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Extending Postpartum Medicaid: State and Federal Policy Options During and After COVID-19

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Tracking Health Reform

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Abstract The United States is facing a maternal health crisis with rising rates of maternal mortality and morbidity and stark disparities in maternal outcomes by race and socioeconomic status. Among the efforts to address this issue, one policy proposal is gaining particular traction: extending the period of Medicaid eligibility for pregnant women beyond 60 days after childbirth. The authors examine the legislative and regulatory pathways most readily available for extending postpartum Medicaid, including their relative political, economic, and public health trade-offs. They also review the state and federal policy activity to date and discuss the impact of the COVID-19 pandemic on the prospects for policy change.

Keywords Medicaid, postpartum, maternal health, insurance

American women today are more likely to die from pregnancy-related causes than women in other high-income nations and their own mothers a generation before (CDC 2020; GBD 2015 Maternal Mortality Collaborators 2016). While many efforts to address poor maternal health outcomes in the US have focused on preventing deaths during labor and delivery, recent data have highlighted the need for interventions to lower the burden of morbidity and mortality among postpartum women. The US Centers for Disease Control and Prevention (CDC) estimates that one in three pregnancy-related deaths occur from one week to one year after delivery, and more than half are estimated to be preventable (CDC 2019). Postpartum deaths are the tip of the iceberg. Many more women experience

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morbidity from physical and mental health conditions in the year after childbirth, and severe postpartum morbidity has risen in the past decade (Creanga et al. 2014).

There is increased interest in leveraging Medicaid as a powerful policy tool in the effort to address the maternal health crisis, and to reduce postpartum morbidity and mortality in particular. Medicaid pays for nearly half of all US births and an even greater share of births to low-income women and women of color, who bear the majority of the burden of maternal morbidity and mortality (Martin, Hamilton, and Osterman 2018; Petersen, Davis, Goodman, and Cox 2019). Recent state estimates from Louisiana, Texas, and West Virginia have found that the majority of maternal deaths are among women with Medicaid coverage at delivery (62%, 69%, and 83%, respectively) (Kieltyka et al. 2018; Maternal Mortality and Morbidity Task Force 2018; Office of Maternal, Child and Family Health 2015). At present, women who qualify for Medicaid due to pregnancy lose their coverage 60 days after birth. Although some women will then qualify for Medicaid for other reasons (e.g., income, disability), others are forced to leave the program and risk becoming uninsured.

To address this gap in the Medicaid program, one policy proposal is gaining particular traction: extending the period of eligibility for pregnancy-related Medicaid coverage beyond 60 days after the end of pregnancy. The last year has seen a dramatic rise in bipartisan policy activity at both the federal and state levels to achieve this extension. Although no state has fully implemented a postpartum coverage extension, an unexpected test of this strategy is ongoing nationwide: During the COVID-19 public health emergency, states accepting extra federal Medicaid funds cannot terminate coverage for anyone enrolled in Medicaid (Families First Coronavirus Response Act, Pub. L. 116–27, 2020). The Centers for Medicare and Medicaid Services (CMS) has interpreted this requirement to include pregnant women who would typically lose coverage 60 days after the end of pregnancy. This legislation (detailed below) has achieved a de facto extension of Medicaid for postpartum women, but longer-term solutions are needed to ensure postpartum coverage once the emergency declaration is lifted.

We review the legislative and regulatory pathways available for extending postpartum Medicaid, including their relative political, economic, and administrative trade-offs. We also discuss the spate of state and federal policy activity to date and the impact of the COVID-19 pandemic on the prospects for policy change.

Current Status of Postpartum Medicaid

Pregnant women have been a mandatory population under the Medicaid program since its inception in 1965. Initially, pregnant women only qualified if they were also receiving federal cash assistance (e.g., through Aid to Families with Dependent Children or Supplementary Security Income). Congress subsequently broadened eligibility, as did states, and since 1990, federal statute has required states to provide Medicaid coverage for pregnant women with household incomes up to 133% of the federal poverty level (FPL). Many states eventually set income eligibility levels for pregnant women above this threshold (the state median is 205% FPL as of January 2020) (Brooks et al. 2020). During this formative policy period, the intention of many state expansions was to reduce high and rising rates of *infant* mortality (Schlesinger and Kronebusch 1990). The design of pregnancy Medicaid reflects this focus on infant risk: women are only insured during pregnancy and 60 days after birth, rather than during the full postpartum period of pregnancy-related risk. To remain insured after this time, new mothers must requalify for Medicaid under another eligibility category (e.g., as low-income parents) or find a private source of insurance. This is in contrast to infants who are born to women with Medicaid coverage, all of which are automatically covered through the first year of life regardless of changes in household income. Although many states expanded Medicaid to low-income adults under the Affordable Care Act (ACA), this expansion did not directly affect coverage for pregnant women.

The current policy interest to extend Medicaid for women for one year after birth—to mirror that which is available to infants—is reminiscent of the original rationale for expanding Medicaid to pregnant women, this time focusing on addressing a new crisis: high and rising *maternal* mortality rates. As there was concern that lack of prenatal care access was contributing to poor infant outcomes in the 1980s, there is now concern that lack of access to postpartum follow-up care is contributing to poor maternal outcomes for America's mothers. The underlying hypothesis is that sudden changes in insurance status for low-income women 60 days after birth are contributing to unmet health needs and reduced access to timely health care that could prevent morbidity and mortality in the year following pregnancy.

Indeed, the evidence is clear that the current policy structure results in high rates of insurance disruption after pregnancy Medicaid ends (Daw et al. 2017; Daw, Kozhimannil, and Admon 2019). Postpartum insurance disruptions affect women in all states but are higher in states that have not

expanded Medicaid under the ACA. From 2015 to 2017, 35% of women in nonexpansion states reported an insurance change or loss from birth to the postpartum period, compared to 24% in expansion states (Daw, Kozhimannil, and Admon 2019).

Why do so many postpartum women continue to lose Medicaid coverage, even after implementation of the ACA? This is a result of the large gap between the household income level that qualifies women for Medicaid during pregnancy, compared to the income level that qualifies women for Medicaid after pregnancy. This income gap is particularly large in nonexpansion states. In 2020, the median income gap for a family of three is between 203% FPL and 138% FPL in expansion states and between 199% FPL and 41% FPL in nonexpansion states (Brooks et al. 2020). In nonexpansion states, postpartum women falling in this income gap and earning under 100% FPL have particularly limited options: they qualify neither for Medicaid nor for federal subsidies on the ACA Marketplaces. The larger income gap in nonexpansion states is reflected in postpartum uninsurance rates: in 2017, 24.8% of low-income women who gave birth in the past year reported being uninsured in nonexpansion states, compared to 7.8% in expansion states (Johnston et al. 2020).

In expansion states, all women in the income gap have the option for subsidized Marketplace coverage, and thus are more likely than women in nonexpansion states to switch from Medicaid to Marketplace coverage, than to go uninsured. However, the costs of Marketplace coverage may be prohibitive or place substantial financial burden on families, even after subsidies: for two adults earning 205% FPL (the median state pregnancy Medicaid threshold), premiums for a silver level plan would cost 6.6% of household income ($2,876 per year) and entail additional cost-sharing (up to an out-of-pocket limit of $13,000 per year or 30% of household income) (KFF 2019). Switching from Medicaid to Marketplace coverage at 60 days may also present challenges for maintaining continuity of care in the immediate postpartum period, for example, by requiring women to identify and establish relationships with new in-network providers.

Insurance disruptions—both changes and gaps in coverage—are associated with reduced access to care, lower adherence to medication, worsened self-reported quality of care, and lower health status (Sommers et al. 2016). In a 2019 report, the CDC identified key factors that contribute to the high rate of preventable maternal deaths in the US: inadequate access to care, missed or delayed diagnoses, and failure to recognize early warning signs (Petersen, Davis, Goodman, Cox, et al. 2019). These factors all relate

to the ability of women to connect to timely, high-quality health care after pregnancy, which could be compromised by the high rates of unstable insurance among new mothers.

In both expansion and nonexpansion states, extending pregnancy-related Medicaid coverage to a full year would allow continuity of coverage during a vulnerable time, and it would reduce women's exposure to cost-sharing that can make care financially prohibitive or burdensome. Clinical bodies, including the American College of Obstetricians and Gynecologists and the American Medical Association, have issued support for a postpartum Medicaid extension (American College of Obstetricians and Gynecologists 2019; AMA 2019). The rapid rise in policy activity in the last year signals that a rising share of state and federal policy makers on both sides of the aisle also view a postpartum extension as a critical piece of the solution to address the US maternal mortality crisis. However, uncertainty remains about which of the many policy pathways that could be taken to achieve an extension—each with their own advantages and disadvantages—will ultimately prove to be successful. This uncertainty has only been heightened in the wake of the COVID-19 crisis and its likely significant and long-run impact on state finances.

State Policy Options

Table 1 provides a summary of state policy measures to pursue a postpartum extension as of December 31, 2020. States have two primary avenues by which they could implement and finance a postpartum Medicaid extension: (1) a federal waiver, which requires approval from the CMS but may also allow access to federal matching funds; or (2) a "state-only" approach fully financed by the state.

Waivers

The most straightforward mechanism for a state to pursue a postpartum Medicaid extension is a waiver under Section 1115 of the Social Security Act. This provision allows states to modify their Medicaid programs to pursue "experimental, pilot, or demonstration projects" that are "likely to assist in promoting the objectives" of the Medicaid program. Importantly, Section 1115 waivers give states access to federal matching funds for waiver programming (at the standard Medicaid matching rate). As shown in table 1, nearly all states currently pursuing a postpartum extension are using this mechanism, which has previously been used to expand benefits and categories of eligible individuals. Section 1115 waivers are typically

Table 1 State Policy Activity to Extend Postpartum Medicaid in 2020 State Legislative Sessions (January 1–December 31, 2020)

State	Approach	Length of extension	Population covered	Services covered	Current status
Alabama	1115 Waiver (legislative)	1 year	All women with PM (146% FPL)	All PM services	Legislation introduced (HB 448)
California	State-only (legislative)	1 year	Women with PM and a maternal mental health condition (213% FPL)	All PM services	Legislation passed (SB 104); implementation began July 2020
District of Columbia	1115 Waiver (legislative)	1 year	All women with PM (324% FPL)	All PM services	Legislation introduced (B23–0362)
Georgia	1115 Waiver (legislative)	6 months	All women with PM (225% FPL)	All PM services	Legislation passed (HB 793); waiver pending at CMS
Hawaii	State-only (legislative)	1 year	All women with PM (196% FPL)	All PM services	Legislation introduced (SB 2429 and HB 1943)
Illinois	1115 Waiver (legislative)	1 year	All women with PM (213% FPL)	All PM services	Legislation passed (SB 1814); waiver pending at CMS
Iowa	1115 Waiver (legislative)	1 year	All women with PM (380% FPL)	All PM services	Legislation introduced (SF 2024 and SF 2062)
Maine	1115 Waiver (legislative)	6 months	All women with PM (214% FPL)	All PM services	Legislation introduced (HP 1401)
Mississippi	Not specified (legislative)	1 year	All women with PM (199% FPL)	All PM services	Legislation introduced (HB 1152); died in Committee
Missouri	1115 Waiver (legislative)	1 year	Women with PM and a SUD (201% FPL)	SUD treatment only	Legislation passed (HB 2280); waiver pending at CMS
New Jersey	1115 Waiver (legislative)	180 days	All women with PM (199% FPL)	All PM services	Legislation passed (S2020); waiver pending at CMS

Table 1 (*continued*)

State	Approach	Length of extension	Population covered	Services covered	Current status
New York	1115 Waiver (legislative)	1 year	All women with PM (223% FPL)	All PM services	Legislation introduced (A9156 and S7147)
Pennsylvania	1115 Waiver (legislative)	1 year	All women with PM (220% FPL)	All PM services	Legislation introduced (HB 2108)
South Carolina	1115 waiver (regulatory)	1 year	All women with PM (199% FPL)	All PM services	State removed postpartum extension from 1115 request
Tennessee	1115 Waiver (legislative)	1 year	All women with PM (200% FPL)	All PM services	Legislation introduced (SB 1902 and HB 2039); pilot not funded in FY2020 budget
Texas	1115 Waiver (legislative)	1 year	All women with PM (203% FPL)	All PM services	Legislation passed the House (HB 744); never taken up in the Senate
Virginia	1115 Waiver (legislative)	1 year	All women with PM (200% FPL)	All PM services	Legislation passed (HB 30); waiver forthcoming
Washington	1115 Waiver (legislative)	1 year	All women with PM (198% FPL)	All PM services	Legislation passed (SB 6128); vetoed by the governor due to COVID-19
West Virginia	1115 Waiver (legislative)	1 year	All women with PM (190% FPL)	All PM services	Legislation introduced (HB 4416)
Wisconsin	1115 Waiver (legislative)	1 year	Women with PM and a SUD who receive SUD health services while pregnant (306% FPL)	All PM services	Legislation introduced (AB 693); failed to pass the House

Note: PM = pregnancy Medicaid; SUD = substance use disorder.

approved for five-year terms but can be renewed indefinitely, and some have been in place for decades. States are familiar with this approach; 43 states have one or more Section 1115 waivers approved for other purposes (KFF 2020b).

Notably, several of the first states to pursue an 1115 waiver to extend postpartum coverage have Republican governors and legislatures, highlighting how support for this policy crosses party lines. Efforts in some of these states, such as Tennessee, have been put on hold in response to pandemic-related state budget cuts for fiscal year 2021 (Kelman 2020). However, others have maintained support despite budgetary concerns: Governor Kemp of Georgia signed a budget with $19 million in new funding for a six-month postpartum extension effective upon waiver approval by the CMS (Office of the Governor 2020).

Section 1115 waivers offer states considerable discretion in specifying inclusion criteria for the new postpartum Medicaid population as well as the set of covered benefits. Although it would be desirable to expand postpartum Medicaid as a simple extension of pregnancy-related Medicaid (covering all standard benefits and all postpartum women), state flexibility on these features may allow negotiations that are important for political feasibility. Even for states where a waiver application can be submitted through executive approval only, state legislatures will exercise control over waiver implementation through the appropriations process. This is where the flexibility that waivers offer for program design and costs may be critical. For example, Missouri has pursued a limited extension for postpartum women receiving treatment for substance use disorders; lawmakers expressed concern about the state costs of the bill (estimated to be $5.8 million in state funds for the first two fiscal years), and a broader extension may have received less support (Psaledakis 2018).

The Section 1115 pathway also has several potential drawbacks. These include the state administrative burdens of waiver applications including public notice and comment, the need for reapproval at regular intervals, and monitoring and evaluation requirements. Uncertainty also looms as to whether the CMS will be willing to approve state waiver applications to extend postpartum coverage. Notably, in November 2017, President Trump's CMS posted revised goals for Section 1115 waivers, which do not include expanding coverage as a program objective (CMS 2017). South Carolina's 2019 waiver application—the first to be submitted with a postpartum extension—may be a potential harbinger for the CMS's position. While other provisions in South Carolina's application were approved (e.g., work requirements), the CMS approval letter from December 2019

explains that the state withdrew its postpartum extension request (CMS 2019). It is unclear whether this withdrawal reflected the CMS's position or state priorities. Additionally, it remains to be seen how a Biden CMS may interpret waiver requests to extend postpartum coverage; significant revisions to the goals of Section 1115 waivers are expected.

An additional challenge of the Section 1115 waiver approach is the CMS's request for states to show budget neutrality—namely, that the waiver will not cost the federal government more compared to ordinary Medicaid rules. The postpartum population is likely a lower-cost group to cover: the average spending one year postpartum for privately insured women aged 25–34 was $2904 in 2016 (Bloschichak and Martin 2020), compared to $6382 for the average privately insured woman aged 26–44 in 2018 (Biniek and Hargraves 2020), and $5965 for the average low-income, nondisabled Medicaid beneficiary aged 20–64 in 2017 (CMS 2020). However, there is considerable uncertainty about the cost and cost-effectiveness of a postpartum extension. In applications to date, some states have treated new spending under postpartum extension waivers as hypothetical, while others have considered postpartum extension costs to be offset by savings elsewhere in their Section 1115 programming. As the CMS responds to state waiver applications, we will soon have a clearer sense of which arguments for budget neutrality are acceptable.

States have access to other types of federal waivers, though these options are less applicable to a postpartum Medicaid extension and none have yet been pursued. For example, Section 1331 of the ACA gives states the option of creating a Basic Health Program (BHP) to provide coverage for low-income residents (133% to 200% FPL). This income range would cover the vast majority of women who lose pregnancy Medicaid at 60 days in ACA expansion states, but would leave many women without coverage in nonexpansion states. The BHP does not require federal budget neutrality and offers attractive federal support: states receive 95% of the federal tax credits and subsidies that would have been provided to individuals through the ACA Marketplace. Since states have some discretion over the design of the program, states with a BHP could define women with a recent birth such that their benefits include the same (or similar) level of benefits as pregnancy Medicaid and offer no cost-sharing. Combined with automatic enrollment in the BHP at 60 days after birth, a BHP could provide a seamless postpartum coverage transition for women enrolled in pregnancy Medicaid. States, particularly those that already have or are planning to implement a BHP (e.g.. NY, MN, WA), could evaluate whether this offers a more financially viable path to a postpartum extension relative to the federal matching funds they would receive under an 1115 waiver. Section

1332 waivers may offer another creative route to a postpartum extension. While state budget crises in the wake of the COVID-19 pandemic are already stifling interest in any additional state Medicaid spending, states that are highly committed may seek waiver pathways that were less obvious during the last decade of economic growth.

State-Only Approach

States also have the option to fully finance a postpartum Medicaid extension without federal support, though the current economic downturn has quickly rendered this pathway much less feasible. Nevertheless, the state-only approach is an expedient option for states that bypasses the waiver process, avoiding the need for federal approval and the associated administrative burden. Like the waiver approach, the state-only approach can be initiated by the legislative or executive branch, depending on the state. However, in all states, legislative approval will ultimately be required for appropriation of funds to support the extension. Legislative support may be challenging (even in good economic times) given that the state-only approach leaves significant federal funds on the table. Fiscal constraints may also affect the generosity of the postpartum extension. To date, California is the only state to pass legislation with state-only funding. This has meant that the state has proceeded quickly and will be the first state to implement a (limited) extension, even after contentious budget negotiations in the wake of COVID-19 (Dembosky 2020). Notably, the extension in California was always planned to be limited, covering only women with a diagnosed maternal mental health condition. The California case highlights the trade-offs among expediency, costs, and program design inherent to the state-only approach.

Federal Policy Options

Even for the state-driven approaches, the CMS has a role to play in prioritizing and approving Medicaid waivers, which will ultimately determine their success. However, Congress could also act to provide for longer-term postpartum Medicaid coverage. This includes two primary pathways: (1) a state plan amendment to make postpartum women an optional population for state coverage, or (2) a change to federal statute that would designate postpartum women as a mandatory population under the Medicaid program. Proposals in the 116th Congress (2019–2020) took both of these approaches (table 2). Federal actions related to the COVID-19 crisis are also currently weighing heavily on the prospects for a postpartum extension.

Table 2 Federal Legislative Activity in the 116th Congress

Legislation	Approach	Length of extension	Population covered	Services covered	Details	Status at the end of the 116th Congress
HR 4996: Helping Medicaid Offer Maternity Services (Helping MOMS) Act	State plan amendment	1 year	All women with PM	All PM services	5% increase in standard federal match for first year; standard match thereafter	Passed by the House of Representatives in September 2020; died in the Senate
HR 1897/S 916: Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act	Federal mandate	1 year	All women with PM	All PM services	100% federal financing for first five years; 90% thereafter	Referred to the House Committee on Energy and Commerce on March 27, 2019, and the Senate Committee on Finance on October 29, 2019, respectively; failed to advance
HR 2602/S 1343: Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services Act (MOMMIES) Act	Federal mandate	1 year	All women with PM	All PM services	100% federal financing in perpetuity	Referred to the House Committee on Energy and Commerce on May 8, 2019, and the Senate Committee on Finance on May 7, 2019, respectively; failed to advance

(*continued*)

Table 2 Federal Legislative Activity in the 116th Congress (*continued*)

Legislation	Approach	Length of extension	Population covered	Services covered	Details	Status at the end of the 116th Congress
HR 2778/S 1481: Healthy Maternity and Obstetric Medicine (Healthy MOM) Act	Federal mandate	1 year	All women with PM	All PM services	Standard federal match	Referred to the House Committees on Energy and Commerce, Ways and Means, Oversight and Reform, Education and Labor on May 15, 2019, and the Senate Committee on Finance on May 15, 2019, respectively; failed to advance
S 3443: Improving Coverage and Care for Mothers Act	Federal mandate	1 year	All women with PM	Specific list of services	100% federal financing in perpetuity	Referred to the Senate Committee on Finance on March 11, 2020; failed to advance

Note: PM = pregnancy Medicaid.

State Plan Amendment

At present, low-income pregnant women are a mandatory category for Medicaid coverage during pregnancy and up to 60 days postpartum. However, federal statute also designates optional Medicaid eligibility categories. Where Congress designates a group as "optional categorically needy," states have flexibility to opt into covering these populations, and they do so through a State Plan Amendment (SPA). Once a state elects to cover one of these groups, the federal government automatically provides federal matching funds (at the standard Medicaid rate) without the need for a waiver. The Helping Medicaid Offer Maternity Services (Helping MOMS) Act (H.R. 4996) uses this approach. This bill would adjust the Medicaid statute to specify that "at the option of the State," women will be eligible for coverage for one year beginning on the last day of pregnancy.

Using a legislative pathway to designate postpartum women as an optional covered population has advantages. States retain flexibility to opt in or not, which may make the policy more politically feasible in a polarized Congress. For example, the Helping MOMS Act gained bipartisan support and passed unanimously out of the House of Representatives in September 2020. If enacted in the current or a future Congress, this legislation would give states a relatively easy route to coverage through a simple SPA. The state need not show budget neutrality or perform an evaluation, and administrative burdens are minimal.

But although this federal legislation would be a big step forward, there are potential downsides. First, legislative appropriation of state funds would still be required and state participation may be limited unless there is a generous enhanced federal match rate. Under the originally proposed H.R. 4996, states would be eligible for a 5-percentage point increase in federal matching funds in the first year of implementation; however, the House-passed version of H.R. 4996 included no increased federal match. No increase in the matching rate, or even a short-term and modest increase (such as 5%), will significantly reduce the feasibility of adopting a SPA in many states, particularly in a post-COVID-19 environment (the fiscal year 2021 standard federal match rate ranges from 50% to 78% across states) (KFF 2020a). Differential state opt-in would exacerbate already wide state disparities in coverage of optional populations, and disparities between ACA expansion and nonexpansion states. Opt-in states are more likely to be prosperous states with relatively generous Medicaid and social safety net programs, leaving women in other states even further behind. This problem is not unique to the SPA option, and also applies to the state-driven

approaches previously described. Furthermore, a statutory change to Medicaid would require passage in both the House and Senate followed by presentment to the president. It is unclear how an optional postpartum extension would fare. Designating postpartum women as an optional, rather than mandatory, coverage category would impact fewer women and could inadvertently undermine political momentum to push for a mandatory designation. On the other hand, striking this compromise may offer an incremental step toward building a mandate, particularly if benefits are realized in early-adopting states.

Federal Mandate

Congress can also modify the Medicaid statute to make coverage mandatory in the postpartum year after a Medicaid-covered pregnancy. Most proposed federal legislation has taken this approach, including the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act (H.R. 1897) and the Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services Act (MOMMIES) Act (H.R. 2602/S 1343). Making the postpartum extension mandatory has obvious advantages: it would be a permanent extension, making it more durable than the waiver-based approach, and it would reach all states, making it more comprehensive than either waivers or the SPA option. There are also important disadvantages, principally in political feasibility. To be welcomed by states, a mandate would likely require full federal financing or at the least a very high federal match rate (i.e., closer to the enhanced 90% match rate for the ACA Medicaid expansion population). It is for this reason that the MOMMA's and MOMMIES Acts propose making a postpartum extension cost-free to states, committing that the federal government will bear 100% of the costs.

Even with full federal funding, a mandatory extension would run counter to recent political efforts by Republicans and CMS to limit access to the Medicaid program, including proposals to transform the program to block grants and limit enrollment by documented migrants. It is unclear whether this legislation will garner the support needed to pass both houses and muster presidential approval. Notably, while the SPA option under the Helping MOMS Act received support from House Republicans, neither the MOMMA's nor the MOMMIES Act have Republican sponsors.

If enacted, a mandatory coverage extension would invite legal challenges by states with leadership unwilling to implement it. States that

refuse to comply would be exposed to the possible consequence that CMS would withdraw all Medicaid funds, but in the wake of the ACA, states may be encouraged to contest this penalty. The Supreme Court ruled in *National Federation of Independent Businesses v. Sebelius* (2012) that withdrawing all Medicaid funds was unconstitutionally coercive when applied to penalize states' refusal to enact the ACA Medicaid expansion to low-income adults. The arguments may be weaker for a postpartum extension, given important distinctions from the ACA expansion population. The court's objection to this penalty rested on its (controversial) view that the ACA expansion was "different in kind" from traditional Medicaid, which included populations experiencing poverty and another source of disadvantage (e.g., children, pregnant women, disabled adults). There are persuasive arguments that the Medicaid postpartum extension is *not* a program "different in kind"—it serves the same goals (furnishing assistance to childbearing women and infants), it extends time but does not add new individuals to the program, and past expansions of the pregnancy group have successfully relied on the Medicaid defunding penalty to guarantee compliance.

COVID-19 Response

As part of the federal response to COVID-19, Congress enacted the Families First Coronavirus Response Act (FFCRA), which offers Medicaid programs a 6.2 percentage point increase in federal matching funds during the period of national emergency. To be eligible for these funds, state Medicaid programs are required to provide continuous coverage for any state resident who was covered as of March 18, 2020, or who subsequently becomes covered at any time during the emergency. This "maintenance of effort" (MOE) requirement functionally extends Medicaid during the postpartum period for any woman who had pregnancy-related Medicaid when the FFCRA became law. As of now, the MOE will expire on the last day of the month after the national emergency declaration ends. If that occurs while the country is still facing a severe economic downturn, it is possible that Congress will continue to use Medicaid as an expedient vehicle to support the social safety net and as a stimulus program for states through an enhanced federal match for MOE.

This experiment could offer a surprising pathway to a more durable postpartum extension. States will have the opportunity to test this new programming and realize its potential benefits, which ought to be subject

to rigorous evaluation as we describe below. If the MOE requirement persists for an extended period of time, citizens may develop new expectations for continued postpartum coverage and the political impetus for maintaining a postpartum extension may be strengthened. As we have seen with the failed ACA repeal efforts, it is extremely politically challenging to rescind benefits after people come to use and rely on them.

Defining the Details: Timing, Services, and Who Is Covered

Federal legislation to date proposes a comprehensive postpartum extension that would extend coverage for all services covered by pregnancy Medicaid to all eligible women for one year. However, the details of federal legislation or individual state extensions (whether achieved through waivers or the state-only approach) are likely to evolve on the route to passage and could vary across a number of important dimensions.

First, an extension could be granted for varying lengths of time. So far, one year after pregnancy is typical but some states (e.g., GA, ME, NJ) have opted to pursue a six-month extension. In most cases, the six-month timeframe has been the result of state budgetary limitations. Second, the population covered could include all women eligible for pregnancy-related Medicaid or specific groups of women defined by income, specific health conditions, or other criteria. California's extension, for example, only covers women with a diagnosed maternal mental health condition. States also have the freedom to place stringent rules on eligibility that may ultimately limit the number of women who will benefit. For example, Missouri's postpartum extension waiver application is limited to women with a diagnosed substance use disorder and the state estimates the extension will only impact 684 women per year (MO DSS 2019). Third, the services covered by an extension could include all those covered under a state's pregnancy-related Medicaid program or be limited to specific services. Covered services need not be, but are likely to be, linked to the choice of population covered; for example, Missouri's waiver will only cover substance use treatment whereas California's extension will cover all services. Restrictions on the time period, population, and/or services covered will shape the potential for an extension to avert preventable postpartum morbidity and mortality. States may wish to seek the broadest benefit they can possibly achieve, for the causes of postpartum morbidity and mortality are wide-reaching and often less predictable conditions, such as cardiovascular

events, infections, and bleeding, that can occur at any time in the year after birth and are not easily translated to Medicaid eligibility criteria (Petersen, Davis, Goodman, Cox, et al. 2019).

Need for Evaluation

Given the significant policy momentum behind a postpartum Medicaid extension, it will be critical for any states that successfully implement one to evaluate the impact of the policy on maternal health outcomes. While evaluations are a requirement for Section 1115 waivers, any implementing state should ensure that evaluation is planned alongside the development of the policy, ideally using independent investigators and rigorous evaluation methods (e.g., randomization or quasi-experiments) that allow for causal inferences to be made about the effect of the policy. This evidence is critical to ensure that these extensions are wise investments in the strategy to reduce maternal morbidity and mortality in the US and, if so, to establish additional motivation for further adoption by other states and/or the federal government. Importantly, the FFCRA continuous coverage provision provides such an opportunity, although it may be challenging to apply the lessons learned during the pandemic. This is in part due to the temporary nature of the coverage extension (which expires at the end of the national emergency declaration) and because any gains in coverage may not directly translate to improved outcomes or increased utilization of services given other limitations placed on the health care system due to COVID-19.

Conclusion

Extending postpartum Medicaid could be a key strategy in the effort to reduce alarming rates of maternal mortality and morbidity in the United States. Bipartisan momentum toward an extension has been building at both the state and federal levels. States have viable options to gain federal matching funds for an extension through Section 1115 or 1331(2) waivers; alternatively, they could choose to fund the extension using state-only resources. Congress has some choices as well; they could designate postpartum women as an "optional" population or they could expand current mandatory pregnancy eligibility to encompass the full, 1-year postpartum period. There are trade-offs to be considered in each approach, including political feasibility, administrative complexity, sources of additional funding, and ensuring equity within and across states (table 3).

Table 3 Advantages and Disadvantages of Primary State and Federal Approaches to a Postpartum Medicaid Extension

Approach	Advantages	Disadvantages
State-only (state)	■ Potential for faster implementation ■ Does not require CMS approval or proof of federal budget neutrality ■ Bypasses waiver process and associated administrative burden for states ■ Can be a permanent change ■ Allows state flexibility in terms of population or services covered	■ State costs may not be sustainable, particularly after COVID-19 ■ Leaves federal money on the table ■ Cost implications may lead to reduced scope of benefits (timing, population, services) ■ Differential state uptake may worsen state disparities in coverage
1115 Waiver (state)	■ Secures federal matching dollars (standard rate) to lower state cost burden ■ Allows state flexibility in terms of population or services covered	■ More onerous administration process including application, public comment period, evaluation ■ Requires CMS approval and proof of federal budget neutrality ■ Temporary change requiring regular extensions ■ Even with federal dollars, state costs could compromise political feasibility or reduce the scope of benefits ■ Differential state uptake may worsen state disparities in coverage
State plan amendment (federal)	■ Provides an efficient mechanism for implementation for all states ■ Optional opt-in may improve political feasibility ■ Does not require CMS approval or proof of federal budget neutrality ■ Bypass waiver process and associated administrative burden for states ■ Can be a permanent change	■ Requires congressional approval (political feasibility may be low with current administration) ■ Does not provide state flexibility in terms of population or services covered, which could reduce political feasibility ■ Differential state uptake may worsen state disparities in coverage

Table 3 (*continued*)

Approach	Advantages	Disadvantages
	■ Secures federal matching dollars (likely at an enhanced rate) to lower state cost burden	
Federal mandate (federal)	■ Provides an efficient mechanism for implementation for all states ■ Does not require CMS approval or proof of federal budget neutrality ■ Bypass waiver process and associated administrative burden for states ■ Can be a permanent change ■ Likely to result in highest federal contribution (enhanced match or 100% funding) to lower state cost burden	■ Requires congressional approval (political feasibility may be low with current administration) ■ State requirement to extend Medicaid may result in constitutional challenges ■ Does not provide state flexibility in terms of population or services covered

It is also essential that the benefit package offered to postpartum women be robust and appropriate to their needs.

The impact of COVID-19 on every policy avenue remains uncertain. Stimulus funding has created a temporary de-facto postpartum extension with federal support, but the economic impacts of the pandemic may undermine state interest in implementing an extension long-term. Likewise, congressional focus on addressing maternal mortality and morbidity may wane during the national crisis. Conversely, it is possible that COVID-19 might propel states forward as concern grows for lower- to middle-income families, particularly in light of stark racial and ethnic disparities in COVID-19 mortality. Medicaid has the advantage of being an established mechanism for funneling federal resources to states in need and we could see continued support for the maintenance of coverage currently offered during the period of national emergency. Given the policy activity during the past year, an extension of comprehensive, postpartum coverage for low-income women seemed all but inevitable only months ago. Now federal and state responses to the pandemic and long-term economic realities will shape the future of this promising policy change to address maternal morbidity and mortality.

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