State by State Comparison

The Commonwealth Fund
CHCS Center for Health Care Strategies, Inc.

	COVERAGE AND BENEFITS											CARE DELIVERY TRANSFORMATION								DATA AND OVERSIGHT					
STATE	COVID-19 Telehealth Benefits	Postpartum Coverage	Home-Visiting Services	Freestanding Birth Centers	Doula Services	Midwifery Services	Immigrant Five-Year Waiver	Pre-COVID-19 Telemedicine for Pregnancy Care	Presumptive Eligibility	High-Risk Subpopulations	Education to Enrollees	Models of Care Delivery	Monetary Incentives for Enrollees	Payment Reform (of 6 policies)	Substance Use Disorder Programs	Integrating Mental Health	Provider Bias Training	Enhancing Obstetric Workforce	Quality Improvement Collaborative	Advisory Councils	Maternal Mortality Review Committees	Race-Stratified Data	Maternal Health Research	Enhancing Data Collection	Recognition Resolutions
Alabama	✓	✓	✓			✓						✓		1 out of 6	✓	✓			✓	✓	✓	✓	✓	✓	
Alaska	✓			✓		✓								2 out of 6	✓			✓	✓	✓	✓	✓		✓	
Arizona	✓			✓		✓		✓		✓				1 out of 6	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Arkansas	✓		✓			✓	✓							2 out of 6	✓			✓	✓		✓	✓		✓	
California		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		1 out of 6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓		1 out of 6	✓	✓			✓	✓	✓	✓			
Connecticut	✓			✓		✓	✓		✓					1 out of 6	✓	✓			✓		✓	✓	✓		
Delaware	✓	✓		✓		✓	✓			✓	✓	✓			✓	✓			✓	✓	✓		✓	✓	✓
District of Columbia	✓	✓	✓	✓		✓	✓		✓	✓					✓	✓				✓	✓	✓		✓	
Florida	✓		✓	✓		✓			✓	✓	✓	✓		2 out of 6	✓				✓		✓	✓		✓	
Georgia	✓	✓		✓		✓			✓	✓		✓		1 out of 6	✓	✓		✓	✓		✓	✓	✓		✓
Hawaii	✓	✓				✓	✓								✓	✓			✓		✓				
Idaho	✓					✓			✓					1 out of 6	✓	✓			✓		✓		✓		
Illinois	✓	✓	✓	✓		✓		✓	✓	✓					✓	✓		✓	✓	✓	✓	✓	✓	✓	
Indiana	✓			✓		✓			✓	✓		✓		2 out of 6	✓	✓		✓	✓		✓	✓	✓	✓	✓
Iowa	✓	✓	✓			✓			✓	✓	✓			1 out of 6	✓	✓		✓		✓	✓		✓	✓	
Kansas	✓			✓		✓			✓					1 out of 6					✓	✓	✓		✓	✓	
Kentucky	✓		✓	✓	✓	✓			✓	✓	✓				✓	✓			✓	✓	✓	✓		✓	✓
Louisiana	✓			✓		✓				✓				1 out of 6	✓	✓			✓	✓	✓	✓		✓	
Maine	✓	✓				✓	✓		✓						✓	✓			✓		✓				
Maryland	✓		✓	✓		✓	✓			✓	✓	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	
Massachusetts	✓			✓		✓	✓	✓			✓			2 out of 6	✓	✓		✓		✓	✓	✓		✓	
Michigan	✓	✓	✓			✓			✓	✓	✓	✓		2 out of 6	✓	✓	✓		✓		✓	✓		✓	✓
Minnesota	✓		✓	✓	✓	✓	✓			✓	✓	✓		1 out of 6	✓	✓		✓	✓	✓	✓	✓		✓	
Mississippi	✓	✓	✓			✓				✓	✓			1 out of 6	✓	✓			✓		✓	✓	✓		
Missouri	✓	✓	✓	✓		✓		✓	✓		✓	✓		1 out of 6	✓	✓				✓	✓	✓		✓	
Montana	✓			✓		✓			✓	✓		✓		1 out of 6	✓	✓		✓	✓		✓				
Nebraska	✓			✓		✓	✓		✓	✓	✓			1 out of 6	✓			✓	✓		✓			✓	
Nevada	✓			✓		✓				✓	✓	✓		1 out of 6	✓	✓				✓	✓			✓	
New Hampshire	✓		✓	✓		✓			✓		✓		✓		✓	✓					✓			✓	
New Jersey	✓	✓		✓	✓	✓	✓		✓			✓		1 out of 6	✓	✓		✓	✓		✓	✓	✓	✓	
New Mexico	✓		✓	✓		✓	✓		✓			✓	✓	1 out of 6	✓	✓		✓	✓		✓	✓		✓	
New York	✓	✓	✓	✓		✓	✓		✓	✓		✓		3 out of 6	✓	✓		✓	✓	✓	✓	✓	✓	✓	
North Carolina	✓		✓	✓		✓	✓		✓	✓	✓	✓		3 out of 6	✓	✓		✓	✓		✓	✓	✓		
North Dakota	✓		✓			✓				✓	✓				✓	✓			✓						
Ohio	✓			✓		✓	✓		✓	✓				1 out of 6	✓	✓			✓		✓	✓	✓	✓	
Oklahoma	✓			✓		✓								1 out of 6	✓	✓			✓		✓	✓	✓		
Oregon	✓		✓	✓	✓	✓				✓	✓			1 out of 6	✓	✓		✓	✓		✓	✓			
Pennsylvania	✓	✓		✓		✓	✓		✓						✓	✓			✓		✓	✓	✓	✓	✓
Rhode Island	✓					✓									✓	✓					✓			✓	✓
South Carolina	✓	✓	✓	✓		✓	✓			✓		✓		2 out of 6	✓	✓		✓	✓		✓	✓			✓
South Dakota	✓			✓		✓				✓					✓	✓			✓			✓			
Tennessee	✓	✓	✓	✓		✓			✓	✓			✓	3 out of 6	✓	✓			✓	✓	✓	✓		✓	
Texas	✓	✓	✓	✓		✓		✓	✓	✓		✓		3 out of 6	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Utah	✓		✓	✓		✓			✓		✓	✓				✓			✓		✓	✓			
Vermont	✓		✓			✓	✓			✓		✓			✓	✓			✓		✓				
Virginia	✓	✓				✓	✓	✓		✓	✓	✓			✓	✓			✓		✓	✓			✓
Washington	✓	✓		✓	✓	✓	✓			✓	✓			3 out of 6	✓	✓			✓		✓	✓			
West Virginia	✓	✓	✓	✓		✓	✓		✓		✓				✓	✓			✓		✓			✓	
Wisconsin		✓	✓	✓		✓	✓	✓	✓	✓		✓			✓	✓			✓	✓	✓	✓	✓	✓	
Wyoming	✓					✓	✓		✓	✓	✓			2 out of 6	✓	✓		✓	✓						

State by State Comparison

For more detailed information about policies in each state, click here to view these data as a series of maps or a full database.

NOTES

1. Data for this project were collected through the COVID-19 public health emergency. The publication of this information does not capture updates on funding and programs after August 2020.
2. A key consideration in reviewing these resources is that under certain policy areas implementation may appear to be extensive, but access for prenatal and postpartum people may be limited. As an example, the ACA requires that states provide Medicaid reimbursement for freestanding birth center facility service fees and the professional fees of a birthing attendant. However, the reality of "on-the-ground" factors, such as establishing formal collaborative and contractual agreements, financial pressures of low reimbursement rates for midwifery services, and high insurance liability rates present significant barriers to access. Because states have significant flexibility in how they structure benefits, providers, and payments, service gaps may continue to exist.
3. All maternal health outcomes improvement policies by state and federal government included in this policy database have been enacted with the exception of the Postpartum Coverage Expansion for Medicaid Enrollees. The Postpartum Coverage Expansion policy is advancing in several states, some of which have initiated legislative action. Legislative actions are also in progress in the federal House and Senate.
4. For COVID-19 Telehealth Benefits, California already explicitly added telehealth coverage prior to the pandemic. California's first telemedicine parity laws passed in 1996, and the state has a long history in telemedicine reimbursement. The Wisconsin Department of Health Services (WI DHS) was working to expand options around telehealth even before the COVID-19 outbreak began. On March 18, WI DHS notified Medicaid providers of two changes that should increase the use of telehealth.
5. For Postpartum Coverage Expansion, federal law requires Medicaid coverage until 60 days postpartum and does not currently have an option for extension beyond 60 days. No state is permitted to extend coverage beyond 60 days without a waiver mechanism.
6. Freestanding Birth Centers: Birth center policy/regulation options extend beyond the information on state benefits provided below. This dataset includes information on what freestanding birth center services are reimbursed and any limitations in coverage. The Affordable Care Act required that states provide Medicaid reimbursement for the birth center facility service fees and the professional fees of the birthing attendant. This section of the ACA added freestanding birth center services, and the professional services of birth attendants in birth centers, as a category of "medical assistance" under section 1905(a) of the Act. This section also included freestanding birth center services as one of the services mandated by section 1902(a)(10)(A) for Medicaid-enrolled pregnant individuals. Despite this mandate, accessibility of freestanding birth centers is limited in the U.S. The primary issues that make freestanding birth centers complex can be focused on three key areas: 1) the reimbursement rate of midwives under Medicaid; 2) regulations regarding payment for the facility fee; and 3) transfer agreements. The Notes section below the map provides resources that capture current freestanding birth center regulations and challenges.
7. Substance Use Disorder Programs: All state Medicaid programs are required to cover certain behavioral health services, including medically necessary inpatient hospital services, outpatient hospital services, rural health clinic services, nursing facility services, home health services, and physician services. Many other services used for the treatment of substance use disorders are optional services in the Medicaid program. Standard behavioral health benefits for general enrollees are not included in the information below. This dataset includes information on benefits or programs that are provided specifically for pregnant or postpartum people. In regards to pregnancy-related services, the Affordable Care Act requires states to expand Medicaid coverage of cessation services for pregnant women. States must add counseling and pharmacotherapy benefits for pregnant women, which under Section 4107 of the Affordable Care Act are now mandatory benefits under Medicaid. This coverage is defined as diagnostic, therapy, counseling services, and pharmacotherapy for cessation of tobacco use by pregnant women. States have flexibility in how they structure benefits, providers, and payments. States may have added benefits beyond this mandated requirement. In addition, program funding may be transferred to the state behavioral health agency or to local behavioral health agencies, which do not primarily serve pregnant and postpartum people. Despite the ACA mandate and different mechanisms to provide behavioral health services, accessibility to programs for pregnant and postpartum people may vary widely or be limited in practice.
8. Integrating Mental Health: Under the Affordable Care Act mental health benefits are automatically included as part of the standard pregnancy-related coverage benefit. In addition, all state Medicaid programs are required to cover certain behavioral health services, including medically necessary inpatient hospital services, outpatient hospital services, rural health clinic services, nursing facility services, home health services, and physician services. Many other services used for the treatment of mental health issues are optional in the Medicaid program. Standard mental health benefits for general enrollees are not included in the information below. This dataset includes information on benefits or programs provided specifically for pregnant or postpartum people. States have flexibility with regard to how they structure benefits, providers, and payments, and mental health coverage may vary widely or be limited in practice.
9. Payment Reform: The policies captured in this chart include: 1) Comprehensive Payments for Mother and Newborn, 2) Bundled Payments for Maternity Episode of Care, 3) Blended Payment Rates, 4) Reduced Payment or Nonpayment for Nonmedically Indicated Procedures, 5) Pay for Performance (P4P), and 6) Pay for Success Models for Medicaid-Enrolled Mothers.
10. Models of Care Delivery is defined as one of three: 1) Care Coordination/Care Management, 2) Group Prenatal Care, and 3) Maternity Medical Home.

POLICY DESCRIPTIONS

COVID-19 Telehealth Benefits: Under HHS's declaration of a national public health emergency, states could increase flexibilities around telehealth access and coverage for the Medicaid population. Maternity care is one service that states could include.

Postpartum Coverage: The American College of Obstetricians and Gynecologists (ACOG) recommends insurance coverage policies are aligned to support a tailored approach to "fourth trimester" care. States have taken steps to advance legislation that would extend Medicaid eligibility until six months or one year after delivery or when the pregnancy ends. Medicaid must cover pregnant individuals with incomes up to 133 percent of the federal poverty level through 60 days postpartum.

Home-Visiting Services: State Medicaid programs can allow home-visiting services for individuals and families. Home visiting is not mandated under the federal Medicaid program. This evidence-based program provides a variety of in-home services to families, including for pregnant people, new parents, or infants through Medicaid.

Freestanding Birth Centers: A freestanding birth center is a health care facility that uses a midwifery model of care to provide services during pregnancy, labor and delivery, and the postpartum period. Freestanding birth centers are not connected to or affiliated with hospitals. The Affordable Care Act required that states provide Medicaid reimbursement for the birth center facility service fees and the professional fees of the birthing attendant. Coverage of freestanding birth centers under CHIP is not required, but states may cover services in these facilities to the extent that the state licenses or otherwise recognizes such providers under state law.

Doula Services: A professionally trained doula provides nonclinical emotional, physical, and educational support to a mother before, during, and after childbirth. Doula services help individuals meet their goals for labor and birth by using techniques that require minimal interventions and have high rates of patient satisfaction.

Midwifery Services: The Affordable Care Act mandated Medicaid programs to provide access to midwives. Midwifery services include a full range of primary health care services for women from adolescence to beyond menopause, including primary care, gynecologic and family planning services, preconception care, and care during pregnancy, childbirth, and the postpartum period. Midwives also provide well-woman care across the lifespan.

Immigrant Five-Year Waiver: States are waiving the requirement for pregnant immigrants to lawfully reside for five years before Medicaid eligibility. In general, permanent resident immigrants (Green Card holders) are eligible for Medicaid and CHIP after five years of residence on the same basis as U.S. citizens and must meet all other program requirements. Though not included in this database, for undocumented and DACA-eligible immigrants, states may provide undocumented immigrant women with federally funded prenatal services through CHIP. Some states also may provide prenatal care entirely using state funds.

Pre-COVID-19 Telemedicine for Pregnancy Care: States reimburse for telemedicine services for pregnancy care. A broad range of pregnancy-related services can be offered via telemedicine. Telemedicine can be used to support access to maternity care services, such as at-home monitoring for diabetes and hypertension, and for phone/video consultation with specialists.

Presumptive Eligibility: Presumptive eligibility is an option that states can use to allow authorized providers to begin treating pregnant people when they first seek prenatal care rather than waiting until after their Medicaid eligibility is reviewed and determined, which can take several weeks.

High-Risk Subpopulations: States use screening tools to identify enrollees whose pregnancies are at high risk for poor maternal or newborn outcomes and provide specific benefits to address risk.

Education to Enrollees: States include Medicaid coverage and benefits that educate pregnant people about maternal health issues.

Models of Care Delivery: States provide person-centered models of maternity care delivery, including pregnancy medical homes, group prenatal care, and care coordination/case management. Maternity models of care delivery provide coordinated services by an interdisciplinary team of clinicians and health care workers for pregnant people. Please note that models of care delivery also include the midwifery-led model of care, but this model is included in its own section in the database.

Monetary Incentives for Enrollees: States provide monetary incentives under their benefits to improve maternal health outcomes for enrollees. Pregnant enrollees may receive money or goods after completing certain care visits or tasks.

Payment Reform: States are adjusting financial incentives for providers to improve maternal health outcomes. States are using payment incentives to reduce poor outcomes and increase access to pregnancy-related and postpartum care.

Substance Use Disorder Programs: Under the Affordable Care Act, Medicaid must cover all basic aspects of drug and alcohol dependency recovery. States are increasing access to substance use screening and treatment during pregnancy. Each state determines the specific scope of maternity benefits for enrollees related to substance use disorder identification and treatment. Services vary from state to state, but typically include detoxification, individual and group therapy, and medication-assisted treatment (MAT).

Integrating Mental Health: Medicaid for pregnant people covers services related to pregnancy, including behavioral health services for mental health and substance use disorders. States are implementing approaches to address maternal mental health conditions and postpartum depression. States have increased access to prenatal and postpartum screening for risk factors, as well as the presence of mental health conditions, and include access to treatment and support services for individuals at high risk of postpartum depression.

Provider Bias Training: Provider bias contributes to health care disparities by shaping physician behavior and producing differences in medical treatment by race, ethnicity, gender, or other characteristics. States are implementing an implicit bias training requirement for health care professionals working in perinatal services.

Enhancing Obstetric Workforce: With an uneven distribution of obstetric services in the United States and limited culturally competent care, states are working to improve obstetric care and maternal health outcomes by providing training and broadening the workforce that is able to provide maternity care to areas that currently have limited obstetric care capacity.

Quality Improvement Programs: Maternal health quality improvement programs bring together multiple stakeholders committed to ending preventable morbidity and mortality in maternal health. States are implementing quality care collaboratives or initiatives that improve the quality of maternal health care through provider education.

Advisory Councils: Maternal Health Advisory Councils are groups of individuals with technical knowledge and skills in maternal health care that are charged with providing support to states and policymakers in order to promote maternal health and improve outcomes. States are establishing Advisory Councils for interagency coordination and policy recommendation.

Maternal Mortality Review Committees: Maternal Mortality Review Committees (MMRC) investigate pregnancy-related mortality and morbidity and develop comprehensive recommendations for states and legislatures to reduce future deaths.

Race-Stratified Data: Analyzing data by race and ethnicity requires the collection of data that are linked to health outcomes to identify similarities and differences between and among different races and ethnicities. States are requiring managed care organizations to collect race-stratified data.

Maternal Health Research: Maternal health research is conducted to understand birth outcomes, including the impact of different models of care to address maternal mortality and morbidity. Funding from this type of research can come from a variety of sources, including federal and state government or philanthropy. The information in this section focuses on research funded by states.

Enhancing Data Collection: State Medicaid managed care organization contracts are including reporting requirements to enhance data collection for performance improvement and quality measures in maternal health.

Recognition Resolutions: States are designating days and months to promote awareness of maternal morbidity and mortality through education and promotional campaigns. These events are typically to honor or commemorate a public issue or social cause, ethnic group, historic event, or noted individual. However, (with several exceptions) there is no requirement that government or business close on these days, and many enrollees of the general public may not be aware that such holidays even exist.