

Questions and Answers: Extending Medicaid Coverage for Pregnant People beyond 60 Days Postpartum

(As of September 2023)

Q: How many states have extended or are in the process of seeking federal funds to extend Medicaid coverage beyond the federal requirement of 60 days postpartum?

A: Forty-seven states, the District of Columbia, and the U.S. Virgin Islands have taken action to pursue this coverage extension. [See our map.](#)

Q: Does a postpartum coverage extension have bipartisan support?

A: Yes. Legislators, governors, and state health officials across the country in both red and blue states are pursuing coverage extensions. The list of interested states continues to grow. [See our map.](#)

Q: Should my state choose a state plan amendment (SPA) or a Section 1115 waiver to extend coverage?

A: ACOG recommends that states pursue the SPA option, as that option provides less administrative burden, avoids budget neutrality requirements, and guarantees continuous coverage with the full scope of Medicaid benefits for the entire 12-month postpartum period.

Q: What other medical societies and health groups support a postpartum coverage extension?

A: In addition to ACOG, the [American Medical Association](#), American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American College of Cardiology, American Hospital Association, American Osteopathic Association, American Psychiatric Association, March of Dimes, and Society for Maternal-Fetal Medicine support extending Medicaid coverage for pregnant people beyond 60 days postpartum.

Q: Is federal approval required for states to extend postpartum coverage for Medicaid-insured individuals in their states?

A: Yes. If a state wants federal financial support for the coverage extension, they must submit a Section 1115 waiver to CMS or a SPA, which does not require a public comment period or budget neutrality conditions. Both pathways require approval from CMS.

Q: How much will it cost states to do extend Medicaid coverage to one year postpartum? And what are the potential cost savings?

A: State costs will vary based on Medicaid eligibility criteria and targeted population. If a state chooses to extend postpartum coverage through a SPA or a Section 1115 waiver, they will be provided with significant federal funds based on their [state's federal matching rate](#).

Q: My state already expanded Medicaid coverage under the ACA. Why would we pursue Medicaid extension?

A: Even in states that expanded Medicaid to childless adults up to 138% of the federal poverty level under the ACA, coverage gaps and insurance disruptions remain. This is especially true throughout the perinatal period. Recent analysis shows that nearly one in three women in Medicaid

expansion states experienced an insurance disruption from prepregnancy to postpartum. Extending Medicaid coverage from 60 days to one year postpartum could help state Medicaid programs establish seamless coverage, allowing individuals to stay with their current health care professional. Policy makers and experts surmise that the continuity of care will decrease the increasing maternal mortality and morbidity rates in the United States because approximately 30% of all pregnancy related deaths occur between 43 and 365 days after delivery.

Q: Can states that haven't implemented Medicaid expansion extend Medicaid coverage for the postpartum period from 60 days to 12 months?

A: While most low-income women in non-expansion states can qualify for Medicaid while pregnant and up to 60 days postpartum, more than one in five experience uninsurance in the postpartum period. The 12 non-expansion states are: AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI and WY. These states have extremely restrictive eligibility thresholds allowing only the poorest individuals to qualify for Medicaid. For example, in Texas, an income of more than \$302 a month disqualifies parents with one child from receiving Medicaid. While a postpartum coverage extension is not an alternative to Medicaid expansion under the ACA, it is a good option for promoting better continuity of care in the vulnerable postpartum period.

Q: What types of services will be covered under a postpartum coverage extension? Is this coverage limited to services related to pregnancy?

A: While each state Medicaid program is different, the benefits that pregnant and postpartum people receive through Medicaid meet the federal definition of minimum essential coverage, meaning that pregnant and postpartum people can receive care for services unrelated to their pregnancy. There are only three states where the coverage that individuals receive through Medicaid does not qualify as minimum essential coverage: Arkansas, Idaho, and South Dakota. The SPA requires coverage of the full scope of Medicaid benefits for the entire year postpartum for

- beneficiaries eligible and enrolled in any Medicaid eligibility category while pregnant
- eligible pregnant minors enrolled in Children's Health Insurance Programs not included in the state Medicaid program
- targeted low-income pregnant adults receiving coverage through the Children's Health Insurance Program

Q: How will a postpartum coverage extension affect my payment under the global obstetric code?

A: It should not. The purpose of the coverage extension is to give people health insurance for longer so that they can receive health care for a year postpartum regardless of their condition. While some visits may be with an obstetrician-gynecologist, they should be billed outside of the global obstetric code after the in-office postpartum visit occurs.