to improve access to and continuity of care for pregnant and postpartum people enrolled in Medicaid/CHIP. Benefits can include:<br>• Home visiting, wherein states have significant flexibility in benefit design and financing.[4] The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program represents the largest source of federal investment in home visiting. To supplement this funding, states leverage other federal, state, local, and private funding sources. (Notably, home visiting is not a covered benefit under Medicaid, but states can use Medicaid to fund some components of it—e.g., assessments, referrals, care planning/monitoring—by leveraging a variety of authorities.)<br>• Enhanced dental services, recognizing states have flexibility to determine what dental benefits are provided to adult Medicaid enrollees through their state plans. States have used section 1115 waiver authority to provide different (more robust) dental benefits to pregnant people.<br>• Social services, such as transportation, child care, housing provided through a variety of Medicaid authorities. | • **California's** CalWORKs Home Visiting Program, administered by counties, provides prenatal, infant and toddler care; infant and child nutrition; child developmental screening and assessments; parent education, parent and child interaction, child development, and child care; job readiness and barrier removal; and domestic violence and sexual assault, mental health, and SUD treatment.<br>• **Maryland's** governor launched in 2021 a $72 million maternal and child healthcare transformation initiative to fund expansion of current maternal health-focused programs/services (e.g., home visiting services, Healthy Steps, CenteringPregnancy).<br>• **Oregon** uses section 1115 waiver authority to provide dental services to most adults, and to provide more robust dental services to pregnant people. **Maryland**, **Minnesota** and **Louisiana** also offer dental benefits for pregnant people. *See more information on Medicaid adult dental benefits coverage by state linked here.*<br>• **Medi-Cal's** Enhanced Care Management (ECM) Benefit supports payment for care management activities related to social and behavioral health needs, including referral to Community Supports (14 services that MCOs may provide that address health-related social needs). States such as **North Carolina** and **Washington** have also submitted section 1115 waivers to cover services that address social needs for qualifying Medicaid enrollees, tackling social drivers of health to address poor health outcomes. |

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| Addressing Racism in the Healthcare Workforce | To address institutionalized racism in the healthcare workforce, state agencies are:<br>• Establishing and requiring implicit bias/ racism training as well as cultural competency standards for providers and health plans.<br>• Making changes to clinical algorithms and diagnostic tools for biases and inaccuracies.[5]<br>• Prioritizing community and stakeholder engagement to improve health outcomes. | • **California** requires hospitals and birth facilities to implement evidence-based implicit bias programs for all healthcare providers involved in the perinatal care continuum. *(See more on provider bias training linked here.)*<br>• **Colorado** requires providers participating in its Maternity Bundles Payment Program to complete cultural competency training, including "the importance of racial congruence between patients and providers, and hiring and retention strategies for maintaining a diverse staff."<br>• **Maryland** requires all healthcare practitioners to attest that they have completed an implicit bias training program on their license renewal application.<br>• **Minnesota** passed the Dignity in Pregnancy and Childbirth Act in 2021, which requires hospitals that provide obstetric care and birth centers to offer continuing education/training on implicit bias and anti-racism.<br>• **D.C.** qualified health plans review and address clinical algorithms and diagnostic tools for biases (e.g., the Adjusted Glomerular Filtration Rate results in Black individuals getting delayed medical intervention for kidney disease and delays or not qualifying for kidney transplants).<br>• The Birth Outcomes Initiative effort by the **South Carolina** Department of Health and Human Services, South Carolina Hospital Association, Blue Cross Blue Shield of South Carolina, South Carolina Department of Health and Environmental Control, March of Dimes, and over 100 stakeholders aims to improve the health outcomes for all moms and babies. |
| ***Eligibility and Enrollment/Coverage Expansion*** | | |
| Eligibility Expansions | States can evaluate and expand current income eligibility levels beyond the federally-required minimum [138% of the federal poverty level (FPL)] for their Medicaid pregnancy eligibility group. | • **D.C.** covers pregnant people up to 324% of the FPL.<br>• **Minnesota** covers pregnant people up to 283% of the FPL.<br>• **Maryland** covers pregnant people up to 264% of the FPL.<br>• **California** covers pregnant people up to 213% of the FPL.<br>• **Tennessee** covers pregnant people up to 200% of the FPL.<br>• **Louisiana** covers pregnant people up to 138% of the FPL. |

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| Streamlined Enrollment[6] | Presumptive Eligibility: Enables healthcare providers and other qualified entities[7] to provide pregnant people (and other groups) access to Medicaid/CHIP services without having to wait for their application to be fully processed. | • 30 states offered presumptive eligibility to pregnant people as of January 2020.<br>• **California's** Presumptive Eligibility for Pregnant Women (PE4PW) program grants immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy. Qualified providers may utilize telephonic signatures for PE4PW applications in light of COVID-19. |
| | Express Lane Eligibility (ELE): Allows states to rely on eligibility information from "Express Lane" agency programs[8] to streamline and simplify enrollment and renewal in Medicaid and CHIP for children (and potentially adults via section 1115 authority)—including those who are pregnant. | • As of August 2021, **Alabama**, **Colorado**, **Iowa**, **Louisiana**, **Massachusetts**, **South Carolina**, and **South Dakota** are implementing this strategy in Medicaid and/or CHIP. **Louisiana** provides ELE for Medicaid populations and allows streamlined enrollment from the Supplemental Nutrition Assistance Program (SNAP) and the National School Lunch Program. In September 2012, **Massachusetts** implemented ELE at renewal for families enrolled in Medicaid/CHIP and SNAP. The state obtained authority from CMS to expand ELE to parents and caregivers and eventually to childless adults under the 1115 demonstration. According to an evaluation conducted from 2014 to 2017, the automated ELE process reduced the paperwork burden on families, kept eligible families enrolled in coverage, decreased churn, and mitigated the administrative burden of processing renewals. The full evaluation is available here. |
| | Targeted SNAP Enrollment SPA: Permits states to use SNAP (or other means tested benefits) information to facilitate Medicaid enrollment and renewal. Requires the identification of a subset of SNAP participants who are certain to be income-eligible and non-elderly, non-disabled (including those who are pregnant) into Medicaid; and identifies Modified Adjusted Gross Income (MAGI)-based eligibility criteria that states must apply to SNAP participants before enrollment in Medicaid.[9] *(See more information linked here.)* | • **Louisiana** received approval for a Targeted SNAP Enrollment SPA in 2016.<br>• **New York**, **Pennsylvania**, and **Virginia** also obtained SPA approval as of 2019 (New York for TANF findings, Pennsylvania for SNAP and Low Income Home Energy Assistance Program findings, and Virginia for SNAP findings). |
| 12-Months Continuous Postpartum Coverage | ARP established a new state option to extend Medicaid and CHIP coverage for pregnant individuals for one year following the baby's birth. States that take up this option (effective on or after April 1, 2022) must provide comprehensive benefits and continuous Medicaid/CHIP coverage throughout the 12-month postpartum period. | • As of October 2022, 34 states including D.C. have implemented or are planning to implement a 12-month postpartum extension, either through the ARP SPA option and/or a section 1115 demonstration.<br>• **Washington**, like **Virginia**, is pursuing section 1115 authority to go above and beyond the SPA option, seeking to cover populations not otherwise eligible under the SPA option.[10] |

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| Affordable Health Coverage for Immigrant Populations[11] | Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Section 214 makes available federal matching funds to provide Medicaid and CHIP coverage to "lawfully present" children and pregnant (and postpartum) individuals regardless of if they are subject to a five-year waiting period due to immigration status.[12] | • Most states have taken up this SPA option to cover Medicaid and CHIP pregnant individuals and/or children up to age 19 in CHIP or age 21 in Medicaid.<br>• **New Jersey** covers children (up to the respective age limits) and pregnant people in both Medicaid and CHIP.<br>• **California** covers CHIP kids; Medicaid kids and pregnant people.<br>• **Louisiana** covers CHIP kids; Medicaid kids (but only up to age 19).<br>• **Maryland** covers Medicaid kids and pregnant people (Maryland is a CHIP Medicaid expansion state).<br>• **Minnesota** covers CHIP kids; Medicaid kids and pregnant people. |
| | Affordable CHIP Coverage for Pregnant Immigrants and Their Children (federally referred to as the "unborn child" option) makes available federal funding to provide prenatal, labor and delivery, and postpartum services to pregnant individuals, regardless of immigration status, and their children. | • More than one-third of states have taken up this coverage option via a CHIP SPA.<br>• **California** covers up to 322% of the FPL.<br>• **Illinois** paired this option with a CHIP Health Services Initiative to offer *extended* postpartum coverage for 12 months. |
| | State-Funded Medicaid/CHIP-Based or Comparable Coverage Programs refers to affordable coverage programs for lower-income individuals (including pregnant and postpartum people) who do not qualify for federally funded coverage programs due to immigration status. | • States such as **California**, **D.C.**, **Illinois**, **Massachusetts**, **New York**, **Oregon**, and **Washington** have implemented state-funded Medicaid/CHIP-based or comparable coverage programs authorized via state legislation. **California** is covering children, young adults, adults, and older adults in an effort to provide universal coverage for low-income residents, regardless of immigration status, by 2024. |

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ABOUT MANATT HEALTH

This issue brief was prepared by Patricia Boozang, Linda Elam, Kaylee O'Connor, and Michelle Savuto. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit *https://www.manatt.com/Health*.

# ENDNOTES

1. Existing literature has shown that Black mothers are nearly three times more likely to die than their White counterparts (accounting for about one-third of all maternal deaths nationally).
2. In Fall 2023, CMS will establish a "Birthing-Friendly" hospital designation: a publicly-reported, public-facing hospital designation on the quality and safety of maternity care.
3. This authority gives specific reference to birth attendant services, which is interpreted to mean any non-licensed practitioner (such as lactation consultants, doulas, etc.) recognized by the state to provide prenatal, labor, and delivery or postpartum care in a freestanding birth center.
4. Home visiting programs can 1) promote maternal health by connecting mothers to postpartum medical care, mental health, SUD treatment, and community-based resources; 2) reduce mothers' stress levels by providing educational services such as lactation, nutrition, and parenting education; and 3) bring clinical services to mothers in their homes.
5. "Studies have identified significant racial bias in healthcare algorithms used to identify patients who would benefit from additional healthcare services and for medical decision-making. This results in people of color being less likely to (1) be eligible for intensive care management; and (2) receive timely diagnoses or appropriate care for heart failure, kidney disease, certain cancers and osteoporosis."
6. See this Center on Budget and Policy Priorities report, Opportunities to Streamline Enrollment Across Public Benefit Programs, for more information on cross-program enrollment and linkages.
7. A qualified entity is an entity determined by the state to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements. Qualified entities can include hospitals, community health centers, schools, and other entities.
8. Express Lane agencies may include SNAP, school lunch programs, Temporary Assistance for Needy Families (TANF), Head Start, and WIC, among others.
9. During the period of unwinding, states that obtain section 1902(e)(14) waiver approval may extend coverage for any individual who is eligible for SNAP, without conducting a separate MAGI redetermination and despite the differences in household composition and income counting rules.
10. Populations in Washington's waiver include individuals who apply for coverage past the 60 days postpartum period who were not previously enrolled in Medicaid or CHIP and individuals who receive pregnancy-related services under the CHIP "unborn child" option.
11. Lawfully present immigrants may qualify for Medicaid and CHIP but are subject to certain eligibility restrictions. In general, lawfully present immigrants must have a "qualified" immigration status to be eligible for Medicaid or CHIP, and many, including most lawful permanent residents or "green card" holders, must wait five years after obtaining qualified status before they may enroll. Noncitizens, including lawfully present and undocumented immigrants, are significantly more likely to be uninsured than citizens. Among the nonelderly population, 26% of lawfully present immigrants and ~42% of undocumented immigrants were uninsured compared to 8% of citizens.
12. Section 214 of CHIPRA does not permit the application of this option under CHIP only.