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Postpartum Health Care Use in Medicaid During the COVID-19 Public Health Emergency: Implications for Extending Postpartum Coverage

Among beneficiaries with Medicaid-paid births, postpartum health care use covered by Medicaid was higher during the COVID-19 public health emergency when extended Medicaid coverage was in place, with the largest increases seen in rates of primary care visits.

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KEY POINTS

- The average rate of births in which the mother attended at least one primary care visit covered by Medicaid in the first year postpartum increased by 9.3 percentage points when comparing postpartum care use before and during the public health emergency (PHE), while the Medicaid continuous enrollment condition was in place.
- Among women with at least one chronic condition, for whom primary care visits can play a particularly important role, primary care visits increased by 8.6 percentage points during this period.
- The rate of visits to an obstetrician/gynecologist covered by Medicaid in the postpartum year also increased by 3.9 percentage points from before the PHE to during the PHE.
- Compared to the pre-PHE period, emergency department (ED) visits in the postpartum year among women covered by Medicaid increased 2.4 percentage points during the PHE, with decreases seen during the early postpartum period (months 0-2) but increases seen slightly later in the postpartum period (months 4-12).
- The largest increases between the pre-PHE and PHE periods across all Medicaid postpartum utilization measures were observed in states with the lowest parental income eligibility limits, states that had not expanded Medicaid to low-income adults, as well as states in which postpartum women were previously estimated to experience the largest gains in coverage under a postpartum coverage extension.
- Rates of postpartum primary care and ED visits covered by Medicaid increased in areas with low access to maternity care, including maternity care deserts. However, despite coverage gains, the same magnitude of increases in postpartum care use covered by Medicaid were not observed in rural areas, which may reflect other limitations, such as provider access constraints.

INTRODUCTION

Stable postpartum insurance coverage is an important tool to improve maternal health outcomes and is particularly important given the increased risk of adverse health outcomes in postpartum women. Across 38 states in 2020, 26.9 percent of pregnancy-related deaths, defined as deaths that occur during or within one year of the end of pregnancy, occurred between 43 and 365 days postpartum.[1] The leading causes of death among all pregnancy-related deaths were mental health conditions, including deaths to suicide and substance use disorder, and cardiovascular disease.[2] It is estimated that four out of five of all pregnancy-related deaths could be prevented through changes to patient, community, provider, facility, and/or system factors.[1] During the COVID-19 pandemic, the United States experienced an increase in its maternal mortality rate* from 20.1 deaths per 100,000 live births in 2019 to 32.9 deaths per 100,000 live births in 2021, in part due to elevated risks associated with contracting COVID-19 while pregnant.[3] However, provisional data indicate the maternal mortality rate decreased to 19.6 deaths per 100,000 live births in 2023.[4]

In addition to maternal mortality, the rate of severe maternal morbidity (SMM), or unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to the mother's health, has increased between 2010 and 2020.[5] In 2021, 43,600 Medicaid-paid deliveries were associated with an SMM condition.[6] It is estimated that over 40 percent of SMM is preventable.[7]

The American College of Obstetricians and Gynecologists (ACOG) sets evidence-based clinical care guidelines for postpartum care to improve health outcomes.[8] Recommendations include contact with an obstetrician and gynecologist (OB/GYN) within the first three weeks postpartum and ongoing care as needed, and a comprehensive postpartum visit by 12 weeks postpartum. ACOG further emphasizes that patients with chronic medical conditions† should follow up with a primary care provider to monitor and manage these conditions due to an association between certain pregnancy-related complications and future health risks, such as arteriosclerotic cardiovascular disease.[9] If not already followed by a primary care practitioner, ACOG states that women and their OB/GYN providers should work together to identify a primary care medical home.

Medicaid plays a large role in ensuring continuity of coverage for postpartum women nationally as the program finances over 40 percent of all births.[10] However, previous research has shown that Medicaid coverage losses during the postpartum period were common in part because federal statute requires states provide Medicaid coverage for pregnancy only through the end of the month in which 60 days postpartum falls. In a national analysis of Medicaid enrollment data from 2018, 31 percent of Medicaid beneficiaries were disenrolled from Medicaid within six months of a live birth, and 40.6 percent of Medicaid beneficiaries with a live birth were disenrolled within a year.[11] One study found that between three and five months after birth 22 percent of postpartum individuals with Medicaid-paid births reported being uninsured and 19.7 percent reported commercial coverage.[12]

During the COVID-19 public health emergency (PHE), which began on March 18, 2020, states were eligible for enhanced federal matching funds under certain conditions, including providing continuous coverage to Medicaid beneficiaries through the end of the PHE. This "continuous enrollment condition" generally halted postpartum disenrollment among Medicaid beneficiaries, including among pregnant and postpartum

* The World Health Organization defines maternal mortality as deaths among women while pregnant or within 42 days of being pregnant.

† ACOG guidance references chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders.

beneficiaries until March 31, 2023.[‡] During this period, the American Rescue Plan Act of 2021 (ARP), which became law on March 11, 2021, offered states a five-year state option, effective April 1, 2022, to use federal matching funds to provide full-benefit Medicaid or CHIP coverage for one year postpartum. This option was made permanent in the Consolidated Appropriations Act, 2023 (CAA). This state option acknowledges the ongoing health risks postpartum individuals face between 60 days and 12 months postpartum and promotes continuity of postpartum coverage for people enrolled in Medicaid during pregnancy. To date, 47 states, the District of Columbia, and the U.S. Virgin Islands have implemented 12-month postpartum extensions under the ARP option, and one additional state is planning to implement the extension.[13,14]

This Issue Brief provides a descriptive analysis of postpartum health care use among the Medicaid population before and during the PHE, when the continuous enrollment condition was in effect. Although the COVID-19 pandemic itself had unique effects on health care use patterns, the continuous enrollment condition provides insight into the potential impact of nearly nationwide adoption of recent ARP and CAA 12-month postpartum coverage extensions. Data presented in this Issue Brief may be used by state Medicaid agencies as a resource to estimate costs of and usage of services by the postpartum population in Medicaid.

METHODS

We used claims data from the Centers for Medicare and Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) from 2018-2023. We identified women ages 12-64 who had claims indicating labor or delivery from the inpatient, long-term care, or other services files in T-MSIS. We included women who had stillbirths but women who had pregnancies that did not result in labor or delivery-related claims were not captured. We also excluded those who were dually enrolled in Medicaid and Medicare in the year of their labor or delivery. We do not exclude those who had multiple births within the study.

We first assessed national rates of any postpartum health care use, including having a visit with an OB/GYN, a visit with a primary care provider, an emergency department (ED) visit, and inpatient hospital stays among all beneficiaries linked to a Medicaid-paid birth. We also assessed two postpartum quality measures: contraception rates among all beneficiaries with Medicaid-paid births and glucose testing among beneficiaries with gestational diabetes.

We compared rates among two cohorts: (1) a pre-PHE cohort, composed of Medicaid-paid births that occurred March 2018-February 2019, with a postpartum follow-up period that spans through February 2020; and (2) a PHE cohort, composed of Medicaid-paid births that occurred March 2020-February 2022, with a postpartum follow-up period that spans through February 2023. Within these cohorts, we looked at the six outcomes described above.

Results are presented by cohort (spanning 2018-2023), demographics, state, and month postpartum. The denominator for monthly rates of interest is the overall number of births in that cohort, and the numerator is the number of births associated with that service. We stratified all outcomes by age, race and ethnicity, eligibility pathway, Medicaid expansion status, parental eligibility limits, and state. Table 1 and Appendix Table 1 also contain five additional covariates: (1) whether the birth was covered via Medicaid managed care coverage, (2) whether the birthing person resided in a rural versus urban county or zip code,[§] (3) whether the

[‡] The Families First Coronavirus Response Act (FFCRA) initially set an expiration of this continuous enrollment condition as the last day of the month in which the COVID-19 PHE ends; the Consolidated Appropriations Act, 2023 made several amendments to FFCRA section 6008, including an amendment separating the end of the continuous enrollment condition from the end of the COVID-19 PHE and sunsetting the condition on March 31, 2023.

[§] For more detail on the rural-urban methodology using T-MSIS data, see Appendix A of a previous ASPE analysis, available at: https://aspe.hhs.gov/reports/medicaid-chip-telehealth-utilization-enrollee-provider-rurality-2019-2021

birthing person resided in a county designated as a maternity care desert,[**] (4) whether the birth was complicated by severe maternal morbidity (SMM), and (5) whether the birthing person experienced chronic conditions. Managed care plan types described in this study are organized into two categories: managed care organizations (MCOs) and non-MCOs (includes beneficiaries with fee-for-service coverage, as well as those in non-comprehensive managed care arrangements such as accountable care organizations and traditional primary care case management provider arrangements, among others).

Limitations

This analysis has several limitations. First, these findings are descriptive and cannot attribute a causal relationship between the continuous enrollment condition and postpartum health care use. We do not report statistical significance for any percentage point differences presented in this analysis. In addition, we rely on raw T-MSIS data, which have not undergone extensive quality review by CMS, and our interpretation of these data assumes that the enrollment and utilization information is accurate. Our sample also does not capture pregnancy losses or terminations.

Reporting race and/or ethnicity is not required for enrolling in Medicaid, and therefore we observed high rates of missingness for these variables within T-MSIS. We indicate "missing" as a separate category to show the level of completeness for these variables. Additionally, these data do not capture "Multiracial" as a category.

As we are only using a Medicaid data source, this analysis compares utilization of Medicaid-financed services before and after implementation of the continuous enrollment provision. It does not compare total utilization of care from all potential sources of coverage. We do not observe the utilization of individuals whose births were covered by Medicaid but who lost coverage after 60 days postpartum prior to the PHE; these individuals either became uninsured or transitioned to alternative, non-Medicaid health insurance. As such, we do not have insight into whether these individuals were getting similar care through another source of coverage during the remainder of their 12-month postpartum period. Further, global billing in many state Medicaid programs may result in an undercount of routine postpartum visits, which are included in standard maternity care bundles.

Our analysis does not exclude those who had multiple births within the overall study period (2018-2023), and therefore results may capture prenatal care from a subsequent pregnancy within one year of birth.[††]

Though the analysis includes telehealth care, our study did not distinguish services delivered via telehealth vs. in-person, which may explain why annual utilization rates of some types of primary care (e.g., primary care visits and OB/GYN visits) are not suppressed during 2020 compared to other, more acute types of utilization (e.g., ED visits). In addition, the study did not subclassify ED use into urgent vs. non-urgent or preventable vs non-preventable conditions.

RESULTS

Changes in Rates of Key Outcomes Before the PHE and During the PHE

Table 1 compares the rates of key outcomes among births that occurred before the PHE (Pre-PHE Cohort; Medicaid-paid births that occurred March 2018-February 2019) – before the continuous enrollment condition was in place – to births that occurred during the PHE (PHE Cohort; Medicaid-paid births that occurred March

[**] Maternity care desert status is defined using the March of Dimes methodology, available at: https://www.marchofdimes.org/maternity-care-deserts-report-2022.

[††] The national rate of multiple births conceived less than 6 months after a previous birth was 7.1 percent in 2021. (Source: https://www.medicaid.gov/medicaid/benefits/downloads/2024-maternal-health-at-a-glance.pdf)

2020-February 2022). Overall, the largest increases of postpartum care use were seen in rates of primary care visits. The average rate of births in which the mother attended at least one primary care visit covered by Medicaid in the postpartum year increased by 9.3 percentage points between the two time periods.[‡‡] Clinical guidelines recommend women receive an annual preventive visit with a primary care provider, including for postpartum people.[15] Postpartum primary care is particularly important for those who may have experienced pregnancy or birth complications related to chronic conditions such as hypertension, diabetes, or obesity, which require long-term management by a patient's primary care provider. Primary care visits typically occur later in the postpartum year, after the conclusion of obstetric care. Because primary care visits are more likely to occur after 60 days postpartum, primary care utilization may be more responsive to extended Medicaid coverage.

Rates of OB/GYN visits and ED visits covered by Medicaid also increased for births that occurred during the PHE relative to those that occurred before, though the increases were smaller in magnitude. The rate of births with any Medicaid-financed OB/GYN visit within the postpartum year increased by 3.9 percentage points and the rate of births with any Medicaid-financed ED visit within the postpartum year increased by 2.4 percentage points between the two time points. Because of the clinical guidelines for timing of postpartum OB/GYN care, the majority of OB/GYN-based postpartum care typically occurred within a 60 to 90-day window and is therefore potentially less responsive to extended Medicaid coverage. Further, routine postpartum care visits provided by an OB/GYN are often included as part of a bundled maternity payment, which may lead to lower claims volume for this service relative to primary care visits in Medicaid claims data.

In contrast, Medicaid-financed inpatient hospitalizations remained flat across the two time periods, possibly reflecting that the majority of postpartum health issues that require inpatient hospitalization after birth occur within a narrow postpartum window and thus may be less responsive to coverage extensions. Further, the acute nature of inpatient hospitalization may be less affected by changes in health care utilization induced by the COVID-19 pandemic.

Beneficiaries with births who were ages 26 to 35 and 35+ had the largest change in rates of Medicaid-financed OB/GYN visits (+4.4 percentage points each) and primary care visits (+9.9 percentage points and +10.3 percentage points, respectively) relative to all other age groups, while beneficiaries with births who were ages 19 to 25 had the largest change in ED visits (+3.3 percentage points) relative to all other groups.

Differences in Medicaid-covered postpartum health care utilization between births that occurred prior to the PHE versus during also varied by Medicaid eligibility category and state Medicaid policies. Utilization rates for all services increased the most for the pregnancy eligibility category relative to the other eligibility categories. This is unsurprising as prior to the continuous eligibility condition, women who qualified for Medicaid through the pregnancy eligibility category were also more likely to lose Medicaid coverage after the required 60-day postpartum period, as opposed to other eligibility pathways. Comparing states that have expanded Medicaid to low-income adults to those that have not, non-expansion states experienced greater increases in rates of all types of Medicaid-financed utilization, with increases ranging from +0.9 (inpatient hospitalizations) to +14.8 (primary care visits) percentage points. Expansion states experienced changes ranging from a decrease of 1.3 percentage points (ED visits) to an increase of 4.8 percentage points (primary care visits) between the two time periods. By income, the greatest increases were observed for all types of utilization in states with Medicaid eligibility limits for the parental eligibility group of less than 40 percent of the federal poverty level (FPL) relative to births to those with income levels above 40 percent FPL.

[‡‡] Percentage point changes throughout this section are calculated by subtracting the percent of visits in the Pre-PHE period from the percent of visits in the PHE period.

Increases in Medicaid-financed OB/GYN visits during the PHE were higher among births in urban relative to rural areas. Beneficiaries living in urban areas experienced a 4.4 percentage point increase in the rate of at least one OB/GYN visit in the postpartum year, compared to a 2.3 percentage point increase in rural areas. Medicaid-financed ED visits increased more in rural areas, with an increase of 3.2 percentage points relative to 2.4 percentage points in urban areas. Within maternity care deserts and areas with low access to maternity care services, we observed the largest increases in the rate of Medicaid-financed ED visits during the PHE relative to before (approximately +5 percentage points in each). Maternity care deserts experienced a 10.8 percentage point increase in Medicaid-financed primary care visits, and low access areas experienced an even larger 12.0 percentage point increase. An increase of 4.6 percentage points was observed in areas with moderate access to maternity care, and an increase of 9.6 percentage points in full access areas. Additional geographic stratification by state is presented in Appendix Table 1.

For both the pre-PHE and PHE periods, the Medicaid-financed inpatient hospitalization rate was higher in the SMM group relative to the rate among all other Medicaid-financed births (approximately 21 percent vs. 8.5 percent). These rates did not change between the pre-PHE and PHE time periods. Additionally, the rate of SMM remained stable in all study years and between birth cohorts (about 0.7 to 0.8 percent of all Medicaid-paid births).

We observed larger increases in the rate of any Medicaid-financed OB/GYN visit in the postpartum year among births to beneficiaries with no chronic conditions reported in their claims during pregnancy compared to births among those with at least one chronic condition (+4.1 percentage points vs. +3.6 percentage points). Similar findings were observed for primary care visits (+10.5 percentage points vs. +8.6 percentage points) and ED visits (+2.2 percentage points vs. +1.9 percentage points), although both groups experienced increases.

Table 1. Rates of Key Outcomes by Pre-PHE vs PHE Cohorts, by Beneficiary- and Area-Level Characteristics, Ever-Used Within 12 Months Post-Labor

	OB/GYN Visits		Primary Care Visits		ED Visits		Inpatient Hospitalizations	
	Pre-PHE Cohort	PHE Cohort	Pre-PHE Cohort	PHE Cohort	Pre-PHE Cohort	PHE Cohort	Pre-PHE Cohort	PHE Cohort
Overall	45.2%	49.1%	67.9%	77.2%	31.9%	34.3%	8.5%	8.7%
Age								
12-18	48.1%	49.4%	78.7%	82.2%	46.6%	46.0%	11.4%	10.9%
19-25	46.5%	50.1%	69.6%	79.0%	36.2%	39.5%	9.0%	9.2%
26-35	44.7%	49.1%	66.5%	76.4%	28.6%	31.0%	8.0%	8.3%
>35	40.9%	45.3%	62.2%	72.5%	23.2%	25.7%	7.6%	8.0%
Race/Ethnicity								
American Indian/ Alaska Native	33.3%	35.4%	70.0%	79.3%	35.9%	38.3%	11.1%	11.4%
Asian	45.9%	50.5%	66.2%	75.9%	17.4%	18.7%	5.9%	5.9%
Black	48.1%	51.8%	74.5%	82.8%	42.7%	45.2%	10.3%	10.5%
Hawaiian/Pacific Islander	38.4%	41.6%	60.1%	73.4%	23.8%	28.7%	7.3%	7.7%
Latino	43.3%	48.0%	60.7%	71.4%	26.9%	29.7%	7.9%	8.3%
White	47.3%	50.7%	72.1%	81.3%	32.9%	34.9%	8.5%	8.5%
Unknown	39.3%	42.8%	61.6%	69.6%	25.5%	27.7%	7.4%	7.3%
Eligibility Group								
Medicaid Expansion	50.3%	50.3%	83.8%	86.6%	39.6%	37.9%	11.1%	10.7%
Other	47.0%	48.8%	77.5%	81.7%	45.1%	43.9%	12.4%	11.6%
Parent	51.1%	52.8%	78.9%	83.1%	39.7%	37.2%	10.1%	9.7%

Pregnant	41.4%	47.0%	58.9%	71.6%	25.2%	30.5%	6.9%	7.4%
Managed Care Enrollment								
Non-MCO	34.4%	35.5%	54.0%	62.5%	25.1%	27.7%	7.0%	7.1%
MCO	49.0%	53.1%	72.7%	81.5%	34.3%	36.2%	9.1%	9.2%
ACA Medicaid Expansion Status								
Non-expansion States	41.2%	48.2%	54.4%	69.2%	26.6%	34.2%	7.1%	8.0%
Expansion States	48.1%	49.7%	77.5%	82.3%	35.7%	34.4%	9.6%	9.2%
Medicaid Parental Income Eligibility Limit								
<40% FPL	38.6%	47.7%	49.0%	66.4%	24.0%	33.9%	6.7%	8.0%
40-137% FPL	47.2%	49.3%	66.8%	76.3%	32.7%	35.0%	8.0%	7.9%
138% FPL	48.1%	49.7%	77.7%	82.4%	35.6%	34.3%	9.6%	9.2%
>138% FPL	49.2%	50.8%	74.7%	82.2%	38.6%	35.0%	8.7%	8.0%
Urban/Rural Status								
Rural	45.2%	47.5%	70.9%	80.5%	34.2%	37.4%	8.3%	8.3%
Urban	45.4%	49.8%	67.3%	76.9%	31.4%	33.8%	8.6%	8.8%
Maternity Care Desert Status								
Maternity Care Desert	44.8%	48.0%	68.8%	79.6%	32.7%	37.8%	8.1%	8.5%
Low Access	46.1%	49.9%	63.2%	75.2%	30.9%	36.1%	7.6%	8.0%
Moderate Access	54.0%	55.6%	81.9%	86.5%	42.5%	41.1%	9.8%	9.1%
Full Access	45.2%	49.4%	67.8%	77.4%	31.6%	34.0%	8.6%	8.8%
Severe Maternal Morbidity								
No SMM	45.2%	49.1%	67.8%	77.1%	31.8%	34.2%	8.5%	8.6%
SMM	49.5%	53.2%	77.7%	83.8%	44.3%	44.4%	20.8%	21.2%
Chronic Conditions During Pregnancy								
None	40.7%	44.8%	57.6%	68.1%	21.9%	24.1%	5.6%	5.6%
At Least One	46.6%	50.2%	71.0%	79.6%	35.0%	36.9%	9.5%	9.5%

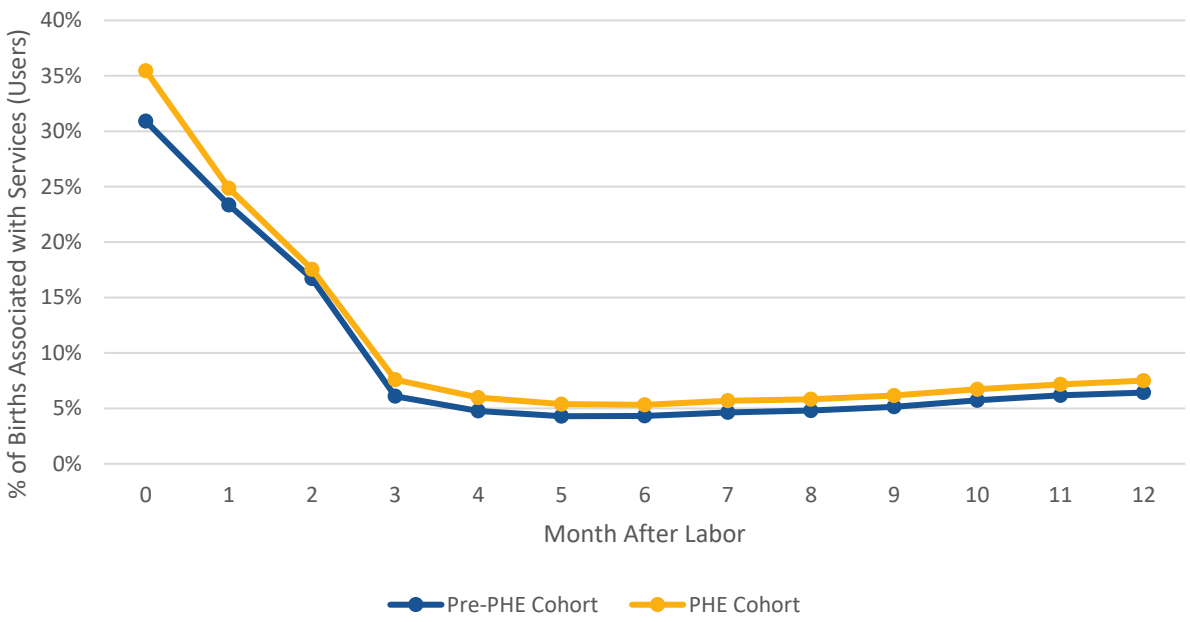
Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.
Notes: Maternity care desert status is defined using the March of Dimes methodology, available at: https://www.marchofdimes.org/maternity-care-deserts-report-2022. MCO = Managed Care Organization. FPL = Federal Poverty Level. SMM = Severe Maternal Morbidity.

Changes in Timing of Key Outcomes Before the PHE and During the PHE

Figures 1 through 6 show rates of any utilization of each service by month 1-12 postpartum among Medicaid-financed births that occurred before the PHE and during the PHE, where the timing of the service is tracked by the month after labor.

Figure 1 shows the timing and rate of any Medicaid-financed OB/GYN visit by month postpartum among births that occurred before and during the PHE. Overall utilization in each month was slightly higher during the PHE, with the highest rate being 35 percent in the same month as labor compared to 31 percent in the pre-PHE cohort. Cohorts' rates trended downward at similar rates, with just 1 percentage point difference in OB/GYN visit rates starting just 2 months after labor.

Figure 1. Monthly Rates of Medicaid-Financed OB/GYN Visits Post-Labor by Cohort

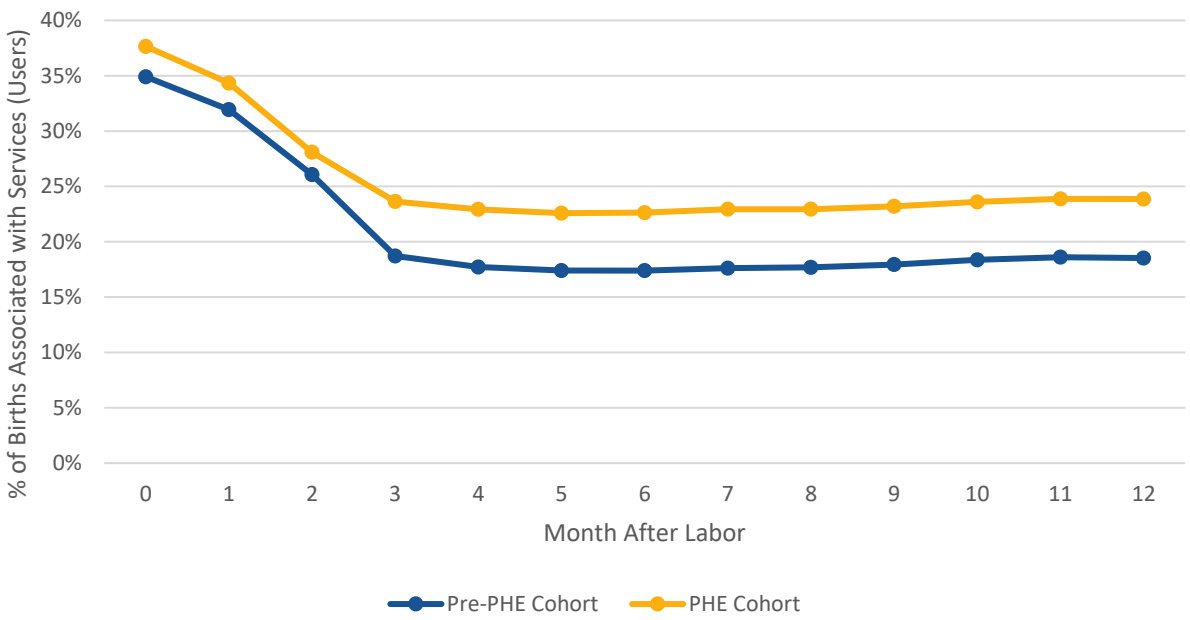


Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

Figure 2 shows the rate of primary care visits by month postpartum among births that occurred before and during the PHE. Similar to OB/GYN visits, primary care utilization was higher overall in each month during the PHE. However, the rates diverged between the second and third month after labor in the PHE cohort compared to the pre-PHE cohort, suggesting that primary care use remained elevated in the extended, post-three-month postpartum period among births that occurred during the PHE relative to before.

As previously described, large differences in timing of care receipt for OB/GYN visits under extended postpartum coverage may not be observed because this type of service is more likely to occur within two months postpartum, while differences in primary care visits may be more apparent as patients may be more likely to visit their primary care provider later in the postpartum year.

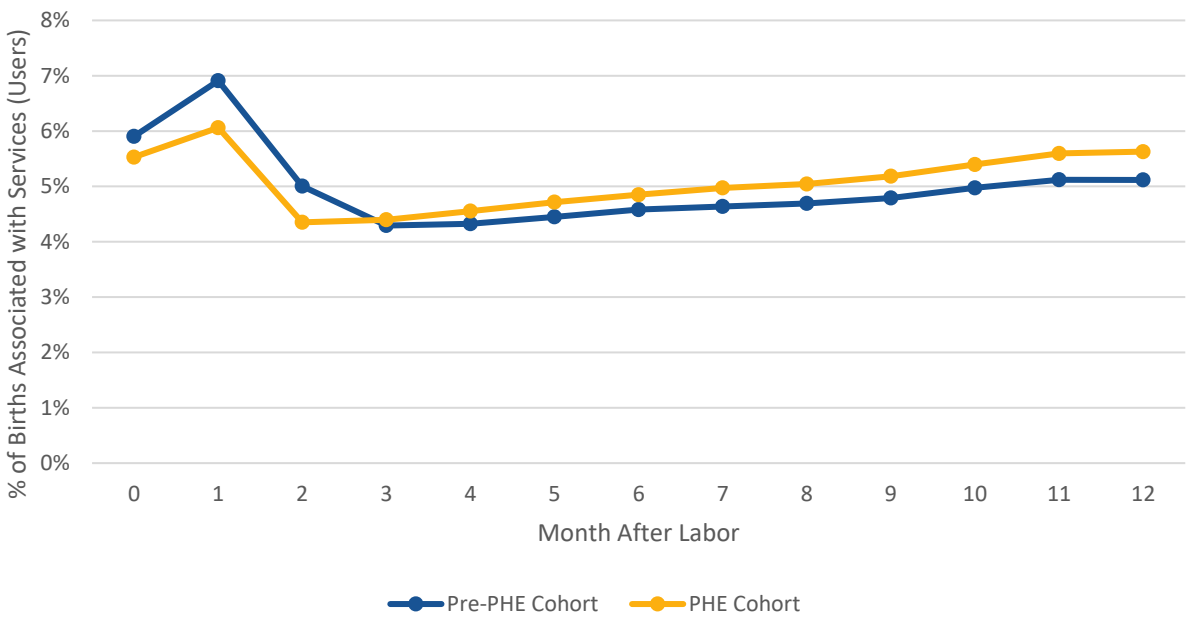
Figure 2. Monthly Rates of Medicaid-Financed Primary Care Visits Post-Labor by Cohort



Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

Figure 3 shows the rate of any Medicaid-financed ED visit by month postpartum among births that occurred before and during the PHE. While the rate of any ED use was slightly lower in the early months after birth, we observed a slight uptick in ED visits in the PHE cohort beginning in month four postpartum, with greater differences seen towards the end of the postpartum year. The lower utilization in the early postpartum months in the PHE cohort may be a result of suppressed utilization during the peak of the COVID-19 pandemic,[16] while increases in later months are potentially attributable to rebound utilization as the COVID-19 pandemic waned, an increase in COVID-related morbidity among the pregnant population that increased demand for emergency services, the fact that more women retained Medicaid coverage for a longer period of time after birth while the continuous enrollment condition was in place, or some combination of these explanations and other factors not discussed here.

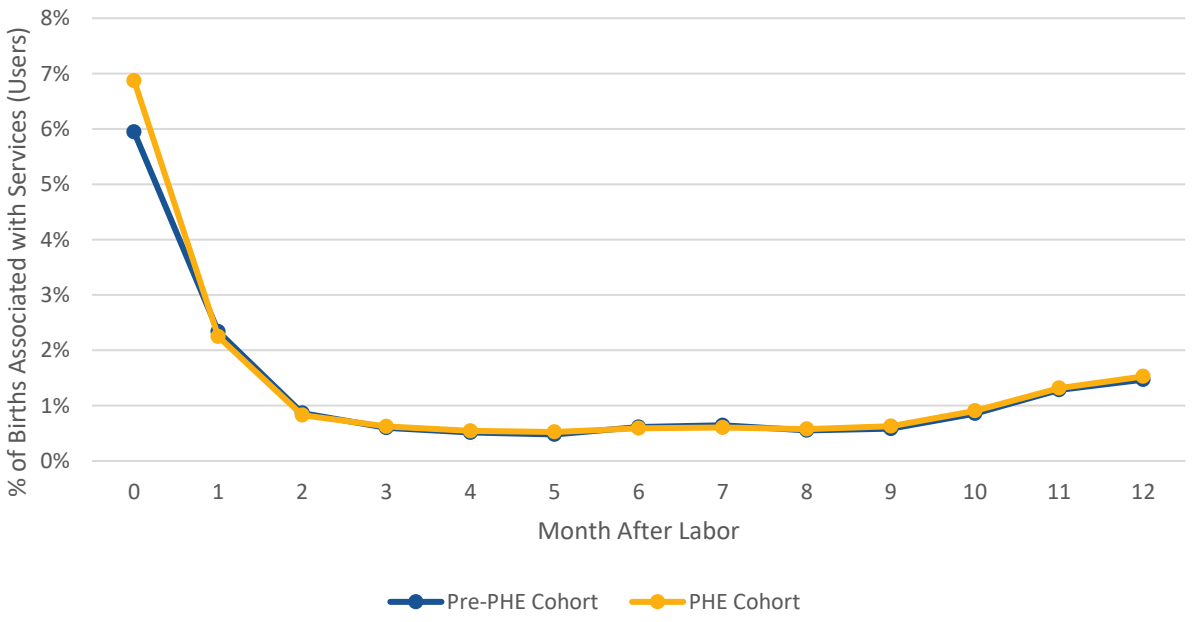
Figure 3. Monthly Rates of Medicaid-Financed Emergency Department Visits Post-Labor by Cohort



Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

Figure 4 shows the rate of any Medicaid-financed inpatient hospitalization by month postpartum among births before and during the PHE. We did not observe evidence of divergent patterns in the rate of any inpatient hospitalizations across the 12 months postpartum before versus during the PHE.

Figure 4. Monthly Rates of Medicaid-financed Inpatient Hospitalizations Post-Labor by Cohort

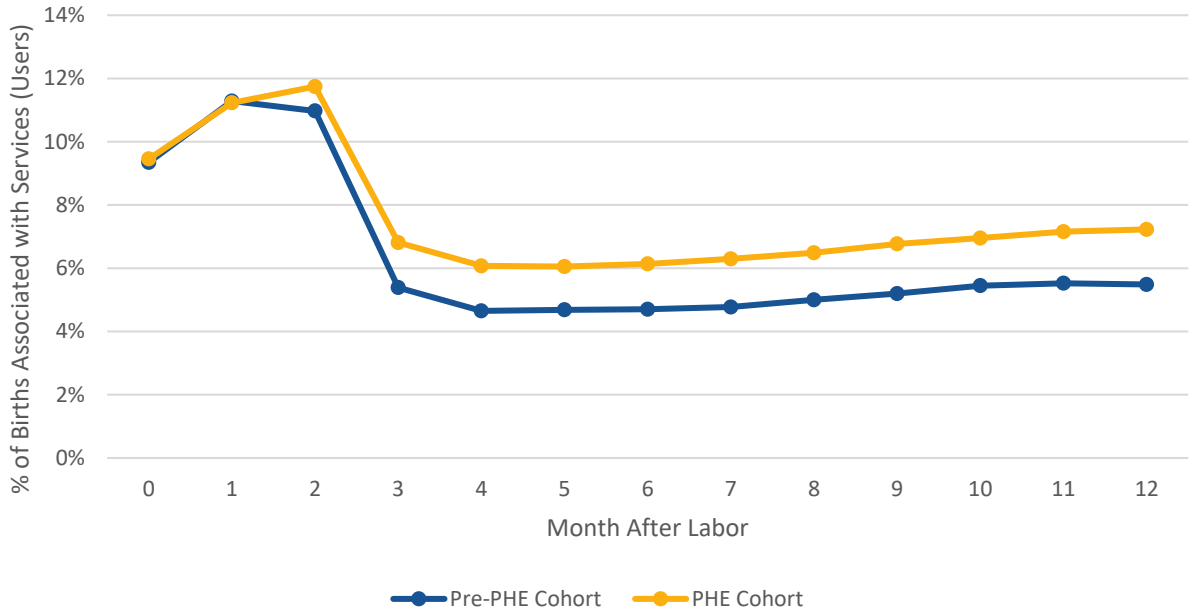


Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

Gestational diabetes affects 5 to 9 percent of pregnancies and can lead to health issues for mothers and babies.[17,18] It is important for glucose to be monitored after birth, as about half of women with gestational diabetes go on to develop type 2 diabetes.[17] Figure 5 shows the rate of any Medicaid-financed glucose

screening among patients with gestational diabetes by month postpartum before and during the PHE. While the timing of glucose screening relative to labor remains largely the same, the rate of screening each month is higher during the PHE relative to before, suggesting screening is occurring in a higher proportion of births during the PHE.

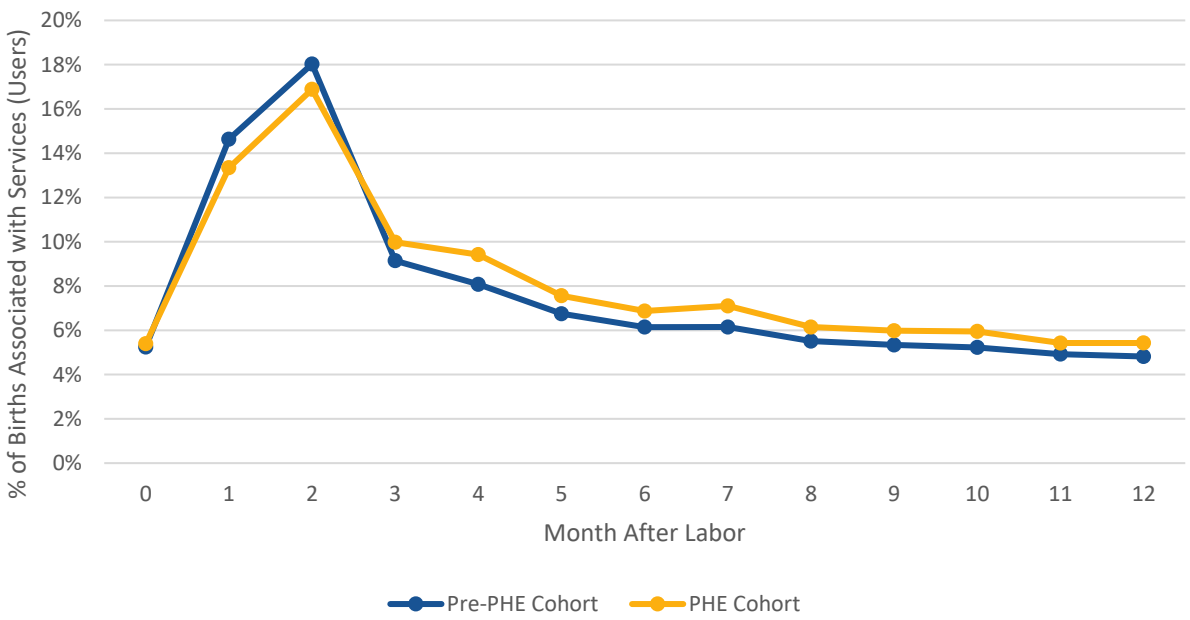
Figure 5. Monthly Rates of Medicaid-Financed Glucose Screening Among Patients with Gestational Diabetes Post-Labor by Cohort



Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

Figure 6 shows the rate of any Medicaid-financed contraception by month postpartum among births before and during the PHE. Contraception rates in months 0 to 2 postpartum were slightly higher before the PHE than during the PHE; however, timing for contraception remains largely the same. We observe an increase in the rate before and during the PHE. For a list of procedure codes contained in the contraception measure, see Appendix C.

Figure 6. Monthly Rates of Medicaid-Financed Contraception Post-Labor by Cohort



Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

DISCUSSION

In this brief, we examined changes in key postpartum utilization measures for Medicaid-financed births before and during the COVID-19 PHE, while the Medicaid continuous enrollment condition was in place. Previous research shows that there was a 31.4 percentage point increase in the rate of continuous Medicaid enrollment during twelve months postpartum for Medicaid-financed births between March to December 2018 and March to December 2020.[19] Our study shows a corresponding increase in utilization of key postpartum services, particularly preventive care services, paid for by Medicaid.

Overall, we found that rates of key preventive services, including OB/GYN visits, primary care visits, and glucose testing among births to Medicaid beneficiaries with gestational diabetes, were higher overall during the PHE while the continuous enrollment condition was in effect. We also observed elevated primary care use in the extended, post-3-month postpartum period among births that occurred during the PHE relative to pre-PHE rates. Coordination of care between maternity care providers and primary care providers is a key juncture in facilitating ongoing, high-quality postpartum care, particularly for high-risk individuals.

Changes in utilization were larger among certain groups of beneficiaries when changes were stratified by select beneficiary- and state-level characteristics. The largest increases across all postpartum utilization measures were in states with the lowest parental income eligibility limits and non-expansion states. This is consistent with previous ASPE research that indicated that the largest gains in postpartum Medicaid eligibility under the ARP postpartum coverage extension would be among non-expansion states with the most restrictive parental Medicaid eligibility requirements.[20] Births to individuals with SMM at delivery and chronic conditions during pregnancy did not experience notable increases in postpartum care use. Primary care and OB/GYN visits were also notably higher among women ages 26-35 and over age 35, while ED visits were higher among women ages 19-25.

Maternity care deserts also experienced large increases in primary care visits and ED visits relative to the overall population of Medicaid-paid births. Previous research has indicated that family physicians often provide maternity care in maternity care deserts,[21] which may contribute to the larger increases in primary care visits seen in these areas. In contrast, rural areas did not experience larger-than-average increases in any of the utilization measures we examined. Similarly, maternity care deserts did not experience large increases in rates of any postpartum OB/GYN visits. These findings may suggest that rural states that have extended postpartum Medicaid coverage continue to face other limitations – such as inadequate provider supply – that dampen the effects of extended postpartum Medicaid coverage on access to postpartum care. Additional efforts to increase access to obstetric and primary care in these regions are critical to the successful implementation of Medicaid postpartum extensions.

Overall, our analysis found that primary care visit attendance within 12 months following labor was not universal among those with Medicaid-paid births. Nearly 68 percent of individuals with Medicaid-paid births had a primary care visit before the PHE and 77.2 percent had a primary care visit during the PHE. Such visits can be particularly important for patients who experience complications of pregnancy, particularly those related to chronic conditions, as follow-up with a primary care provider for ongoing care and management can help prevent future long-term exacerbations of these conditions. Among women with SMM, 77.7 percent had a primary care visit before the PHE and 83.8 percent had a primary care visit during the PHE. Among women with at least one chronic condition, 71.0 percent and 79.6 percent had a primary care visit before and during the PHE, respectively. Our findings are consistent with a recent review of postpartum visit attendance, which found that the mean percentage of Medicaid-insured patients that attended postpartum visits was 64.7 percent, with a range of 37.9 to 85.7 percent.[22]

Rates of postpartum preventive visits observed in our study (37.8 percent in the pre-PHE period and 40.4 percent in the PHE period; see Appendix B for rates by beneficiary- and area-level characteristics) are lower than rates observed among the commercially-insured population. A recent study found that 24 percent of commercially-insured postpartum women had at least one outpatient problem visit and 15 percent had a preventive visit within 21 days of childbirth.[23] Between 21 and 60 days postpartum, 39 percent of postpartum women had an outpatient problem visit and 28 percent had a preventive visit, while between 61 and 365 days postpartum, 80 percent had an outpatient problem visit and 43 percent had a preventive visit. Our findings underscore the importance of care coordination between obstetric and primary care provider teams as women transition from maternity to well-woman care after birth.

Similar to the findings in this report, another study found that individuals continuously enrolled in commercial insurance in Colorado were more likely to have a primary care visit and less likely to visit an ED between three and 12 months postpartum than individuals continuously enrolled in Medicaid coverage.[24] Previous research on the impact of Medicaid expansion on postpartum hospitalizations found an 8 percent reduction in hospitalizations between days 61 and six months postpartum among Medicaid beneficiaries.[25] These results add to this literature, and indicate that there were changes in Medicaid postpartum utilization during the continuous enrollment condition, when postpartum individuals had access to coverage that extended past the 60 days of postpartum coverage required under federal law.

Our findings may reflect other factors that we are unable to fully disentangle in this descriptive analysis. First, the extended coverage provided by the Medicaid continuous enrollment condition may have increased opportunities for those with Medicaid-financed births to access postpartum care. This is supported by the fact that we see the largest increases in the rate of preventive versus acute services, reflecting greater access to Medicaid-financed primary care beyond the pre-pandemic and pre-ARP required 60 days postpartum period.

This interpretation would have implications for the potential effects of ARP and CAA extensions of Medicaid postpartum coverage, suggesting that states that have implemented these extensions may observe similar changes in the overall rate of postpartum services. Second, it is unclear what role the COVID-19 pandemic played in our results. It may partly explain some of the observed changes in postpartum care use we observed by directly affecting patient demand and availability of services. For example, our findings may be due to an increase in services delivered via telehealth, which our analysis does not specifically examine. However, prior research has generally found that the pandemic suppressed utilization, particularly preventive care use. Our findings are not wholly consistent with this interpretation of suppressed utilization, as we observed increases in preventive care use during the pandemic among this population. Finally, because our study used Medicaid administrative claims data, we could not observe whether women accessed postpartum care services through other non-Medicaid coverage sources. Those who leave the Medicaid program may access postpartum services through alternative insurance and rates of postpartum care use among those with Medicaid-paid births may be higher if we were able to observe this population. However, previous research indicates that when individuals switch insurance, healthcare utilization is lower.[26,27,28] In addition, differences between types of insurance, such as provider networks, out-of-pocket costs, or benefit design, may impact continuity of care, which may in turn impact health outcomes.[28,29,30]

CONCLUSION

We observed notable increases in rates of postpartum OB/GYN and primary care use, but no increase in inpatient hospitalizations, when comparing pre-PHE versus during-PHE cohort rates of postpartum service use among Medicaid-financed births. While the increases in postpartum utilization may reflect multiple factors, these results may serve as a helpful proxy for what states may observe in their own postpartum population with Medicaid 12-month postpartum extensions, which nearly all states have already implemented or plan to implement. The Medicaid postpartum extension will help ensure that beneficiaries continue to have access to health care throughout the 12-month postpartum period following delivery, a period that is vital to improving maternal health outcomes.

Despite the increased utilization seen in this analysis, there is evidence that individuals enrolled in Medicaid during the continuous enrollment condition may not have been aware of their continued Medicaid coverage.[31] Such lack of knowledge of the availability of coverage may limit the impact of this coverage expansion. As states implement the permanent 12-month postpartum extension, it will be important for them to ensure postpartum individuals are aware of the Medicaid coverage available to them. In addition, coverage expansions such as those available during the continuous enrollment condition cannot overcome provider access issues. As such, additional work is still needed to facilitate improved provider access in areas with limited access, such as rural areas and maternity care deserts.

APPENDIX A: UTILIZATION OF SERVICES BY STATE

Appendix Table 1. Rates of Key Outcomes by Pre-PHE vs. During PHE Cohorts by State, Ever-Used Within 12 Months Post-Labor

	OB/GYN Visits		Primary Care Visits		ED Visits		Inpatient Hospitalizations	
	Pre-PHE Cohort	PHE Cohort	Pre-PHE Cohort	PHE Cohort	Pre-PHE Cohort	PHE Cohort	Pre-PHE Cohort	PHE Cohort
Overall	45.2%	49.1%	67.9%	77.2%	31.9%	34.3%	8.5%	8.7%
Alabama	45.3%	49.1%	51.1%	67.0%	26.7%	39.4%	7.0%	8.7%
Alaska	21.8%	26.3%	78.5%	83.4%	34.0%	31.3%	8.3%	8.2%
Arizona	38.9%	39.3%	65.5%	71.3%	32.3%	30.5%	9.8%	9.7%
Arkansas	37.5%	39.6%	53.5%	61.1%	30.8%	30.5%	7.0%	7.4%
California	56.4%	60.7%	77.1%	84.2%	33.7%	32.2%	9.7%	9.9%
Colorado	35.1%	35.5%	70.5%	76.8%	32.4%	33.7%	7.1%	7.4%
Connecticut	51.1%	53.5%	79.9%	82.7%	36.1%	33.7%	7.2%	7.7%
Delaware	48.2%	32.1%	73.8%	74.4%	36.0%	33.3%	9.2%	7.4%
District of Columbia	38.4%	38.0%	89.9%	79.7%	48.1%	41.2%	8.0%	9.3%
Florida	22.4%	46.2%	41.9%	68.0%	26.2%	38.5%	7.1%	8.8%
Georgia	40.8%	45.4%	58.3%	70.8%	29.0%	33.7%	6.6%	7.4%
Hawaii	45.8%	49.9%	72.8%	80.1%	28.3%	26.4%	7.8%	8.0%
Idaho	31.6%	36.4%	53.4%	75.0%	22.7%	28.9%	7.0%	6.5%
Illinois	31.6%	28.4%	79.6%	83.9%	33.3%	34.7%	7.1%	7.6%
Indiana	52.3%	56.2%	73.1%	81.5%	38.8%	39.9%	8.9%	9.4%
Iowa	33.2%	34.6%	72.8%	81.4%	32.5%	33.4%	8.5%	7.7%
Kansas	34.5%	38.8%	58.9%	73.7%	29.6%	35.0%	7.6%	8.6%
Kentucky	60.0%	58.3%	86.8%	89.9%	41.6%	38.7%	11.6%	10.3%
Louisiana	65.2%	63.8%	81.0%	83.9%	46.0%	42.9%	10.0%	9.7%
Maine	36.3%	36.4%	81.3%	85.8%	33.9%	34.5%	7.5%	7.6%
Maryland	48.7%	59.2%	85.2%	87.4%	34.7%	31.2%	7.8%	7.6%
Massachusetts	27.5%	27.2%	80.1%	85.5%	34.2%	32.4%	11.4%	10.0%
Michigan	54.0%	55.7%	83.8%	86.6%	44.9%	40.0%	10.8%	10.1%
Minnesota	23.6%	24.8%	81.2%	86.5%	31.8%	32.4%	10.2%	9.6%
Mississippi	46.0%	51.4%	61.3%	79.5%	28.8%	41.7%	7.8%	8.0%
Missouri	47.2%	55.1%	66.9%	79.7%	31.5%	39.2%	8.0%	8.7%
Montana	37.2%	38.5%	85.1%	87.1%	34.9%	34.2%	8.9%	8.3%
Nebraska	32.5%	44.4%	61.9%	81.9%	26.2%	33.0%	7.9%	8.0%
Nevada	38.4%	43.2%	65.5%	70.4%	32.5%	32.7%	8.0%	8.6%
New Hampshire	35.3%	39.1%	73.5%	84.9%	30.4%	33.5%	7.2%	7.8%
New Jersey	49.4%	51.9%	71.5%	77.2%	33.1%	31.0%	13.4%	11.8%
New Mexico	36.2%	39.1%	76.9%	81.5%	33.0%	30.8%	8.5%	8.3%
New York	50.7%	53.6%	77.8%	84.9%	30.2%	28.9%	9.4%	8.7%
North Carolina	52.9%	52.5%	62.8%	72.6%	30.0%	32.8%	7.0%	7.2%
North Dakota	31.8%	40.4%	75.9%	82.9%	33.6%	35.3%	9.3%	9.1%
Ohio	61.2%	60.3%	86.1%	87.7%	49.8%	46.2%	12.0%	11.1%
Oklahoma	32.8%	35.1%	49.2%	65.1%	24.4%	31.7%	6.8%	7.7%
Oregon	39.9%	42.8%	72.1%	78.9%	28.4%	28.1%	6.3%	6.3%
Pennsylvania	58.5%	62.4%	80.2%	85.2%	41.3%	39.1%	12.7%	12.3%
Rhode Island	54.5%	54.8%	88.0%	90.2%	37.6%	32.5%	9.3%	7.1%
South Carolina	61.6%	61.3%	68.9%	77.8%	33.9%	37.2%	7.4%	7.7%
South Dakota	35.2%	35.5%	54.1%	69.9%	24.8%	32.1%	8.1%	9.5%
Tennessee	54.0%	51.8%	86.2%	82.3%	45.9%	36.3%	12.1%	9.3%
Texas	43.1%	48.0%	41.9%	60.2%	17.3%	29.0%	6.0%	7.6%
Utah	27.0%	33.3%	49.5%	66.4%	18.5%	26.4%	4.7%	5.5%
Vermont	13.3%	13.8%	85.4%	88.8%	34.6%	33.7%	10.4%	9.8%
Virginia	45.9%	49.6%	67.1%	75.1%	34.7%	36.0%	8.1%	7.8%

Washington	34.2%	35.6%	79.4%	83.4%	29.4%	29.9%	6.6%	6.7%
West Virginia	37.0%	46.9%	71.2%	85.3%	32.3%	38.4%	9.0%	8.5%
Wisconsin	39.7%	39.8%	75.0%	82.9%	38.0%	39.1%	7.8%	7.1%
Wyoming	36.1%	39.7%	56.0%	76.8%	21.4%	33.0%	6.4%	6.6%

Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

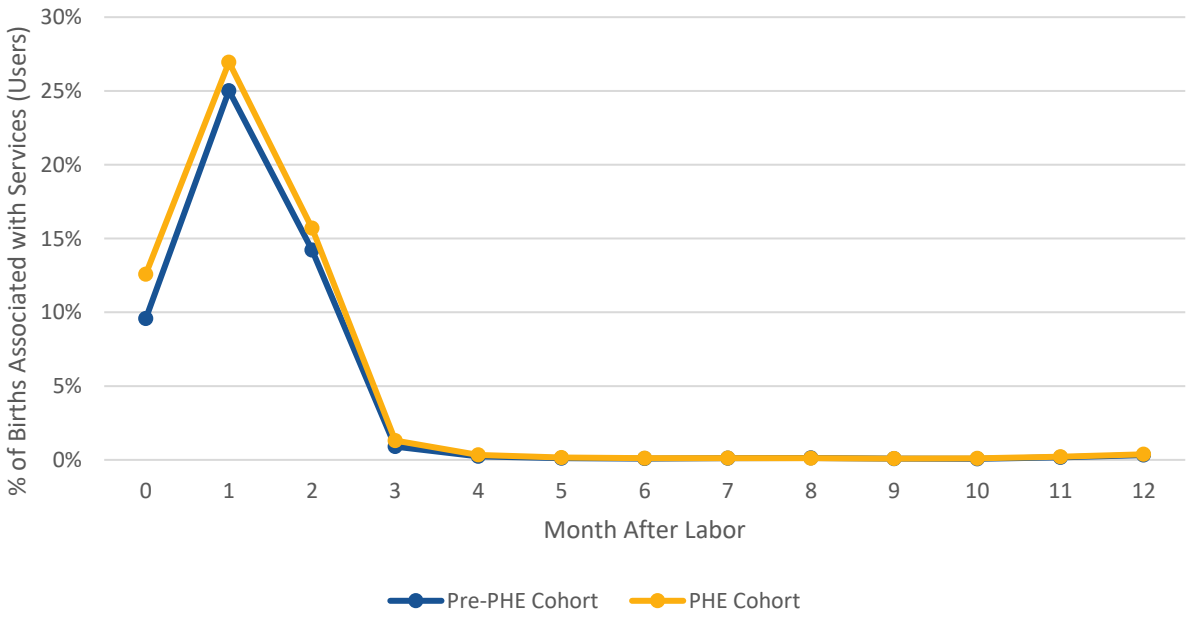
APPENDIX B: ROUTINE POSTPARTUM CARE VISITS

Clinical guidelines recommend contact with an OB/GYN within three weeks of birth, followed by ongoing care as needed, with a comprehensive postpartum visit no later than 12 weeks after birth. For most postpartum people, this results in one to two visits with an OB/GYN within the first 12 weeks after birth, with the majority of OB/GYN-based postpartum visits typically occurring within the 60- to 90-day window within which those with Medicaid-paid births would have retained Medicaid coverage prior to the continuous enrollment condition.

Routine postpartum care visits are included in bundled payments for maternity care in many states, which may mask individual service counts in administrative claims data. Therefore, routine postpartum care visits may be underreported. A review of postpartum visit attendance found that the mean percentage of Medicaid-insured patients that attended postpartum visits was 64.7 percent, with a range of 37.9 to 85.7 percent.[32] This is significantly higher than the share of women attending postpartum care visits in our study.

Appendix Figure 1 shows the timing and rate of any routine postpartum care visit by month postpartum among births before and during the PHE. There is no difference in the timing of routine postpartum care visits and minimal differences in the rate of utilization. Given that routine postpartum care visits are generally recommended at six weeks postpartum, which is within the 60-day postpartum period required under federal law, minimal changes in the rate or timing of such visits are expected.

Appendix Figure 1. Rates of Routine Postpartum Care Visits by Month After Labor and Birth Cohort



Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.

Appendix Table 2 presents the rates of postpartum care visits by Pre-PHE vs. PHE Cohorts by beneficiary and area-level characteristics. By age, beneficiaries over age 19 had the largest change in routine postpartum care visits (+2.6 to +2.7 percentage points). By race and ethnicity, Latino beneficiaries had the largest increases in routine postpartum care visits (+3.6 percentage points). Routine postpartum care visits also had increases larger than their comparison groups among beneficiaries in managed care (+3.7 percentage points), non-expansion states (+6.2 percentage points), and urban areas (+2.9 percentage points).

Appendix Table 2. Rates of Postpartum Care Visits by Pre-PHE vs PHE Cohorts, by Beneficiary- and Area-Level Characteristics, Ever-Used Within 12 Months Post-Labor

	Pre-PHE Cohort	PHE Cohort
Overall	37.8%	40.4%
Age		
12-18	38.4%	40.2%
19-25	37.3%	40.0%
26-35	38.3%	40.9%
>35	37.1%	39.7%
Race/Ethnicity		
American Indian/Alaska Native	30.3%	31.1%
Asian	44.7%	46.9%
Black	39.1%	40.6%
Hawaiian/Pacific Islander	30.3%	30.4%
Latino	39.8%	43.4%
White	36.0%	38.3%
Unknown	33.8%	36.6%
Eligibility Group		
Medicaid Expansion	44.6%	44.8%
Other	36.4%	38.0%
Parent	42.7%	42.6%
Pregnant	34.7%	38.8%
Managed Care Enrollment		
Non-MCO	31.2%	28.8%
MCO	40.1%	43.8%
ACA Medicaid Expansion Status		
Non-expansion States	31.2%	37.4%
Expansion States	42.6%	42.3%
Medicaid Parental Income Eligibility Limit		
<40% FPL	29.5%	37.9%
40-137% FPL	35.0%	35.4%
138% FPL	42.4%	42.6%
>138% FPL	45.9%	36.6%
Urban/Rural Status		
Rural	35.9%	37.4%
Urban	38.7%	41.6%
Maternity Care Desert Status		
Maternity Care Desert	34.0%	36.1%
Low Access	34.2%	36.4%
Moderate Access	40.6%	40.1%
Full Access	38.6%	41.4%
Severe Maternal Morbidity		
No SMM	37.8%	40.4%
SMM	35.7%	38.1%
Chronic Conditions During Pregnancy		
None	34.4%	37.1%
At Least One	38.9%	41.3%

Source: Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS), 2018-2022.
Notes: Maternity care desert status is defined using the March of Dimes methodology, available at: https://www.marchofdimes.org/maternity-care-deserts-report-2022. MCO = Managed Care Organization. FPL = Federal Poverty Level. SMM = Severe Maternal Morbidity.

APPENDIX C: CONTRACEPTION MEASURE

The contraception measure used in our analysis captures any encounters with a claim for contraception, including Long-Acting Reversible Contraception (LARC), Short-Acting Reversible Contraception (SARC), female sterilization, and unspecified contraception. Claims may include CPT/HCPCS codes (Appendix Table 3), ICD-10 codes (Appendix Table 4), or National Drug Codes (NDC) (not listed). A limitation of this measure is that some methods of contraception require ongoing encounters while others do not. However, this limitation would apply uniformly to the pre-PHE and during PHE cohorts.

Appendix Table 3. Procedure Codes Used to Construct Contraception Measure

CPT/HCPCS Code	Description
	Long-Acting Reversible Contraception (LARC)
11981	Insertion, non-biodegradable drug delivery implant (long-acting reversible drug-eluting contraceptive implant)
11983	Removal with reinsertion, non-biodegradable drug delivery implant
58300	Insertion of IUD (intrauterine device)
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring (Nuvaring), each
J7296	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg (5 year duration)
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg (6 year duration)
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg (6 year duration)
J7300	Intrauterine copper contraceptive (Paragard®) (10 year duration)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg (3 year duration
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
Q9984	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg (5 year duration)
S4981	Insertion of levonorgestrel-releasing intrauterine system
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies
	Short-Acting Reversible Contraception (SARC)
57170	Diaphragm or cervical cap fitting
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each
J1050	Injection, medroxyprogesterone acetate, 1 mg (Depo-Provera)
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150mg
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5mg/25mg
J7294	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system (Annovera), each
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each
S4993	Contraceptive pills for birth control
	Contraception (Female Sterilization)
58565	Hysteroscopy, surgical, with bilateral fallopian tube placement of permanent implants
58600	Ligation or transection of fallopian tubes, abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tubes, abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

58611	Ligation or transection of fallopian tubes when done at the time of Cesarean delivery or intra-abdominal surgery (not a separate procedure)
58615	Occlusion of fallopian tubes by device (e.g., band, clip, Falope ring), vaginal or suprapubic approach
58661	Laparoscopy, surgical, with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical, with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical, with occlusion of oviducts by device (e.g., band, clip, Falope ring
58700	Salpingectomy, partial or total, unilateral or bilateral
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
01963	Anesthesia for cesarean hysterectomy
01969	Anesthesia for cesarean hysterectomy after neuraxial nerve anesthesia
59525	Subtotal or total hysterectomy after cesarean delivery (list separately)

Appendix Table 4. Diagnosis Codes Used to Construct Contraception Measure

ICD-10 Code	Description
Contraception – Unspecified	
Z30	Encounter for contraceptive management
Short-Acting Reversible Contraception (SARC)	
Z79.3	Long-term (current) use of hormonal contraceptives
Long-Acting Reversible Contraception (LARC)	
Z97.5	Presence of intrauterine contraceptive device
Contraception (Female Sterilization)	
Z98.51	Tubal ligation status

In addition to these CPT/HCPCS and ICD-10 codes, we captured NDC codes with the following descriptions: Contraceptive Cream/Foam/Device; Contraceptive, Oral Comb, NEC; Progestins, NEC; Estrogens & Comb, NEC.

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