REPORT

Supporting Moms' Health in the Postpartum Period

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

JULY | 2023

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The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories.

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- Improve the quality and effectiveness of state legislatures.
- Promote policy innovation and communication among state legislatures.
- Ensure state legislatures a strong, cohesive voice in the federal system.

The conference operates from offices in Denver, Colorado and Washington, D.C.

Introduction

The postpartum period is an important time for both mothers and newborns and is increasingly recognized as an opportune time for policy intervention. Although pregnancy-related deaths are rare in the United States, hundreds die from pregnancy complications each year. Pregnancy-related deaths have increased over the last several decades and reveal notable disparities by race.

More than half of pregnancy-related deaths occur within one year after childbirth. In 2020, more than 30,000 women experienced severe pregnancy complications that can have serious implications for lifelong health.

Yet most pregnancy-related deaths are preventable. Experts point to ongoing care in the "fourth trimester," the period up to a year following birth, as a crucial time for early recognition and management of potential complications.

Several factors influence a healthy pregnancy, birth and postpartum period for both mother and infant. The postpartum period is an important time for recovery, addressing delivery complications, managing infant care and setting the stage for long-term health and well-being.

Pregnancy-Related Mortality Statistics

53% of pregnancy-related deaths occur 7 to 365 days postpartum.

84% of all pregnancy-related deaths are considered preventable.

The most frequent underlying causes of pregnancy-related death are:

- Mental health conditions (**22.7%**)
- Hemorrhage (**13.7%**)
- Cardiac and coronary conditions (**12.8%**)
- Infection (**9.2%**)
- Thrombotic embolism (**8.7%**)
- Cardiomyopathy (**8.5%**)

Pregnancy-related mortality rates are two to three times higher among non-Hispanic Black and American Indian/Alaskan Native populations compared to white populations.

Strategies that increase access to health care services, mental health services, substance use disorder treatment, family planning services, breastfeeding support and care coordination during the postpartum period can improve health outcomes and ensure a strong start for families. This report includes background on and state examples of legislative policy options for the following issues:

- Postpartum insurance coverage.
- Depression and substance use during and after pregnancy.
- Postpartum long-acting reversible contraception.
- Breastfeeding.
- Home visiting.

Postpartum Coverage

Insurance coverage during the postpartum period is increasingly recognized as a strategy to improve maternal health outcomes. Medicaid is the single largest payer of maternity care in the United States, financing about 41% of all births. Private insurance, both commercial plans and self-funded employer plans, finances about half, followed by births that are self-paid or financed by the Indian Health Service or health insurance for military families.

Medicaid can play an important role in maternity-related services, financing a greater proportion of births among populations with higher rates of pregnancy complications. Federal law requires pregnancy-related Medicaid eligibility to provide coverage through 60 days postpartum, after which postpartum individuals may be at risk of losing coverage. Income eligibility limits for parents may be lower than income eligibility limits for pregnant women, depending on the state. An average of 20% of beneficiaries with pregnancy-related Medicaid become uninsured within six months postpartum; in some states, the rate is nearly twice as high.

High rates of preventable maternal mortality and pregnancy-related complications have caught the eye of state and federal policymakers, and many are taking steps to leverage available pathways to extend Medicaid coverage and improve care for mothers during this period.

Postpartum Medicaid Eligibility and Benefits

To qualify for Medicaid, individuals must first meet two basic criteria: they must be U.S. citizens (or certain qualified non-citizens such as lawful permanent residents) and they must be residents of the states where they are applying. Federal law requires state Medicaid programs to cover pregnant individuals with incomes at or below 133% of the federal poverty level (FPL), plus a mandatory income disregard of 5%, making the minimum eligibility level effectively 138%. In 2023, that equals approximately $20,120 in annual income for a single adult or $41,400 for a family of four. Some states choose to provide coverage at higher income thresholds ranging from 139% up to 380% of the FPL. Some states also provide coverage for pregnant women under their Children's Health Insurance Program at the required minimum eligibility level of at least 185% of the FPL.

Federal Requirements for Private Health Coverage

- Maternity care and newborn care are essential health benefits, which means all qualified health plans must cover them.
- These benefits include mental health and substance use services, breastfeeding supplies and lactation counseling, and preventive health services such as family planning. Several states' essential health benefit plans also cover home health visiting.
- Learn more about essential health benefit benchmark plans in each state.

Pregnancy-related Medicaid must cover at least pregnancy-related services through 60 days postpartum. Benefits vary by state, but the majority provide the full Medicaid package to pregnant beneficiaries. After the 60-day coverage period ends, individuals who are not eligible to remain covered under their state's Medicaid eligibility requirement for parents or low-income adults must obtain coverage from another source.

States may leverage Medicaid program funds to provide the following benefits during the postpartum coverage period:

- **Depression and Substance Use Disorder Services:** Most states cover treatment services for pregnant and postpartum women with substance use disorder beyond the minimum requirements from the federal government.
- **Breastfeeding Support:** States that have expanded their Medicaid programs are required to offer lactation services. States that have not expanded Medicaid can choose to cover lactation services under several benefit categories, including as pregnancy-related services, physician or nursing services, or outpatient hospital services.
- **Long-Acting Reversible Contraception (LARC):** The Medicaid program requires family planning services, including LARC, to be fully covered for patients without cost-sharing.
- **Home visiting:** While not a mandated service under the federal Medicaid program, most states cover both prenatal and postpartum home visits.

Projected Outcomes for Extending Medicaid Coverage to One Year Postpartum

The federal government estimates that extending Medicaid coverage to one year postpartum would provide coverage for an additional 720,000 beneficiaries each year who are not currently covered past 60 days.

The Congressional Budget Office estimates the additional 10 months of coverage under the new federal expansion option to average about $1,500 per person per year in combined federal and state dollars. Potential savings from averted medical conditions and more efficient administrative action might offset some of the cost.

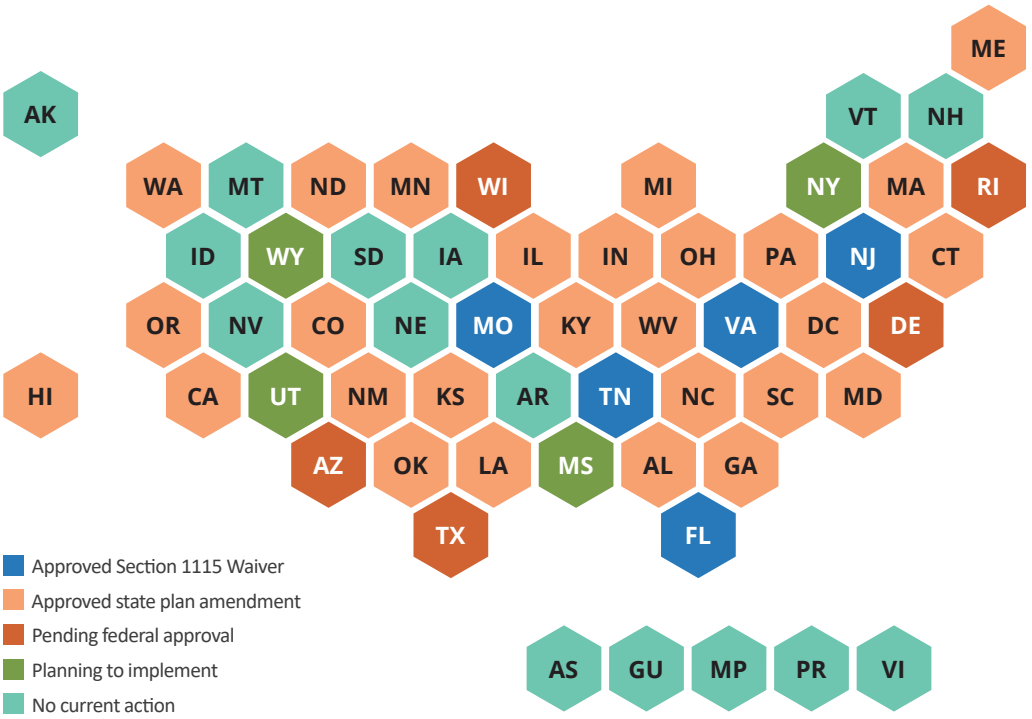
Another study found extended Medicaid coverage to be associated with higher use of services. After coverage was extended in Texas, some Medicaid enrollees used twice as many postpartum services and between two to 10 times as many preventive, contraceptive and mental and behavioral health services.

State Extension of Postpartum Coverage

At least 41 states and the District of Columbia have taken action to extend postpartum coverage in Medicaid beyond the base eligibility and benefits. Thirty-two states have received federal approval to start implementation and at least nine other states are awaiting federal approval or preparing to apply for approval.

Figure 1: Postpartum Medicaid Coverage Extensions

Status of federal approval of postpartum coverage extensions as of March 31, 2023. Unless otherwise indicated, extended coverage lasts for 12 months postpartum.



Before the passage of the American Rescue Plan Act, some states leveraged Section 1115 demonstration waivers to extend postpartum Medicaid coverage. Illinois was the first state to receive federal approval in early 2021, followed shortly by Georgia, which requested coverage through six months postpartum.

The American Rescue Plan Act of 2021, which became law in March 2021, provided a new option for states to extend Medicaid coverage up to one year postpartum through a state plan amendment (SPA). To use the SPA option to extend postpartum coverage, states must:

- Submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval.
- Provide continuous coverage regardless of any change in circumstances for the 12-month postpartum period.
- Provide full Medicaid benefits to pregnant and postpartum individuals that meet the state's income eligibility thresholds.

Since the American Rescue Plan Act became law, states have extended postpartum coverage through legislation directing the state Medicaid agency to extend coverage, as in Alabama and Delaware, or by setting aside funds in the state budget, as in Virginia and Tennessee.

During 2022, 23 states and the District of Columbia extended coverage using the new SPA option either for the first time or by adjusting existing coverage extensions. Georgia lawmakers, for instance, converted their existing six-month coverage extension (originally approved through a Section 1115 waiver) to one year using the new SPA option. Others including Kentucky, Maine and Oregon enacted legislation utilizing the SPA option to extend postpartum Medicaid coverage for the first time.

As of March 31, 2023, three states, Mississippi, Utah and Wyoming, passed legislation to extend postpartum Medicaid coverage and four states, Alabama, Colorado, North Dakota and Oklahoma, received approvals to start implementation. Six states are awaiting CMS approval to start implementation. Arizona and Rhode Island are waiting for CMS approval of the SPA Option. Wisconsin and Texas are waiting on federal approval for Section 1115 waivers extending postpartum coverage to 90 days and six months, respectively.

Maternal Depression

Pregnancy can be an exciting time, but for one in eight women it can also mean experiencing mental health challenges and feelings of depression after giving birth. Depression during pregnancy can be brought on by a number of risk factors including stressful life events, lack of social supports, a history or family history of depression, difficulties with becoming pregnant and pregnancy or birth related complications. Depression during pregnancy can also vary depending on a person's age, race, ethnicity and geography.

For most women, symptoms of pregnancy-related depression can include:

- Baby Blues
- Feelings of sadness.
- A loss of interest in fun or daily activities.
- Changes in appetite, sleep and energy.
- Difficulties with concentrating or making decisions.
- Having feelings of worthlessness, shame or guilt.
- Thoughts that life may not be worth living

While feelings of stress, sadness or anxiety during pregnancy can be common, depression is a condition that can interfere with daily life and last for more than a few days, if not properly treated.

While depression during pregnancy can be a potential indicator for postpartum depression, many women who are diagnosed with postpartum depression will receive a diagnosis of depression for the first time after giving birth. Postpartum depression generally presents within one to three weeks after giving birth and can cause additional depression-related symptoms like crying more often than usual, feeling angry, withdrawing from loved ones and feeling numb or disconnected from the newborn. Reports show fathers can be affected by untreated symptoms of depression during and after pregnancy and that infants can be affected by parental depression. For example, some studies show that parental depression can be associated with infants born prematurely or with a low birth weight, infants may present small for gestational age, have increased irritability, and display a delay in cognitive, linguistic, behavioral or development milestones.

State Policy Options

Postpartum depression, like depression during pregnancy, is treatable by an obstetrics, primary care or mental health provider. However, data indicates screening, coverage and treatment for depression during and after childbirth is lower than recommended. To support and enhance these efforts, state legislatures have created educational and awareness studies or task forces and examined existing screening and coverage protocols.

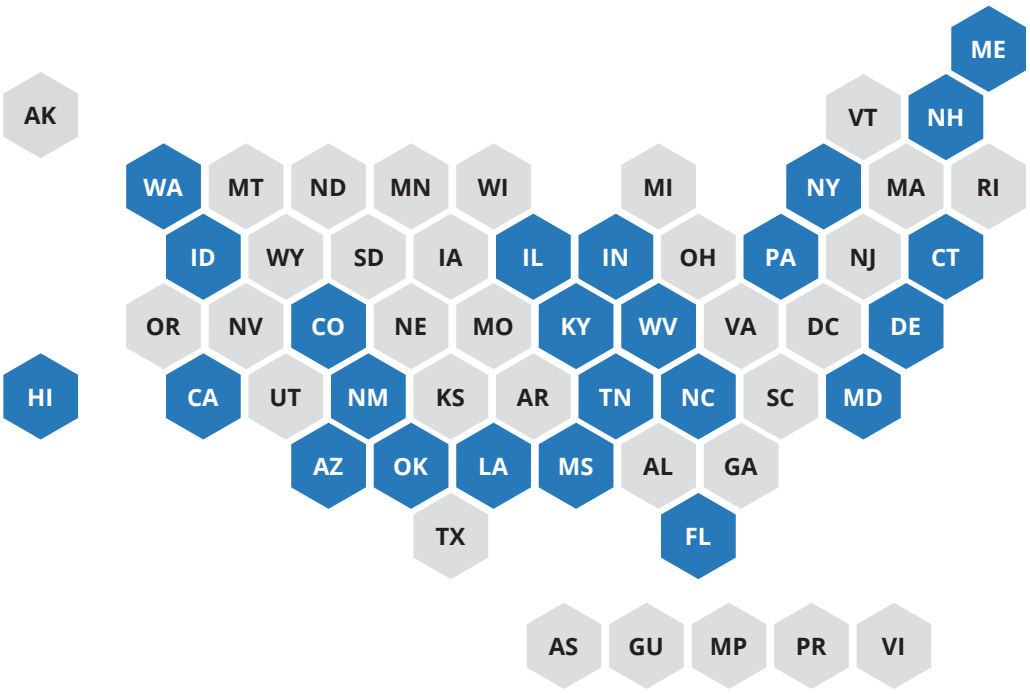
In 2021, the Arizona legislature established the Maternal Mental Health Advisory Committee to review existing screening and treatment resources within the state and provide recommendations for improvement to the legislature by December 2022. In 2022, New York required the office of mental health, in conjunction with

other health and maternal health experts, to conduct a comprehensive study on the "impacts of postpartum depression screening measures in relation to Black women, brown women and birthing people." This study will review existing screening and treatment protocols, as well as consider new questions regarding social determinants of health, isolation and family structure. The legislature will reflect on recommendations from the study in order to improve care for pregnant and postpartum women.

In 2022, Louisiana and Nebraska ensured hospitals, birthing centers and providers meeting with pregnant women screened for perinatal mood and anxiety disorders. Bills in both states established the ability for providers to screen caregivers during a prenatal visit and provide resources regarding symptoms and treatment for depression.

In the last several years, a number of states passed legislation regarding the care and treatment of pregnant and postpartum women in the correctional system (see Figure 2). These actions include training for staff on physical and mental health care needs for pregnant women, ensuring protocols are in place to support pregnant women needing mental or behavioral health care, limiting or prohibiting the use of shackles or restraints for pregnant and postpartum women, having access to treatment for postpartum depression by a qualified mental health professional and access to treatment for women who may experience a miscarriage or sexual violence.

Figure 2: State Actions: Care and Treatment of Women in Correctional Settings



Maternal Mental Health Hotline

People experiencing depression-like symptoms or experiencing challenges related to substance use should consult their physician immediately. The Health Resources and Services Administration created a national maternal mental health hotline, which provides free and confidential support 24/7 before, during and after pregnancy.

Substance Use During and After Pregnancy

Studies have shown unmanaged mental health conditions can be linked to an increased risk of use or misuse of legal and illegal substances. The risk of using substances in response to or to treat depression symptoms can often increase the likelihood of worsening mental health conditions over time and enhance the possibility for dependence. If not managed, pregnancy can complicate the relationship between depression and substance use. Substances including tobacco, alcohol, prescription drugs and illicit drugs can pass from the mother to the fetus and contribute to adverse effects before and after birth, and the risk of drug overdose can increases with the combining of substances such as opioids with benzodiazepines or opioids with alcohol.

The Centers for Disease Control and Prevention studied specific effects of substances during pregnancy and discovered the following:

- Alcohol use can contribute to miscarriages, stillbirth, birth defects and developmental disabilities. These disabilities can be known as fetal alcohol spectrum disorders.
- Opioid use can contribute to poor fetal growth, preterm birth, stillbirth, specific birth defects and neonatal abstinence syndrome or neonatal opioid withdrawal.
- Cigarette smoking can increase the risk of preterm birth, low birth weight, birth defects of the mouth and lips and sudden infant death syndrome.
- Marijuana use may contribute to low birth weight and increased challenges with memory, attention, learning and behavior, according to some studies. Possible effects of marijuana use during pregnancy are still widely unknown. Marijuana remains an illegal, Schedule I substance federally and many current studies of marijuana and pregnancy have been completed through self-reporting individuals.

Federal Action

The White House and federal agencies provided recommendations to increase access to medication for opioid use disorder, prevent unnecessary foster care placement and enhance clinical guidance for treating pregnant and parenting women with opioid use disorder.

State Policy Options

To assist women during and after pregnancy who may experience challenges with substance use, states have increased supports for opioid use disorder and enhanced access to care. In recent years, Colorado and Virginia addressed services for pregnant women who may be experiencing an opioid use disorder, co-occurring substance use disorder or mental health disorder. Colorado's bill includes funding for a pilot program that will co-locate services for substance use disorder, including medication for opioid use disorder and obstetric and gynecological health services in order to enhance service coordination. Virginia will work with the state's Opioid Abatement Authority to provide evidence-based or evidence-informed methods, strategies and programs to support pregnant and parenting women and infants who present with neonatal abstinence syndrome.

Florida and Illinois enhanced existing supports to increase care for pregnant and parenting women. Florida added mental health as a symptom for high-risk pregnancies in order to support targeted outreach. This outreach is intended to provide a peer-based, culturally sensitive and nonjudgmental approach to outreach and education on prenatal care. Illinois will require the department of human services to ensure access to substance use disorder services statewide for pregnant and postpartum women, ensure programs are gender-responsive and trauma-informed, serve women and young children and prioritize justice-involved pregnant and postpartum women.

Postpartum Long-Acting Reversible Contraception

The timing and spacing of pregnancy not only affect health, social and economic outcomes for individuals and their families, but can also have broad societal implications. Responding to the high costs of unplanned pregnancy for women, families and states, some state leaders have explored strategies to help women plan, space or prevent future pregnancies. Some states are increasing access to long-acting reversible contraception (LARC) during the postpartum period to reduce unplanned pregnancies. LARC methods describe types of birth control that provide long-term pregnancy prevention, including intrauterine devices (IUDs) and hormonal implants. They are one of the most reliable and common pregnancy prevention strategies and can make a particular impact during the postpartum period.

For example, one study found that immediate postpartum LARC placement averted 88 unintended pregnancies per 1,000 women over two years. This could save more than $3,200 in medical costs for each unintended pregnancy. In addition to direct health costs, LARCs can also help avoid broader public welfare costs in programs that serve young, low-income women and their children, such as Medicaid and the Temporary Assistance for Needy Families program. When Colorado provided LARCs to individuals with low incomes, teen birth rates and teen abortion rates dropped by half and the state saved nearly $70 million in public assistance costs over a five-year period.

Unplanned Pregnancy

Women who experience an unplanned pregnancy are less likely to receive prenatal care and may have a higher risk for postpartum depression and mental health problems later in life. Unintended pregnancies have been associated with higher rates of preterm birth and low birth weight. One analysis estimated the immediate direct medical costs of unintended pregnancy to be $5.5 billion in 2018, an increase from $4.6 billion in 2011 despite declines in unintended pregnancy rates.

In the first year postpartum, at least 70% of pregnancies are unintended, 10-40% of women do not attend their postpartum visit and 40-75% of women who plan to use an IUD postpartum do not obtain it.

Barriers to LARC provision include a lack of provider training and the inability to perform same-day insertion, which together limit overall use. While LARC methods are incredibly cost-effective, they come with a high upfront cost, often upward of $1,000. Also, many payers do not reimburse for a LARC device immediately after delivery. To reduce these barriers, state policymakers are exploring a range of strategies to help women plan, space or prevent future pregnancies during the critical postpartum period.

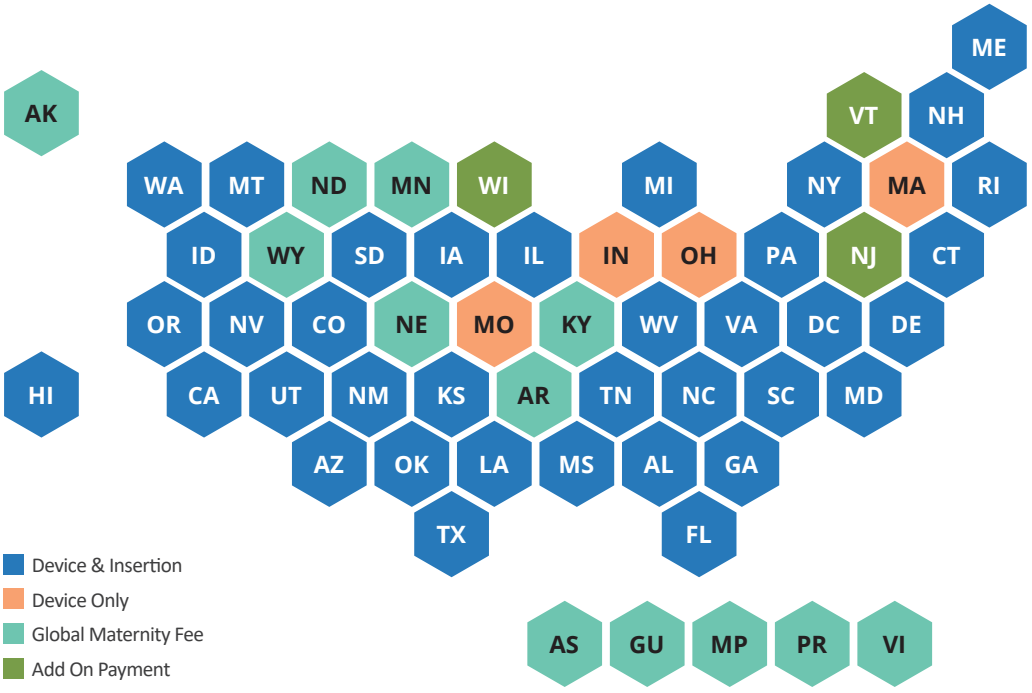
State Policy Options

States have acted in recent years to improve reimbursement, address funding and provide education to remove barriers to postpartum LARC.

States are increasingly unbundling the cost of LARC devices and insertion from other postpartum services to increase reimbursement rates. Traditionally, Medicaid and commercial payors paid for postpartum LARCs as part of a global payment for labor and delivery, meaning that providers were not separately reimbursed for the cost of the device or the placement of the device. In 2016, CMS issued an informational bulletin outlining Medicaid payment strategies state could use to remove barriers to LARCs, including unbundling payments.

States have used these payment strategies in both Medicaid and commercial insurance. At least 26 states separately pay providers for both the cost of the device and for provider placement, 30 states separately pay for the cost of the device, and 34 states separately pay for provider placement.

Figure 3: Immediate postpartum LARC reimbursement policies



Data from Health Policy and Access to Long-Acting Reversible Contraceptives

Most states have also issued guidance on Medicaid reimbursement for postpartum LARC provided in the hospital setting. Illinois requires commercial health plans to allow hospitals separate reimbursement for LARC devices provided immediately postpartum in the inpatient hospital setting before hospital discharge. Mississippi requires any contractors receiving payments under a managed care delivery system to work with providers of Medicaid services to improve the use of LARC.

Some states address LARC access through funding mechanisms. Virginia's 2018 and 2021 budget bills included funding to expand access to LARC methods. The 2018 funding allocated federal funds to a two-year pilot program that provided approximately 4,000 no-cost visits for LARC to eligible patients. In 2018, New Mexico appropriated $250,000 to purchase LARC devices to improve same-day access and for provider training. In 2022, Indiana appropriated $700,000 to expand Medicaid LARC coverage.

Lastly, states can increase access to LARC through education. For example, West Virginia requires pharmacists who dispense self-administered hormonal contraceptives to provide patients with information on the effectiveness and availability of LARC.

FEDERAL ACTION

Section 2713 of the Patient Protection and Affordable Care Act (ACA) requires all non-grandfathered group health and individual health insurance plans to cover certain preventive health services with no cost sharing (e.g., copayment, coinsurance, or deductible). This includes coverage for all contraceptive methods approved by the U.S. Food and Drug Administration, including LARCs, subject to religious exemptions and accommodations for certain employers.

Federal law also requires states to cover prescription contraception without cost-sharing in the state's Medicaid plan as part of the mandatory family planning benefit. States have flexibility to specify the services, supplies, payment methodologies and providers that are included in the Medicaid family planning benefit as long as patient freedom of choice is preserved and federal coverage requirements are met or waived through Section 1115 demonstration waivers. Most states cover LARC methods through their Medicaid family planning benefit.

Under the federal Health Center Program, federally qualified health centers (FQHCs) play an integral role in providing contraception to low-income and uninsured individuals. The Title X family planning program has enabled many FQHCs to keep LARC in stock by covering the devices' up-front costs. FQHCs may also enroll in the 340B Drug Pricing Program, which entitles them to purchase LARCs at a discounted price.

Policy Outcomes

Evidence indicates that policies unbundling payments for postpartum LARC are having the intended effect. A study in South Carolina found the policy change to be associated with increased LARC use and that women who received immediate postpartum LARC were less likely to have a subsequent short-interval pregnancy. Another study of five states found that Medicaid reimbursement of immediate postpartum LARC was associated with a statistically significant increase in the rate of LARC placement.

Breastfeeding

Breastfeeding has wide benefits for both mothers and babies. Skin-to-skin contact increases oxytocin levels in the mother and helps the mother bond with her new baby. Increased oxytocin also helps the uterus contract and can reduce the amount of bleeding after delivery. According to the CDC, mothers who breastfeed have a reduced risk of breast and ovarian cancer, type 2 diabetes and high blood pressure.

Women who breastfeed also experience fewer costs compared to mothers who do not breastfeed. According to the Surgeon General's Call to Action to Support Breastfeeding, breastfed infants have fewer sick visits, prescriptions, hospitalizations and medical care costs compared to infants who were never breastfed. Breast milk contains nutrients and antibodies that can protect babies from infections and promote brain development. Breastfed babies also have a lower risk of sudden infant death syndrome (SIDS), childhood obesity, severe respiratory infections, type 2 diabetes and leukemia.

The U.S. Dietary Guidelines for Americans, American Academy of Pediatrics and World Health Organization recommend exclusive breastfeeding for the first six months, followed by continued breastfeeding while introducing foods. According to a study published by the American Academy of Pediatrics, 60% of mothers stop breastfeeding earlier than they desire. A mother's duration of breastfeeding can be influenced by many factors including issues with lactation and latching, effort associated with pumping milk, mental health and a lack of supportive work policies or parental leave.

Breastfeeding Disparities

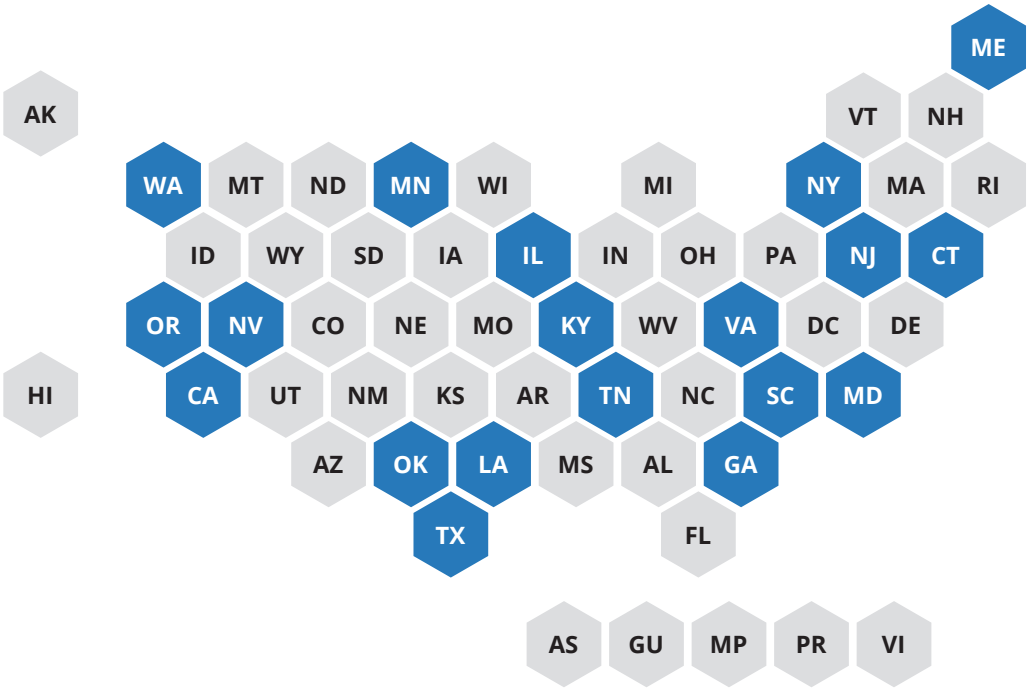
- Fewer non-Hispanic Black infants (74.1%) are ever breastfed compared with Asian infants (90.8%), non-Hispanic white infants (85.3%) and Hispanic infants (83.0%).
- Infants eligible for and receiving the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are less likely to ever be breastfed (74.7%) than infants eligible but not receiving WIC (85.6%), and infants ineligible for WIC (91.2%).
- Younger mothers aged 20 to 29 years are less likely to ever breastfeed (79.9%) than mothers aged 30 years or older (84.9%).

Source: Centers for Disease Control and Prevention

State Policy Options

States have passed at least 70 bills related to the safety and accessibility of breastfeeding in the last several years. Strategies to increase support for breastfeeding include expanding accommodations, increasing insurance coverage of lactation support and increasing access to human donor breast milk.

Figure 4: State Action: Expanding Accommodations for Breastfeeding Mothers, 2019-2022



Since 2019, at least 20 states have passed laws expanding accommodations for breastfeeding mothers in the workplace, in school or in public buildings (see Figure 4). For example, South Carolina required employers to provide reasonable unpaid break time or to permit paid break time to breastfeed at work. In addition, employers shall make reasonable efforts to provide employees areas to breastfeed. Washington required reasonable accommodation by employers for the expression of breast milk without requiring written certification from a health care professional. In 2021, Minnesota stated that state government employers are not allowed to reduce an employee's compensation for time used to express breast milk. As of December 2022, federal law requires employers of all sizes to provide certain employees with reasonable break time and a space to express breast milk for up to one year after their child's birth.

At least three states recently expanded breastfeeding access in schools. Maryland required high schools to have a private lactation space with a nearby electrical outlet and access to a refrigerator for all pregnant and parenting students. In 2022, Louisiana required each governing authority of a public high school to adopt policies regarding breastfeeding and child care for students who are pregnant or parenting. Arkansas required that each public school district shall provide reasonable accommodations for lactating students to breastfeed on school campus.

Several states have also expanded breastfeeding accommodations in public buildings. Oklahoma required the appropriate authority of a covered public building to ensure availability of a lactation room. In 2021, Nevada required courthouses to contain lactation rooms for use by members of the public. New York required airports to provide a room or other location at each airport passenger terminal.

Other states have focused on medical coverage for breastfeeding supports. Under current federal policy, most private health insurance plans are required to provide coverage for specified women's preventive health services, including certain lactation support services, with no cost sharing. As of July 2021, 27 states and the District of Columbia covered at least one breastfeeding support service in the state's Medicaid program. Covered breastfeeding supports may include breastfeeding education, manual and electric breast pumps and lactation consultants in inpatient, outpatient and home visiting settings and will vary by state.

For example, Georgia provides Medicaid coverage for lactation care and services for one year following the date the pregnancy ends, which includes patient education and the recommendation and use of assistive devices. In 2021, Nevada passed a bill requiring the state Medicaid agency to include breastfeeding supports, including electric breast pumps and lactation consultation and support, in the state plan. New Jersey provides comprehensive lactation counseling and consultation, telephonic lactation assistance, and covers the costs for renting or purchasing breastfeeding equipment for the duration of breastfeeding.

At least five states have recently enacted bills related to donor breast milk. For example, Pennsylvania regulated milk banks that provide donor human milk, including expanding licensee requirements and providing for the inspection of facilities. In 2022, Louisiana and Florida passed bills allowing for Medicaid coverage of donor breast milk and Maine required Medicaid reimbursement for pasteurized donor breast milk if a physician or physician assistant or an advanced practice registered nurse signs an order.

Federal Action

The Patient Protection and Affordable Care Act (ACA) passed in 2010 requires new private health insurance plans, including those available in the new health insurance marketplaces, to provide coverage for specified women's preventive health services with no cost sharing. Breastfeeding support services, such as counseling, education and equipment, are one of these specified preventive services. Congress passed the Fairness for Breastfeeding Mothers Act in 2019, requiring certain public buildings to provide a room other than a bathroom that is hygienic and available for use by the public to express breast milk. In 2022, Congress updated the Break Time for Nursing Mothers section of the Fair Labor Standards Act to require employers of all sizes to provide certain employees with reasonable break time and a space to express breast milk for up to one year after their child's birth.

Home Visiting

Home visiting is a preventive service delivery strategy that supports soon to be parents and families through healthy development practices, positive parenting skills and community resource connections.

There are several different models of home visiting that vary by outcome, duration, frequency of visits and intended target population. The U.S. Department of Health and Human Services recognizes 23 evidence-based home visiting models that are eligible for federal funding. Rigorous evaluations of these programs have shown positive impacts across maternal and child health, child development and family economic well-being, among other areas. The Health Resources and Services Administration (HRSA) administers the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program in partnership with the Administration for Children and Families (ACF). The program supports voluntary, evidence-based home visiting services for pregnant people and parents with young children up to kindergarten entry across states, territories and tribal entities.

Postpartum care is one particular area of focus for home visiting programs. Several models seek to enroll people during pregnancy in prenatal services and continue home visiting services after delivery, helping to sustain care during the critical postpartum period. Services can include connecting mothers to mental health care and lactation support, among others.

Virtual Tools

While there are certain limitations to providing virtual home visiting services, MIECHV and other home visiting developers released guidance to encourage using telephone and/or video technology to maintain contact with families when in-person visits are not feasible. Virtual tools are one way to enhance access to important health care services, particularly in rural and underserved communities.

State Policy Options

Following the creation of MIECHV in 2010, at least 27 states have enacted home visiting legislation of their own. Recent policy action ranges from ensuring accountability and targeting quality improvement measures, to addressing home visiting more broadly as a component of states' early childhood systems.

Forty-five states, the District of Columbia and four U.S. territories currently have an active Early Childhood Advisory Council, which works to promote coordination across many early childhood programs and services, including home visiting programs. Some states are taking additional action to connect these systems. In 2021, Maine, for instance, established a comprehensive system of early identification, referral and follow-up care across early education, child care and home visiting services.

Some states, such as Connecticut, have strengthened evidence-based requirements and oversight for home visiting models. Others, including Illinois and Minnesota, have focused on increasing access to services. Minnesota expanded grant awards for home visiting programs that address health equity, utilize community-driven strategies, or serve families with young children or pregnant women who are high risk. In 2022, legislation enacted in Maryland required the state Medicaid program to cover doula services that improve birth-related outcomes, including those delivered through home visiting.

State Program Examples:

- **South Carolina's** Nurse-Family Partnership, funded in part by Medicaid, is the nation's first maternal and child health home visiting program to use a pay-for-success model, where funders provide upfront capital and the state pays for all or part of the program if it measurably improves the lives of participants. This program pairs low-income, first-time pregnant women with a home visiting registered nurse to improve pregnancy outcomes, among other goals. Evaluations have found improvements in breastfeeding initiation and birth weight, and a $7.70 return on investment for every $1 invested.
- **Kentucky's** Health Access Nurturing Development Services (HANDS) Program supports new and expectant parents throughout pregnancy and during the following two years. The program focuses on outreach to first-time parents who face challenges such as single parenthood, low income, substance use or domestic violence. Among other outcomes, research has found benefits in birth weight, maternal receipt of prenatal services and reduced pregnancy-related hypertension.

Finally, some state legislatures are experimenting with offering universal programs. Oregon and New Jersey established voluntary statewide newborn nurse home visiting services available to anyone free of charge in 2019 and 2021, respectively. Oregon's program offers up to five visits and New Jersey offers up to three. Both states are implementing the Family Connects International model and are in varying stages of planning and implementation.

Conclusion

Policymakers and institutions at the local, state and federal level can each play a role in supporting maternal health during the postpartum period. State legislators can help ensure that public investments and policies support data-driven, coordinated strategies that improve pregnancy-related health outcomes and foster healthy families.

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $400,000 with 100% funded by HRSA/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. government.

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