Postpartum Medicaid Extension to Address Racial Inequity in Maternal Mortality

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The United States has one of the highest maternal mortality rates among high-income countries, with deeply troubling disparities that demonstrate long-standing inequity rooted in racism in our health care system. The US pregnancy-related mortality ratio, defined as the number of deaths of women while pregnant or up to one year after delivery from any cause related to or aggravated by the pregnancy or its management, has increased from 14.5 pregnancy-related deaths per 100 000 live births in 2007 to 16.9 per 100 000 in 2016.[1] Nearly a quarter of pregnancy-related deaths occur between 43 days and one-year postpartum, with cardiovascular conditions being the leading cause of death. State-level data show that substance use disorder and poor perinatal mental health are among the leading causes of postpartum mortality. Two of three pregnancy-related deaths may be preventable.[2]

The racial disparities in pregnancy-related mortality in the United States are deeply troubling. Between 2007 and 2016, there were 40.8 pregnancy-related deaths per 100 000 live births among non-Hispanic Black mothers and 29.7 pregnancy-related deaths per 100 000 live births among non-Hispanic American Indian/Alaska Native mothers compared with 12.7 pregnancy-related deaths per 100 000 live births among non-Hispanic White mothers. Recent events have drawn public attention to structural racism, or "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems. . . [that] in turn reinforce discriminatory beliefs, values, and distribution of resources."[3(p1453)]

Biases embedded in algorithms, clinicians' screening tools and predictive models, and underrepresentation of minorities in the provider workforce demonstrate that structural racism is embedded in every aspect of our health care system, which leads to unacceptable health outcomes. The ongoing COVID-19 pandemic has highlighted and exacerbated these issues: Black Americans have more than twice the odds of hospital admission,[4] and Native Americans are infected at up to four times the rate of their White counterparts.[5] Bias and systemic racism in health care must be addressed, given the differences in maternal mortality that Black women experience after accounting for other sociodemographic risk factors.

Although it is not a panacea for addressing all facets of structural racism, extending Medicaid coverage from 6 weeks to 12 months postpartum may reduce inequities in care. Currently, the federal mandate for pregnancy-related Medicaid provides coverage to women living at 138% of the federal poverty line (FPL) up to 60 days postpartum. Women of color are disproportionately enrolled in Medicaid during the perinatal period. Half of women who have Medicaid-funded births are uninsured before pregnancy, and 55% of Medicaid-insured women will experience a gap in insurance coverage by six months postpartum. The improvement in coverage that postpartum Medicaid extension provides may be as beneficial as Medicaid expansion through the Affordable Care Act (ACA), which reduced income eligibility for nonpregnant adults to 138% FPL.

Expansion states decreased the uninsured rate among women who gave birth in the past year, increased preconception Medicaid enrollment among low-income women, reduced racial disparities in preterm birth and low birth weight,[6] and decreased infant mortality. Support from professional societies such as the American College of Obstetricians and Gynecologists and the American Medical Association has led to the passage of legislation extending Medicaid postpartum in several states since 2018, including Missouri, which was a nonexpansion state at that time. Legislation extending Medicaid postpartum has also been introduced in the

nonexpansion states Texas, Georgia, Wisconsin, and South Carolina. Although the passage of legislation is promising, other changes are necessary to facilitate implementation and to collect data supporting adoption of this policy elsewhere.

Reimbursement is a critical aspect of implementation of postpartum Medicaid extension. Most states pay for maternity care through Medicaid by using a bundled payment for the perinatal period, which includes prenatal care, labor and delivery, and postpartum care. Episode payments, particularly with the incorporation of carefully selected quality metrics, could lead to efficient value-based care and waste reduction via gain sharing, whereby providers and institutions can convert savings from efficient care provision to increased service provision in areas that are not covered by insurers. However, the global payment structure needs to be adjusted to account for more visits for postpartum or well-woman care in the first year postpartum. Two options are increasing the value of the global fee and unbundling the payment structure for postpartum care. Without appropriate reimbursement, passing policies extending postpartum Medicaid coverage may not result in increased access to postpartum care.

Innovative health care delivery mechanisms, such as telemedicine and mobile application–supported care, may also allow increased postpartum care delivery. There has been significant development of health care infrastructure and workforce capacity to support these innovative delivery mechanisms during the COVID-19 pandemic. There are limited data showing that perinatal telemedicine can provide health outcomes comparable with those of traditional methods of health care delivery for diabetes, hypertension, and perinatal depression. Preliminary data also show that telemedicine has the potential to be cost saving when utilized on an appropriate scale. Although the feasibility of telemedicine services can be limited by factors such as access to appropriate technology and the availability of appropriate childcare support, mobile applications have been shown to reduce racial disparities in postpartum blood pressure management. At the state level, Illinois Medicaid recently agreed to provide home blood pressure cuffs to support telemedicine efforts during the COVID-19 pandemic.

Research examining differences in maternal and perinatal outcomes after the implementation of postpartum Medicaid extension as well as the impact of innovative health care delivery mechanisms on inequities in postpartum care will provide critical data that can guide the state-level adoption and implementation of postpartum Medicaid extension. As previously discussed, data from states that opted into the ACA's Medicaid expansion show promising effects on health outcomes. Research specifically examining populations benefiting from postpartum Medicaid extension and the impact of innovative health care delivery mechanisms in the perinatal period could support the adoption of policy changes and new models for postpartum care delivery nationally.

Reductions in racial disparities in maternal mortality will ultimately require transforming care across the perinatal continuum, of which postpartum care improvement is a significant component. Other proposed solutions—including improved maternal death reporting, sustainable support for perinatal quality collaboratives and maternal mortality review committees, increased pregnancy and postpartum support (e.g., doulas, patient navigators, breastfeeding peer counselors, home visits, and case management), pregnancy-centered medical homes, and implicit bias training—have been well characterized in the literature.[7] Increased access to postpartum health care via Medicaid extension could allow safer birth spacing via improved access to contraception, increased provision of mental health care, improved access to medication-assisted treatment and recovery services, and longer follow-up for medical complications that occur during pregnancy as well as chronic diseases.

As we face the stark racial and ethnic disparities of COVID-19 and nationwide civil unrest in response to structural racism, it is critical that we build on the momentum created by increased public awareness of racism's detrimental consequences on health outcomes, the recent consensus of professional societies, and the passage of legislation in several states to advocate effective implementation of postpartum Medicaid extension. Efforts focused on implementation may include changes to reimbursement in the postpartum period, support for innovative health care delivery mechanisms, and research examining resulting health outcomes. We have an opportunity not only to promote equity and improve access to postpartum care but also to take needed action to address racial disparities in maternal and perinatal outcomes in the postpartum period. AJPH

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CONFLICTS OF INTEREST

M. A. Simon is a member of the US Preventive Services Task Force (USPSTF), and her views and those of the USPSTF do not necessarily represent the views expressed in this editorial.

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