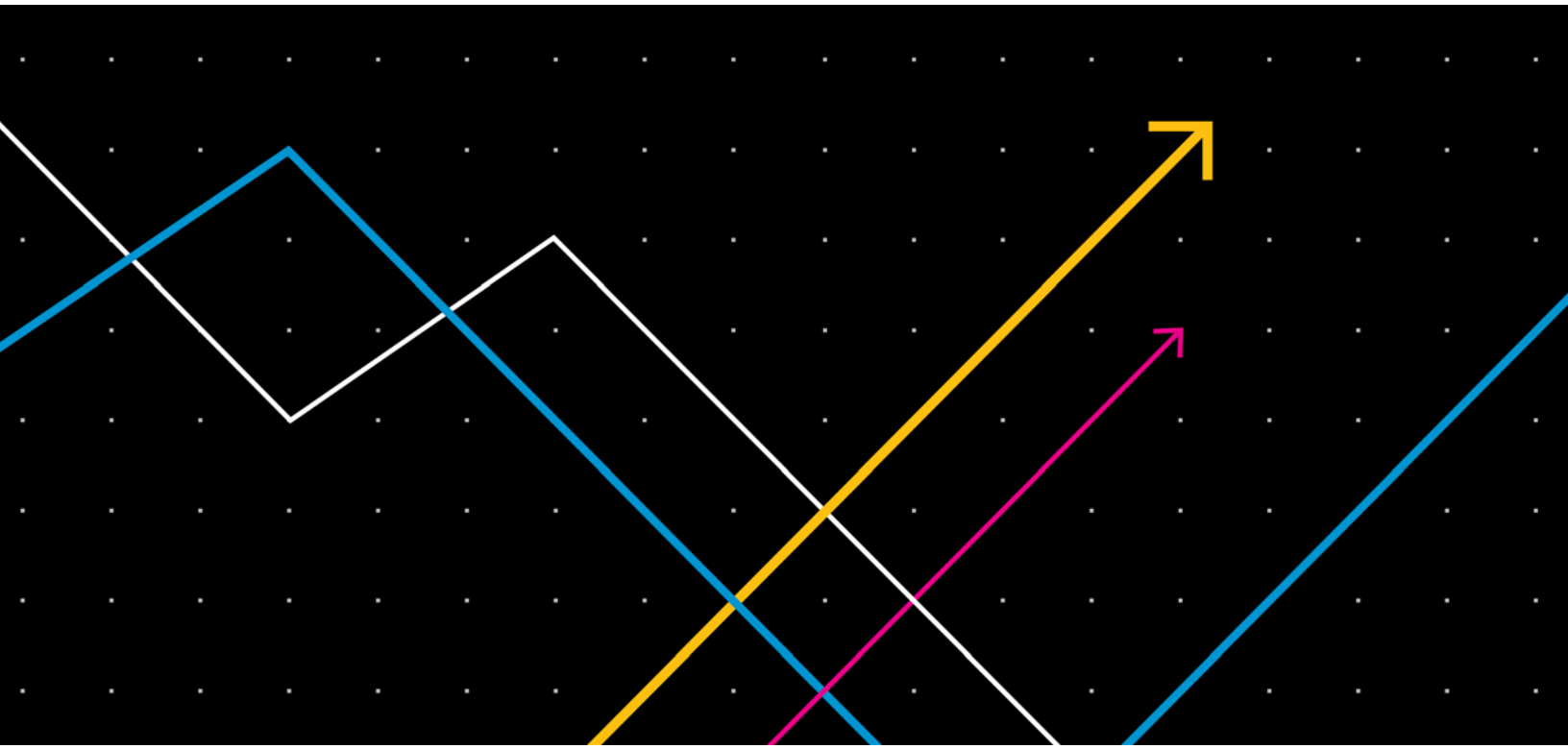


RESEARCH REPORT

Advancing Maternal Health Equity in Southern States

What Are Medicaid Programs Doing and What More Could They Do?

Jennifer M. Haley *Sofia Hinojosa* *Leandra Lacy* *Carla Willis*

November 2022

URBAN INSTITUTE

Robert Wood Johnson Foundation

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity, that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Contents

Acknowledgments

This report was funded by the Robert Wood Johnson Foundation. The views expressed do not necessarily reflect the views of the Foundation.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

We are grateful for the interviewees who provided important insights; for helpful feedback from Emily Johnston, Ian Hill, Genevieve M. Kenney, and Kimá Joy Taylor; and for comments, suggestions, and questions that resulted from discussions with members of a community advisory board organized by the Urban Institute and Community Catalyst and overseen by Kimá Joy Taylor and Myriam Hernandez-Jennings of the Urban Institute.

Executive Summary

The US is facing a severe maternal morbidity and mortality crisis, and Black women[*] and other women of color are at particularly high risk (Petersen et al. 2019). Maternal mortality is also higher in the South than in other regions (Snyder et al. 2020). Given evidence that abortion restrictions are associated with higher maternal mortality (Stevenson 2021; Vilda et al. 2021), such risks could grow under the recent Supreme Court ruling overturning *Roe v. Wade*, especially in the South, where in many states abortion is now severely restricted.[1] With more than 40 percent of all births nationally, 65 percent of births among Black women, and 59 percent of births among Hispanic women covered by Medicaid, state Medicaid policies and practices have the potential to improve maternal health and reduce racial and ethnic inequities in maternal health outcomes (Declercq and Zephyrin 2020; Martin, Hamilton, and Osterman 2020).

For this study on Medicaid and maternal health, we conducted interviews with national experts, a national policy scan, and case studies in three southern states (Georgia, Louisiana, and Texas) that are using various approaches to promote improvements in maternal health care for their Medicaid populations. We sought to identify facilitators of and barriers to maternal health equity and promising programs and policy levers that could advance maternal health equity to inform approaches in other southern states. We found the following:

- **Many states, both nationally and in the South, are adopting Medicaid policy changes aimed at improving maternal health care**, including care delivery transformation, data and oversight initiatives, and postpartum coverage extensions. However, given a lack of evidence on which policies successfully close equity gaps, the extent to which these initiatives will reduce disparities is unclear.
- Stakeholders we interviewed in our three study states described several promising Medicaid initiatives and generally broad and bipartisan support for strengthening maternal coverage and care, **but these maternal health initiatives were not consistently designed to address racial and ethnic inequities in maternal health outcomes**. In one of our study states, equity was

[*] Throughout this report, we strive to use inclusive pregnancy-related language to reflect the diverse identities of people who get pregnant and use pregnancy and other maternal care. The Social Security Act defines pregnancy-related Medicaid eligibility as being for "pregnant and postpartum women." We remain committed to using respectful, inclusive language.

deliberately incorporated into some program planning, but in another, key informants reported a lack of political support for policies that directly aim to address racial inequities.

- Stakeholders identified several **barriers to promoting maternal health equity in Medicaid**, including political sensitivities in some states and data limitations. They also highlighted various **strategies to encourage state policymakers to support addressing racial and ethnic inequities in Medicaid**, including
  - » taking advantage of lower political hurdles for improving pregnant women's and new mothers' coverage and care relative to other Medicaid populations,
  - » broadening the framing of disparities from racial and ethnic to include income and geographic (rural versus urban) disparities,
  - » considering whether policymakers would be more motivated by cost-based or emotion-based reasoning,
  - » considering whether and how to place maternal health equity goals within a larger reproductive health and reproductive justice context,
  - » educating policymakers about the benefits of a wider array of perinatal health providers such as doulas, and
  - » identifying leaders to champion policy changes.
- **Our key informants emphasized that driving support for improving maternal health equity in Medicaid will likely require a broader set of stakeholders than just the state Medicaid agency and state legislators**, including managed-care organizations; state perinatal quality collaboratives; other state agencies; maternal mortality review committees; maternal health coalitions, professional groups, advocates, and community-based organizations; providers and hospitals; academics, philanthropists, and researchers; and community members. They also highlighted the need for collaboration across groups and sectors.
- **Key informants identified several federal policy actions that could support states' progress on advancing maternal health equity**, including better incentivizing the adoption of optional policy changes (like postpartum Medicaid extension or diversification of the maternal health workforce), supporting efforts to improve the extent and quality of data collection, and supporting evaluations of how maternal health initiatives affect racial and ethnic disparities.
- **In addition, they highlighted many existing state-level policy levers that could potentially support maternal health equity**. When larger-scale policy changes such as adoption of full Medicaid expansion are unlikely, some initiatives that may face fewer political hurdles could

still potentially advance maternal health equity, including pilots to test the efficacy and impacts of new benefits and services, hospital-level investments and interventions, and the use of managed-care organization procurement and contracting mechanisms to incentivize reductions in disparities.

Many southern states are already adopting Medicaid policies that could improve maternal health outcomes broadly. But whether those policies explicitly focus on closing racial and ethnic gaps is more varied. Moreover, high-quality, accurate data on which policies reduce disparities are currently lacking, and stakeholders reported that plans for evaluating whether such efforts can and do lead to meaningful improvements in maternal health equity are limited.

Both data and intentional evaluation will be needed for tracking the impact of program and policy changes on maternal health outcomes and assessing whether equity gaps are closing. Though broader changes in other sectors will also be needed to address the many factors that contribute to racial and ethnic inequities, Medicaid programs have numerous tools that could be used more fully and effectively to improve maternal health care and address unjust differences in maternal outcomes.

Advancing Maternal Health Equity in Southern States

Before the COVID-19 pandemic, rates of maternal mortality (deaths occurring during pregnancy, at delivery, or up to a year after the end of pregnancy) and morbidity in the US were high and growing (Callaghan, Creanga, and Kuklina 2012; MacDorman et al. 2016; Petersen et al. 2019). The pandemic introduced additional challenges by limiting access to care, increasing stress, and limiting the social support available before, during, and after birth (Burroughs et al. 2021).

Maternal mortality and morbidity rates also vary dramatically by race and ethnicity. The Centers for Disease Control and Prevention's Pregnancy Mortality Surveillance System data from 2007 to 2016 show an overall pregnancy-related mortality ratio (i.e., pregnancy-related deaths per 100,000 live births) of 16.2 for the general population of US women.[†] The ratio for White women was 12.7, whereas such ratios for non-Hispanic Black and American Indian/Alaska Native women were 40.8 and 29.7 (Heck et al. 2021). In 2020, Black women were about three times more likely than White women to die of pregnancy-related causes, and the maternal mortality rate rose significantly from 2019 to 2020 for both Black and Hispanic women (Hoyert 2022).

These gaping racial and ethnic maternal health disparities are likely the result of decades of policies that have systematically discriminated against Black people, Indigenous people, and other people of color in the US. Such policies undermine these populations' access to high-quality health care services and limit their economic opportunities (Ndugga and Artiga 2021), and such populations also experience interpersonal racism in everyday life, including when seeking health care (Gonzalez et al. 2021; McDaniel et al. 2021; Skopec, Gonzalez, and Kenney 2021). For instance, implicit biases—defined as the attitudes, beliefs, and stereotypes that unconsciously affect one's treatment of others based on categorizations like race—can affect maternal health clinicians' perceptions of Black women and other women of color and result in unequal treatment decisions, patient-provider interactions, and health outcomes that compound other inequities these women face (Saluja and Bryant 2021; Taylor et al. 2019).

[†] Throughout this report, we strive to use inclusive pregnancy-related language to reflect the diverse identities of people who get pregnant and use pregnancy and other maternal care. The Social Security Act defines pregnancy-related Medicaid eligibility as being for "pregnant and postpartum women." We remain committed to using respectful, inclusive language.

Though Medicaid programs have limited ability to address the root causes of racism, they can play an important role in addressing racial and ethnic maternal health inequities by shaping access to and the affordability, appropriateness, and quality of available health care. For instance, postpartum Medicaid/Children's Health Insurance Program (CHIP) extensions could provide greater access to care during a medically fragile time: About one in nine pregnancy-related deaths occurs more than 43 days after delivery (ACOG 2018; Petersen et al. 2019). Recent research estimated that more than a quarter of uninsured new mothers—including more than one-third of non-Hispanic Black mothers—could benefit from the nationwide adoption of a 12-month postpartum coverage extension (Johnston et al. 2021). Likewise, increased reimbursement of services such as doula care could reduce rates of preterm births, Cesarean sections, and birth complications and could generate significant cost savings for Medicaid programs (Platt and Kaye 2020). Additional research suggests doula care can be especially beneficial to the health and birth experiences of women of color (Mallick, Thomas, and Shenassa 2022).

We focus our attention on improving maternal health in the southern region of the US for several reasons. First, maternal mortality rates are especially high in the South (Snyder et al. 2020). In 2018, among the 25 states that reported at least 10 maternal deaths, all 4 states reporting rates greater than 30 deaths per 100,000 live births were in the South (Alabama, Arkansas, Kentucky, and Oklahoma); nationally, the rate of maternal deaths per 100,000 live births was 17.4.[2] A 2021 March of Dimes report card offering a comprehensive overview of the health of mothers and infants across the country gave the lowest grade (F) to six states (Alabama, Arkansas, Louisiana, Mississippi, South Carolina, and West Virginia), all of which are in the South. Twelve states received a D rating, eight of which were in the South (Delaware, Florida, Georgia, Kentucky, North Carolina, Oklahoma, Tennessee, and Texas). The South's highest grade was a C, given to Maryland, the District of Columbia, and Virginia; all of the states with A or B grades were outside the South (March of Dimes 2021). Additionally, rural areas in southern states are disproportionately likely to have experienced hospital closures in recent years, and such closures are especially likely to have occurred in communities with greater shares of Black and Hispanic residents (CMS 2019).

Second, because the South has higher shares of Black and Hispanic populations than other regions,[3] improving care for birthing people of color in the South would increase equity nationally. Residents of the South are also more likely to have low incomes, and some within-state health inequities are worse in southern states. For instance, inequities by race and ethnicity are higher in rural areas in the South than in rural areas in other regions (Shrider et al. 2021).[4]

Third, in 2020, Medicaid covered more than 47 percent of all births in southern states, and in some states in the region Medicaid covered well over half of births.[5] Medicaid also covered nearly two-thirds

of births among Black women in 2019 (Martin, Hamilton, and Osterman 2020). High rates of Medicaid coverage for delivery are partly due to more-generous income and immigration rules for pregnancy-related Medicaid/CHIP coverage than for other adults.[6] However, these rules still leave eligibility gaps for undocumented noncitizens, some documented noncitizens, and people who do not meet the income requirements. Further, the median income eligibility level for pregnancy-related Medicaid/CHIP is 205 percent of the federal poverty level, and about half of states cover legally present immigrant women without a waiting period (Brooks et al. 2020). Pregnancy-related Medicaid/CHIP services are also comprehensive in nearly every state, and cost-sharing requirements are low (Haley et al. 2021).

Fourth, though Medicaid has opportunities to improve maternal health through better care during pregnancy and delivery, Medicaid coverage outside of pregnancy is generally not as expansive in states in the South as in the country as a whole (Brooks et al. 2020), limiting access to reproductive health care, preconception care, and care in the postpartum period, all of which affect maternal outcomes.[7] For instance, 8 of the 12 states that have not adopted Medicaid expansion under the Affordable Care Act (ACA) are in the South.[8] The median Medicaid threshold for nonpregnant adults is 138 percent of the federal poverty level in states that have adopted the ACA's Medicaid expansion, and the median for parents is below 50 percent of the federal poverty level in the 12 remaining nonexpansion states, which lack Medicaid eligibility options for nondisabled, nonpregnant adults without children (Brooks et al. 2020).

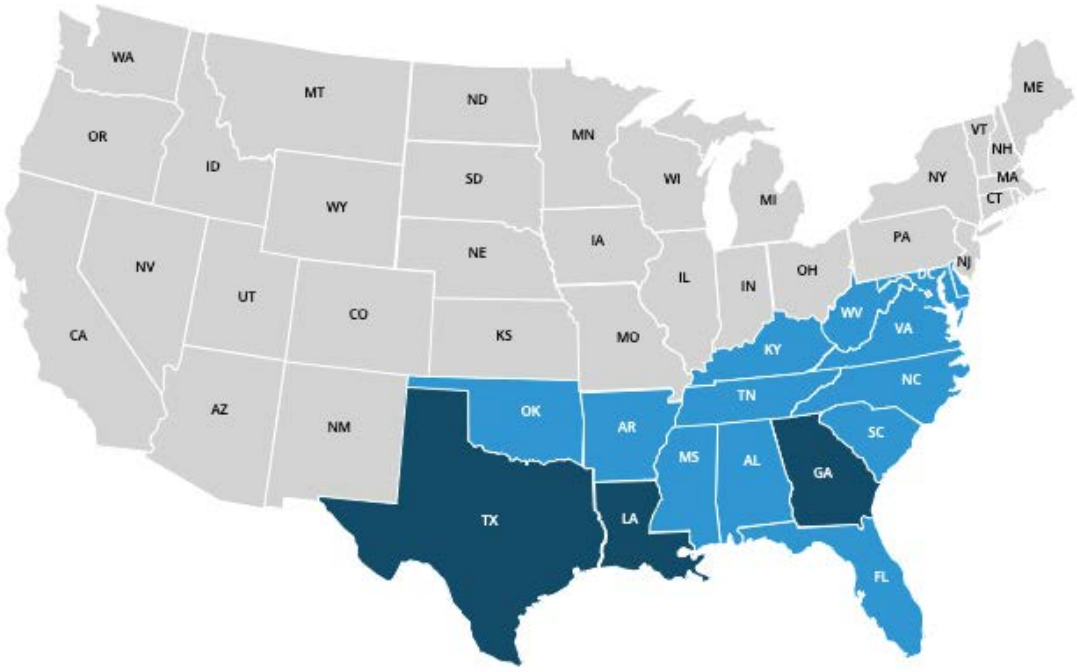
In this report, we summarize findings from interviews in late 2021 and 2022 with national experts and case studies in three southern states (Georgia, Louisiana, and Texas). We examine the approaches being used to improve maternal health outcomes nationally and in the South, whether and how equity concerns are guiding these efforts, and promising policy levers and practices Medicaid programs in southern states could use to advance maternal health and potentially improve equity.

Methods

This research relied on a national policy scan, policy scans in each of the case study states, and stakeholder interviews. We gathered information from published sources on states that have adopted various policies in Medicaid designed to improve maternal health care.[9] We identified the numbers of states both nationwide and in the South that have adopted such actions. Figure 1 shows the 17 southern states, including the District of Columbia, according to Census Bureau definitions, and our three study states.

FIGURE 1

Study States and All Southern States



URBAN INSTITUTE

Note: Dark blue states (Georgia, Louisiana, and Texas) are the study states; other blue states make up the South.

We conducted five interviews with national experts on maternal health and asked their perspectives on the topic, including asking for examples of southern states that have adopted strategies with the potential to advance maternal health equity in Medicaid despite political barriers and other constraints. From these interviews, we selected three study states—Georgia, Louisiana, and Texas—that include both Medicaid expansion and nonexpansion states (figure 1). We conducted 12 interviews with stakeholders in these states, speaking with state officials who work in Medicaid agencies in all three states and with representatives of Medicaid managed-care organizations (MCOs) in two states. We also spoke with maternal health stakeholders in all three states, including researchers and representatives of community-based organizations, advocacy organizations, maternal mortality review committees, and maternal health consortiums.

We conducted semistructured interviews using protocols tailored by key informant type: national expert, state official, state MCO representative, and state maternal health stakeholder. The research team recorded, transcribed, and analyzed interviews to identify common themes and key insights and selected illustrative quotes. Table 1 contains details about our interviews. Throughout the interviews, we probed on

- what efforts the study states have undertaken to improve maternal Medicaid coverage, care, and outcomes;
- the facilitators of and barriers to advancing maternal health efforts (including political, fiscal, legislative, and data-centered issues);
- the role of equity concerns in designing and implementing policies;
- legislative and nonlegislative approaches being used or considered to advance maternal health;
- and levers available in Medicaid programs to improve maternal health and maternal health equity.

TABLE 1

Number of Study Interviews, by Interviewee Type and Location

	State government officials and MCO representatives	Maternal health stakeholders and/or community partners	Total
National	–	5	**5**
Georgia	3	2	**5**
Louisiana	2	2	**4**
Texas	1	2	**3**
Total	**5**	**11**	**17**

Source: Urban Institute interviews conducted between December 2021 and July 2022.
Notes: MCO = managed-care organization. In some interviews, more than one person represented the same organization.

Our research has several limitations. First, the policy scan relied on published information that may not reflect more recent policy changes. Second, because we interviewed a small number of stakeholders in a limited number of states, we may be missing important experiences and perspectives, and the insights interviewees shared may not be generalizable to all maternal health policies in the states studied or in all southern states. We were also not able to speak directly with Medicaid enrollees to hear their perspectives on policies that they think would be most effective at closing racial and ethnic gaps in maternal health. In addition, we did not try to include an exhaustive list of relevant initiatives in the study states.[10] Lastly, though many of the policy approaches stakeholders suggested could be applicable for Medicaid programs around the country, some of the insights stakeholders shared, such as political barriers, may not be as relevant in other regions.

In addition, nearly all interviews took place before the *Dobbs v. Jackson Women's Health Organization* decision and do not reflect policy changes that may be considered or implemented in light of that decision. However, the insights shared by interviewees could be even more relevant after this decision, which permitted new restrictions on abortion access.[11] Most states in the South have restricted or are

expected to severely restrict abortion access, which could worsen maternal outcomes and adversely affect maternal health equity (Stevenson 2021; Vilda et al. 2021).[12] Researchers have noted that though the ruling affects all groups of women and girls, it poses a disproportionate threat to the economic mobility of and access to services among low-income women of color specifically.[13]

Input from the Urban Institute Health Policy Center's Medicaid and health equity community advisory board informed the direction of this project, and the Urban Institute's Institutional Review Board approved our study methods.

Findings

In the sections below, we discuss Medicaid policies that states have adopted both nationally and in the South that could potentially improve maternal health and explore the extent to which equity concerns drove such policy decisions in our three study states. Then we consider the barriers and solutions study participants identified in addressing maternal health equity in Medicaid, federal support that could help states advance maternal health equity, and additional state policy levers that could advance maternal health and help close equity gaps.

What Maternal Health Policies Have State Medicaid Programs Adopted?

In recent years, a growing number of Medicaid programs has adopted policy changes that could improve maternal outcomes. Table 2 describes selected state-level Medicaid policies across three domains: eligibility, coverage, and services; care delivery transformation; and data and oversight. This is not meant to be an exhaustive list; instead, it highlights policies stakeholders identified as important advances occurring in maternal health within Medicaid.[14] The table also highlights the number of southern states and which of our three study states has adopted each policy.[15]

For instance, a large and growing number of states has extended postpartum Medicaid/CHIP coverage from 60 days to up to 12 months postpartum. This optional policy is available as a Section 1115 waiver or through a state plan amendment under the American Rescue Plan Act. As of September 2022, 26 states, including the District of Columbia, have adopted the extension.[16]

But policies that are more directly aimed at trying to address racial and ethnic maternal health care inequities, such as requiring provider bias training, are much more limited; only a few states had adopted such policies by 2020.

TABLE 2

Selected Medicaid/CHIP Maternal Health Policies as of 2020–22

	Policy	# of states	# of southern states (of 17 total)	Study states
Eligibility, coverage, and services	**12-month postpartum extension.** As of September 2022, how many states had adopted a 12-month extension for Medicaid/CHIP postpartum coverage?	26	10	LA
	Permanent coverage of family planning services. As of August 2022, how many states had adopted an option under the ACA to expand eligibility for family planning using a permanent state plan amendment as opposed to a Section 1115 waiver?	17	4	LA
	As of August 2022, how many states had adopted an option under the ACA to expand eligibility for family planning using a Section 1115 waiver?	10	5	GA
	Adoption of ACA Medicaid expansion. As of September 2022, how many states had adopted the ACA's Medicaid expansion, thereby covering nondisabled women with incomes below 138 percent of FPL who qualify for access to health insurance throughout their reproductive years (rather than only if they become pregnant or qualify through other, more-narrow pathways)?	39	9	LA
	Immigrant five-year residency waiver for pregnancy-related coverage. As of January 2022, how many states had waived the five-year waiting period for lawfully residing immigrants to receive pregnancy-related Medicaid/CHIP?	25	8	None
	Unborn child CHIP option. As of January 2022, how many states had adopted the unborn child option in CHIP, covering fetuses as "targeted low-income children" without regard for the mother's immigration status?	18	6	LA, TX
Care delivery transformation	**Freestanding birth centers.** As of November 2020, how many states offered Medicaid coverage for freestanding birth centers, which are health care facilities (not affiliated with hospitals) that use a midwifery model of care to provide services during pregnancy, labor and delivery, and the postpartum period?	37	12	GA, LA, TX
	Provider bias training. As of November 2020, how many states had implemented a provider bias training requirement for health care professionals working in perinatal services?	3	1	None
	Payment reform. As of November 2020, how many states had implemented at least one payment reform for Medicaid providers to improve maternal health outcomes, such as payment for performance and reduced payment or nonpayment for non–medically indicated procedures?	35	11	GA, LA, TX
	Reimbursement for postpartum long-acting reversible contraception (LARC). As of July 2021, how many states reimbursed for immediate postpartum LARC insertion separately from a global maternity fee to clinicians and hospitals, which removes a financial disincentive for postpartum LARC insertion?	26 of 42[a]	9 of 14[a]	LA, TX[a]

	Policy	# of states	# of southern states (of 17 total)	Study states
	Doula services. As of April 2022, how many states actively reimbursed doula services under Medicaid, were in the process of implementing Medicaid doula benefits, or had taken steps toward implementing Medicaid doula benefits (e.g., pilot program, doula registry)?	21	6	LA
Data and oversight	**Race-stratified data.** As of November 2020, how many states required Medicaid managed-care organizations to collect race-stratified maternal health data?	36	15	GA, LA, TX

Sources: "State Policies to Improve Maternal Health Outcomes," Commonwealth Fund, November 19, 2020, https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-policies-improve-maternal-health-outcomes; "Maternal Mortality Review Committees," Guttmacher Institute, October 1, 2022, https://www.guttmacher.org/state-policy/explore/maternal-mortality-review-committees; "Medicaid Reimbursement Policies for Immediate Postpartum Long Acting Reversible Contraceptives (LARCs)," Kaiser Family Foundation, July 1, 2021, https://www.kff.org/womens-health-policy/state-indicator/medicaid-coverage-of-intrauterine-devices-iuds-implants-and-reimbursement-policy/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; "Medicaid Postpartum Coverage Extension Tracker," Kaiser Family Foundation, October 20, 2022, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/; "Doula Medicaid Project," National Health Law Program, accessed October 27, 2022, https://healthlaw.org/doulamedicaidproject/; and "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, accessed July 2022, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

Notes: CHIP = Children's Health Insurance Program. ACA = Affordable Care Act. FPL = federal poverty level.

[a] Forty-two states, including DC, responded to the Kaiser Family Foundation survey; Georgia did not participate in the survey.

What Are Examples of Medicaid Maternal Health Initiatives in Georgia, Louisiana, and Texas?

When asked about state Medicaid efforts to improve perinatal health coverage and care, key informants in our case study states described many of the initiatives highlighted above and other efforts, such as the adoption of the postpartum coverage extension; MCO accountability; performance improvement projects; coverage of additional services in Medicaid; data disaggregated by race, ethnicity, and geography; and reliance on the state's quality strategy as the road map for quality improvement and accountability. Box 1 highlights one strategy from each state designed to directly address maternal health inequities or to potentially affect disparities by expanding access to care for all groups. Though an explicit focus on equity, the longevity of the effort, and plans for evaluation in these example initiatives vary, they represent avenues for addressing maternal health key informants described as promising.

BOX 1

Examples of Potentially Promising Initiatives in Study States

Request for proposals (RFP) for Louisiana Medicaid MCOs. The Louisiana Department of Health's (LDH's) 2021 RFP for Medicaid MCOs included provisions holding MCOs accountable for improving maternal health outcomes in areas such as case-coordinated care, patient engagement, and mitigation of harmful social determinants of health. The RFP also had a section dedicated to health equity, which includes the following:

> The Contractor must participate in, and support, LDH's efforts to reduce health disparities, address social risk factors, and achieve health equity. The Contractor must engage a variety of Enrollees and populations to develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among the Contractor's Enrollees and communities within the State. The Health Equity Plan shall be developed in alignment with the Contractor's Population Health Strategic Plan, the Louisiana Medicaid Managed Care Quality Strategy, and the LDH Health Equity Plan.[a]

In addition, the health equity section includes requirements for recruiting and retaining personnel and leaders who represent the demographic characteristics of Medicaid member populations and for leveraging data analysis and community input to reduce health disparities, address social risk factors, and achieve health equity. Louisiana Medicaid requires its MCOs to annually report on quality measures stratified by race, ethnicity, language, geography (urban versus rural parish), and/or disability and notes that value-based payment is tied to performance on health equity measures.

Healthy Texas Women Plus. The Texas Health and Human Services Commission began the Healthy Texas Women Plus (HTW Plus) program in 2020 with state funding, but it plans to incorporate HTW Plus into the general HTW family planning program, which provides contraception and other family-planning-related services to Texas women otherwise ineligible for full Medicaid coverage. HTW Plus provides an enhanced service package relative to that offered by HTW. For instance, whereas HTW includes services such as screening for pharmaceutical treatment for postpartum depression or other perinatal mood and anxiety disorders, HTW Plus also includes psychotherapy for both individuals and groups or families. And whereas HTW includes screening for conditions such as diabetes and high blood pressure, HTW Plus provides women with such screenings and access to treatment for those conditions. Though this program does not directly address racial and ethnic or other inequities, it has the potential to do so, according to one key informant:

> We have implemented…an enhanced postpartum service package for our women's health Medicaid waiver that is specifically targeting the leading causes of maternal morbidity and mortality….[It is] a specific effort to try to meet [the needs of] women who are most likely to die from childbirth or pregnancy-related death. And we know from public health data that those women are usually women of color or, for whatever other reason, disenfranchised.

Improving maternal and birth outcomes imperative in Georgia. Evidence in Georgia shows that Black women's maternal mortality is nearly three times higher than White women's and that a high share of the state's pregnancy-related deaths are preventable. In response, Georgia's Medicaid agency

published a quality strategy for 2021–23 that outlines current and future activities to address health disparities. Activities include mandatory performance improvement projects to increase the rate of pregnant people who receive timely prenatal care visits and a coordinated effort to enroll a greater number of high-risk pregnant people in high-risk obstetrical case management programs. These efforts receive ongoing monitoring and evaluation by quality improvement specialists who apply PDSA (plan, do, study, act) cycles to assess the impact of the performance improvement projects.

The quality strategy includes activities to enhance partnerships focused on health equity, efforts to deliver linguistically and culturally appropriate care, and collaboration with care management organizations to address health-related social needs. Specific activities taken from the quality strategy include screening for unmet social needs, providing resources and assistance to address unmet social needs, supporting public-private interventions aimed at reducing costs and improving health by addressing unmet social needs, identifying areas of high disparity to better target resources and assistance, and hosting a resource platform for members.

Per Centers for Medicare & Medicaid Services requirements, the quality strategy should be evaluated every three years. The findings from the evaluation would then be used to inform updates to the quality strategy, including revised goals, new quality measures, new targets, and new or scaled performance improvement activities.

Sources: Stakeholder interviews and initiative-specific sources. The source for the section on the RFP for Louisiana Medicaid MCOs is "Louisiana Medicaid Managed Care Organization Model Contract," Louisiana Department of Health. Bureau of Health Services Financing, accessed October 18, 2022, https://ldh.la.gov/assets/medicaid/RFP_Documents/MCO/RFP2021/Attachments/AttachmentA-ModelContract.pdf. The sources for the section on Healthy Texas Women Plus are Stephanie Stevens (state Medicaid director), letter to Lorraine Nawara (Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, Division of State Demonstrations and Waivers) requesting to amend the Healthy Texas Women waiver, December 8, 2020, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthy-women-pa2.pdf; and Andy Miller, "The Ripple Effect When Rural Hospitals Drop Birthing Services," *Georgia Health News*, December 20, 2021, https://www.georgiahealthnews.com/2021/12/rural-hospitals-drop-birthing-services/. The sources for the section on improving maternal and birth outcomes in Georgia are Georgia Department of Community Health, *2021–2023 Quality Strategy* (Atlanta: Georgia Department of Community Health, 2021); and Georgia Department of Community Health, *2022 External Quality Review Annual Report* (Atlanta: Georgia Department of Community Health, 2022).
Note: [a] See p. 92, Section 2.6 Health Equity, in "Louisiana Medicaid Managed Care Organization Model Contract," Louisiana Department of Health.

How Much Support Do Medicaid Maternal Health Initiatives Have, and What Role Do Concerns about Health Equity Play in Policy Formulation?

We also asked key informants in our study states about support for Medicaid maternal health initiatives such as those described in table 2 and box 1 and the role that concerns about equity played in their development and implementation. Several conveyed policymakers' support for maternal health initiatives and often-bipartisan interest in strengthening maternal Medicaid coverage and care. One

interviewee described how almost all stakeholders and legislators in both political parties have been aligned on adopting a postpartum Medicaid/CHIP extension in their states. This contrasted with other efforts to expand Medicaid coverage such as adopting the ACA's Medicaid expansion, which is seen as more partisan or for a population "less deserving" than new mothers. As one key informant stated, seeing nonexpansion states embrace postpartum Medicaid extension is surprising given many lawmakers' general opposition to Medicaid. However, interest in expanding eligibility for Medicaid is not universal: an interviewee mentioned opposition to expanding Medicaid eligibility to any new population because some people in the interviewee's state believe "we need to make Medicaid better for the people that are in it. [They see Medicaid as a] zero-sum game, like if we expand the program, it's going to hurt the current people in it...[Medicaid should only be] for the vulnerable—it's for the kids with disabilities, it's for the seniors."

Despite generally broad support for strengthening maternal coverage and care overall, interviewees reported that interest in using Medicaid policies to address racial and ethnic inequities is much more varied across states. A national stakeholder said that, in general, "states are…really interested in strengthening maternity care and maternity outcomes and with a focus on equity." But we found variation in the extent to which improving maternal health equity was an explicit focus among our three study states. An interviewee described one state as having "equity champions" within Medicaid who drove new initiatives focused on closing racial and ethnic gaps. And one agency representative stated, "Being Medicaid, we will always be involved in equity issues." A national stakeholder who described the interest in equity in Medicaid as "overdue" attributed recent increased interest to media, research, and clinical sectors increasingly highlighting the issue. But, as another key informant shared, it is not clear how long equity has actually been a focus—that is, whether equity concerns have been driving changes within states or whether equity concerns have become an additional justification for action after initiatives were championed with a more general focus. And in other states, some interviewees described a sense that any proposed policy with an explicit goal of reducing racial and ethnic inequities would not garner sufficient support to be enacted and implemented, as we describe in more detail below.

Moreover, key informants also described uneven efforts to address maternal inequities in Medicaid related to language and cultural barriers through the provision of linguistically and culturally appropriate care (i.e., tailoring delivery of health care to patients' linguistic preferences and social and cultural needs). A key informant in one state specifically mentioned efforts to reduce communication barriers by carefully reviewing consumer-focused materials before publication for linguistic and cultural competence. Some study states also listed the provision of linguistically and culturally

competent care as a goal in their quality strategies. But overall, most key informants did not describe intentional efforts within their state Medicaid programs to evaluate the extent of linguistically and culturally appropriate care.

What Are Key Barriers to Improving Maternal Health Equity in Medicaid?

Key informants described numerous barriers to advancing maternal health care equity in their state Medicaid programs, such as (1) political sensitivities, including reluctance to discuss racism or inequity directly; (2) a lack of awareness of or interest in available tools to promote perinatal health; (3) a lack of quality data on racial and ethnic disparities and limited plans for evaluating whether policies can or will address equity; and (4) variation in access to maternal health services and providers and coordination across stakeholders within a state. We discuss each barrier in more detail below.

POLITICAL SENSITIVITIES

In some of our study states, stakeholders reported pressure not to frame policies as addressing racial and ethnic inequities: as one described, "Maternal health equity is still a relatively taboo conversation outside of the public health and clinical space. The legislature is slowly, but grudgingly slowly, starting to recognize the inequities." Some stakeholders described a lack of willingness to support state policies that advance "equity," instead preferring the word "disparity." One interviewee cautioned against an overly simplistic understanding of political alignments, explaining, "Assumptions about how political affiliation tracks to policy [are] not always accurate." Still, multiple informants reported political resistance to focusing on racial and ethnic equity as a barrier to progress on advancing maternal health equity in Medicaid.

According to our key informants, cost concerns (e.g., high state costs for neonatal intensive care), rather than underlying equity concerns, drive some legislators' interest in maternal health. And some legislators reportedly would prefer to attribute disparities to individual decisionmaking or social risk factors, such as housing or food insecurity, rather than to structural factors related to race and ethnicity. In those cases, informants described legislators as not believing the Medicaid agency or even the state has a role to play in addressing disparate outcomes by race and ethnicity. One key informant described such a position as ignoring the underlying racist drivers of disparities: "It places emphasis on social outcomes or social determinants over which a person really doesn't have control, as opposed to…the systemic things that created the social outcomes." In such cases, interviewees observed a need to emphasize other benefits of policy changes rather their potential for reducing racial and ethnic disparities.

In addition, multiple respondents in the two nonexpansion study states (Georgia and Texas) mentioned many policymakers strongly oppose Medicaid expansion. Though these interviewees framed expansion as potentially having strong benefits for maternal care because it would expand access to care over a person's reproductive years, they considered adoption unlikely in the absence of major political shifts.

LACK OF AWARENESS OF OR INTEREST IN TOOLS THAT COULD ADVANCE MATERNAL HEALTH CARE

In some cases, informants described legislators and staff in Medicaid programs or MCOs as unaware of or uninterested in tools that could improve perinatal health care and potentially advance equity. Doula care is an example of this, and informants highlighted it as a type of care for which a lack of awareness of potential benefits could limit the chances of it being offered in Medicaid. One key informant shared the following:

> Even in conversations with…Medicaid folks, they're learning...what a doula is....The policy people don't know...the benefits of these birth workers. So we have to back it all the way up and have presentations on "this is what a doula is. This is how it benefits birthing people, birthing outcomes, infants. And this is why it's important."

Another key informant reported that some obstetrician-gynecologists oppose covering doulas in Medicaid because they believe doulas could cause antagonism between the medical care team and birthing person and that resources should instead be allocated to providers of more traditional clinical care.

LACK OF QUALITY DATA ON RACIAL AND ETHNIC DISPARITIES AND LIMITED PLANS FOR EVALUATING PROGRESS

We found variation in states' focuses on using and publicly reporting data on equity gaps, such as through publicly available dashboards that report maternal health measures for different racial and ethnic groups for individual MCOs. Overall, key informants reported little focus on publicly reporting data about Medicaid enrollees and mentioned the shortcomings of available data. Outside of some data-reporting requirements for MCOs and required evaluations in the context of federal Section 1115 waivers, we found limited efforts to track the impacts of initiatives and few apparent evaluation efforts. Moreover, some key informants reported that even required evaluations do not necessarily assess the extent to which actions are closing equity gaps and meeting the cultural and linguistic needs of populations seeking maternal health care.

VARIATION IN ACCESS TO SERVICES AND COORDINATION ACROSS STAKEHOLDERS WITHIN STATES

Stakeholders also highlighted variation in access to providers and health care services within a state, such as for rural and urban areas, as an additional barrier. Health care resources may be limited in some regions of a state but concentrated in other regions. Key informants flagged that some rural Medicaid enrollees live in a maternity health desert, or counties with little or no access to maternity care (March of Dimes 2020). They indicated that a lack of coordination and partnership among health agencies across the state may exacerbate the uneven distribution of resources.

What Strategies Could Generate Support for Advancing Maternal Health Equity in Medicaid?

Many initiatives to change Medicaid policy require legislative action. An informant described the Medicaid agency in one study state as being "a very collaborative partner" with the legislature, and that "[Medicaid] would not move unless they got legislative direction." Thus, large-scale action to expand eligibility or to take other steps that would have noticeable impacts on state Medicaid spending can require gaining the state legislature's support. Key informants highlighted several considerations for framing policy actions to address maternal health inequities that could generate more widespread support among legislators and other decisionmakers:

- **Capitalize on unique interest in pregnancy and infancy and the lower political hurdles associated with improving maternal health than with Medicaid generally.** According to our key informants, framing the result of Medicaid policy changes in terms of infant outcomes or child health can raise support.
- **Consider focusing on more than just racial and ethnic disparities**. A policy's potential to narrow racial and ethnic disparities can gain support from some policymakers. In other cases, emphasizing a policy's potential to narrow gaps for other populations, such as rural or low-income populations, can be more effective for generating political support. This was particularly relevant in one state where stakeholders said using the word "equity" in the context of racial and ethnic disparities is taboo.
- **Consider whether to focus on costs or emotions to make the case for addressing racial and ethnic inequities in maternal health**. As described above, for some policymakers, money is the motivator for making policy change. Thus, interviewees advised that people pushing for change should let data and fiscal implications make the case for policy change (e.g., low financial

investment for reductions in hospitalizations and better infant health, resulting in a stronger next generation). This is seen as less political. For other policymakers, it is more compelling to hear individuals' stories about the challenges they encountered during the perinatal period to build support for strategies to address those challenges. However, interviewees acknowledged this can require people affected by poor outcomes to revisit their trauma. One stakeholder described the need for a multifaceted approach:

> One of the things that we…looked at was including data on the financial [implications of policies]…[explaining to decisionmakers] how much [money they] spend for every maternal mortality or case of maternal morbidity....But...I think the stories are so important [too], especially when people are able to tell their own story.

- **Educate state legislators and other policymakers about tools for improving perinatal health.** Interviewees reported a need for birth equity stakeholders to educate legislators and staff at MCOs. For example, as described previously, key informants cited the importance of ensuring key policymakers are aware of the role various services, such as doula care, can play in improving perinatal health so they understand the value of covering such services in Medicaid.
- **Identify leaders who will champion change.** Key informants recommended capitalizing on the political influence and reach of lawmakers interested in maternal health, who may belong to any political party.
- **Consider whether and how to place the need for improved maternal health equity in the reproductive health and reproductive justice context**. Some key informants emphasized that maternal health is broader than the perinatal period; it is health before and long after pregnancy and broader than just physical health, including overall well-being too. Therefore, pregnancy-related maternal health issues cannot be separated from the larger reproductive health context. These stakeholders believed, for instance, that abortion restrictions even before the *Dobbs* decision could spur the urgent need for more policy attempts to improve maternal health care in Medicaid that could be supported by legislators in favor of abortion restrictions. But others cautioned against framing maternal health policy in this context given the political minefields; instead, they recommended positioning efforts in a more general child and family health context.
- **Consider incremental steps toward larger policy goals.** As one stakeholder described, "Incremental progress is still progress." Sometimes achieving a smaller policy goal, such as a more modest postpartum Medicaid extension, could set the stage for more ambitious policy change, such as a longer postpartum extension or coverage of additional services in Medicaid.

Which Sectors and Partners Are Needed to Build Support for Advancing Maternal Health Equity in Medicaid?

Many of our key informants argued that driving support for improvements in maternal health equity in southern states' Medicaid programs requires a broader set of stakeholders than just the Medicaid agency and state legislators and requires collaboration across groups and sectors.

Partners' roles can range from bringing neutral, trusted information to conversations to working directly with policymakers to building consensus. However, interviewees sometimes characterized potential partners as not sufficiently integrated with Medicaid to fulfill their potential impact. In addition, informants viewed some partners as having a stronger focus on racial and ethnic equity than others.

For instance, though maternal mortality review committees are outside Medicaid, key informants raised them as a powerful partner in efforts to improve maternal health outcomes. These committees review the health records of each woman who died during pregnancy, delivery, or up to a year postpartum. Professionals with clinical and policy expertise conduct the reviews and make conclusions about what contributed to a person's death. The data coming from the maternal mortality review committee may thus be considered the most reliable assessment of why a woman died and, as such, are a primary source of information for understanding the role of maternal mortality interventions. Maternal mortality review committees exist in most states, but the type and granularity of information they share with the public vary considerably. Several key informants also emphasized the roles these committees and perinatal quality collaboratives can play in helping hospitals understand the importance of disaggregating data by race and ethnicity.[17] But we also heard about uneven patterns of these committees' recommendations leading to policy change; as one state maternal mortality review committee member explained, "We wish [the committee's recommendations] would be picked up more....It feels like we're making the same recommendations year after year."

Informants also highlighted MCOs both for their role in implementing state-driven equity policies and for innovating in the area of equity even without state action.[18] In one of our three study states, MCO contracts were awarded based on MCOs using innovation and flexibility to monitor and work to close certain equity gaps, and payment incentives were based on improvements in quality measures. A key informant in another state described MCOs as driving their own improvements without a state requirement. Proof of the effectiveness of such innovations could influence the behavior of other MCOs and eventually lead to adoption of these innovations in state Medicaid policy.

In addition to engagement with various trusted partners, both state and national informants described the importance of strategic collaboration. One state stakeholder highlighted good relationships between MCOs and perinatal quality collaboratives as a promising way of promoting the most-needed policy changes. Another stakeholder described collaborations as "fluid," with the state public health bureau, a state commission of providers with clinical expertise, MCOs, the state Medicaid agency, and others all engaged in a "conversation." According to the same stakeholder, these conversations can "bridge some of these shared concerns" through collaboration to inform which policy changes to adopt. And a national stakeholder maintained that efforts to advance change in Medicaid can be successful if they "bring in a broader swath of different…constituencies that used to be sort of siloed and different; that can make a big difference, particularly if it's kind of a close vote." Overall, interviewees described many types of organizations that can assist Medicaid programs with building support for equity-focused initiatives in Medicaid. They also described their perceptions of the values and limitations of these organizations' involvement in collaborations to advance policy change (table 3).

TABLE 3

Interviewees' Perceptions of the Roles of Different Groups in Medicaid Maternal Health Equity Initiatives

Group	Opportunities and limitations
Medicaid managed-care organizations (MCOs)	Medicaid policies can directly incentivize MCOs to address maternal health equity by requiring them to track and reduce disparities. Without such policies, MCOs can still serve as drivers of policies, such as by deciding to cover additional optional services; results of these experiences could then be shared with Medicaid agencies and, in turn, potentially spark eventual changes in covered services and in the contracting and procurement processes. But a lack of harmony across MCOs can limit such efforts' reach to enrollees across a state.
State perinatal quality collaboratives and other state-level commissions on perinatal health	Described as being integral to maternal health equity but with variable levels of interaction with state Medicaid programs that may limit these collaboratives' and commissions' reach.
Other (non-Medicaid) state agencies such as social services and public health	Seen as knowledgeable and trusted; can serve as a conduit to the Medicaid agency or can "test the waters" for policy proposals. However, they are often siloed and not integrated with Medicaid.
Maternal mortality review committees	Seen as fact based, reliable, legitimate, and politically palatable; interviewees described their recommendations as powerful to lawmakers but having uneven impacts on policy.
Bipartisan coalitions	Seen as successful in promoting common goals and boosting political support for initiatives. For example, one interviewee described the Healthy Mothers Healthy Babies coalition in one state as pushing for policy changes for years that are "now starting to materialize."

Group	Opportunities and limitations
Professional groups such as midwife and doula organizations, ACOG	Can address policymakers' knowledge gaps; specialized knowledge makes these groups ideal partners for Medicaid agencies in designing initiatives well (e.g., ACOG clarifying criteria for receiving postpartum care and how frequently; doulas helping design doula coverage that will support the provision of culturally competent care). However, their involvement in the policy process and equity focuses vary, and conventional health systems' trust in these groups may also vary.
Cross-state affinity groups	Cross-state initiatives, such as CMS's Postpartum Care Learning Collaborative, are seen as allowing states to learn from each other about promising practices and to share strategies and lessons learned.
Advocates and community-based organizations	Can address policymakers' knowledge gaps and "talk directly" to Medicaid agencies; can also advocate for policies and reinforce what Medicaid agencies are asking for to generate political support (i.e., they give the state cover to say "people are asking for this"), but agencies are not always willing to engage with these organizations.
Individual providers	Described as a potentially trusted and bipartisan voice for policymakers. However, they are often not racially and ethnically diverse.
Hospitals	Described as implementing Alliance for Innovation on Maternal Health[a] patient safety bundles, birthing-friendly hospital designations,[b] and other accreditations but not always with an equity focus; according to one stakeholder, some hospitals initially opposed equity-focused initiatives because of discomfort with discussing racism.
Academics, philanthropists, and researchers	Seen by some stakeholders as impartial and able to unify the knowledge base across fragmented sectors; can be a source of neutral, fact-based resources to educate policymakers, and members can serve on advisory committees and share ideas for innovation with Medicaid agencies. However, these entities may not have sufficient contact with communities to reflect their input and goals.
Community members	Often only represented by proxy (via advocates, medical schools, community organizations, etc.), which is insufficient; when community members are involved, voices are insufficiently diverse and are seldom from historically marginalized groups. Often called upon to share stories but not given a voice in the design of policies and not incorporated in decisionmaking.

Sources: Key informant interviews conducted in late 2021 through summer 2022.

Notes: ACOG = American College of Obstetricians and Gynecologists. CMS = Centers for Medicare & Medicaid Services.

[a] The Alliance for Innovation on Maternal Health is a cooperative agreement between ACOG and the Health Resources Services Administration Maternal and Child Health Bureau.

[b] Centers for Medicare & Medicaid Services, "CMS Announces Key Actions to Reduce Maternal Mortality and Morbidity," news release, April 13, 2022, https://www.cms.gov/newsroom/press-releases/cms-announces-key-actions-reduce-maternal-mortality-and-morbidity.

What Federal Support Could Help States Advance Maternal Health Equity?

State-level informants described several federal policy actions, shown in table 4, that could support broader state-level action on maternal health care and potentially improve equity in Medicaid. Though informants did not always specify the actions the federal government would need to take, they could include regulations or guidance from the Centers for Medicare & Medicaid Services to states, federal

laws enacted by Congress, regulations from other federal agencies, and better enforcement of existing federal policies to provide a stronger racial and ethnic equity focus. In some cases, such efforts are embedded in federal priorities identified by the current administration (e.g., the Centers for Medicare & Medicaid Services prioritizing data collection as part of its overall equity plan[19]), whereas other efforts are larger-scale changes, such as mandating evaluation for state plan amendments, that would represent more abrupt shifts.

TABLE 4

Federal Policy Actions That Could Support State Maternal Health Equity Initiatives in Medicaid

Theme	Policy action
Eligibility and coverage	▪ Strengthen incentives and support for **adopting currently optional policy changes** like postpartum Medicaid extension. ▪ Increase **federal support for employing patient navigators** to assist birthing people, mothers, and women of reproductive age with enrollment processes to limit coverage gaps.
Expanding the perinatal workforce	▪ **Encourage alignment** between racial, ethnic, linguistic, and cultural characteristics of workforces and the communities they serve.[a] ▪ Expand efforts to increase the size, geographic distribution, and diversity of the **perinatal workforce**.[b]
Patient-centered care	▪ Create and enforce broader use of **clinical checklists**, such as those related to hemorrhage, for providers to follow. ▪ Enforce patients' **rights to translation services**. ▪ Incentivize hospitals to adopt the **birthing-friendly designation**.[c]
Data and oversight`	▪ Support improved **data collection on equity** in maternal health care in Medicaid. ▪ Continue **funding for maternal mortality review committees** and expand the availability of **information on Medicaid-funded births with poor outcomes**. ▪ Mandate **evidence-based antibias training** and related efforts to prevent bias from affecting how people are treated, conditions are coded, or diagnoses are assigned. ▪ Mandate, fund, and enforce the **incorporation of community voices** into Medicaid design and implementation decisions with respect to perinatal care.[d] ▪ Mandate **equity-focused evaluations of policy changes** conducted via state plan amendments or waiver options.

Source: Key informant interviews conducted in late 2021 through summer 2022.

Notes: [a] An example from one key informant is the Health Resources and Services Administration (HRSA) providing guidance to hospitals on using community benefits.

[b] Examples provided include increasing residency slots in most-needed areas and promoting HRSA National Health Service Corps programs that incentivize providers to practice in health professional shortage areas in exchange for student loan repayment; expanding access to entry-level and other positions requiring fewer than two years of training for licensed and certified positions in health care; and increasing funding to support advanced degrees through diversity grants, scholarships, and loan forgiveness programs prioritizing historically Black colleges and universities, minority-serving institutions, and tribal colleges and universities.

[c] Centers for Medicare & Medicaid Services, "CMS Announces Key Actions to Reduce Maternal Mortality and Morbidity," news release, April 13, 2022, https://www.cms.gov/newsroom/press-releases/cms-announces-key-actions-reduce-maternal-mortality-and-morbidity.

[d] Informants mentioned community advisory committees as one avenue for achieving this, and this is occurring in at least one southern state: in December 2021, the Washington, DC, Department of Health Care Finance developed its Maternal Health Advisory Group to guide the agency on adopting postpartum coverage extension and adding doula and transportation benefits to Medicaid. See Maggie Clark and Elizabeth Wright Burak, *Opportunities to Support Maternal and Child Health through Medicaid's New Postpartum Coverage Extension* (Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families, 2022).

Key informants also highlighted additional federal actions that could support the needs of pregnant and postpartum people beyond the health care sector, including universal child care, early childhood development programs, and parental skill building.

What Additional Policy Levers Could State Medicaid Programs Use to Advance Maternal Health?

Many key informants identified additional actions beyond the policy changes discussed above and listed in table 2 that Medicaid programs and their partners could take to improve care; table 5 shows examples of such approaches. In some cases, interviewees recommended more-limited actions such as a small pilot program which, if successful, could be expanded more broadly. In other cases, they identified larger-scale actions like capitalizing on Medicaid's buying power to incentivize changes, such as through value-based payment models with MCOs; as one state stakeholder explained, money can facilitate change. Another stakeholder noted that MCO quality measures that are incentivized with payments tend to lead to change more than those without financial incentives. In addition, interviewees expressed interest in programs' support of broader efforts to increase the size, breadth, and diversity of the maternal health workforce. As one state-based key informant noted, "Until the workforce looks like the people we serve, there will be racial bias. And we've got to have more Black folks who are doctors, nurses, everything else…part of the problem is you just don't have enough Black providers."

Notably, the policy levers interviewees mentioned varied in whether they are within the state Medicaid agency's control. Levers ranged from solutions that are relatively easy to implement (e.g., using inclusive and respectful language in state communications) to those that would require action from other sectors (e.g., getting funding for maternal mortality review committees or increasing the size and diversity of the perinatal workforce). Moreover, though stakeholders mentioned many of these options as promising for improving racial and ethnic inequities in maternal health, few of them explicitly focus on equity.

TABLE 5

Additional Levers State Medicaid Programs Can Use to Advance Maternal Health and Potentially Improve Maternal Health Equity

Theme	Policy lever
Eligibility, coverage, and services	▪ **Pilot new benefits and services** to test and demonstrate their value on a smaller scale before adopting them statewide.[a] ▪ Encourage traditional perinatal care teams to include **providers like midwives** in states where they can practice. ▪ Strategically and intentionally **connect postpartum Medicaid enrollees who will lose coverage at the end of the COVID-19 public health emergency** to other coverage. ▪ **Streamline enrollment** for WIC, SNAP, and other social benefit programs when possible to help ensure patients' other needs are met. ▪ **Ensure enrollees are receiving services to which they are entitled** (e.g., translation services and evidence-based substance use disorder and mental health services).
Patient-centered care	▪ Connect people getting pregnancy-related coverage to **other patient-centered social services and programs.** ▪ **Incorporate diverse community voices** in program design, implementation, and evaluation (e.g., by using community advisory boards). ▪ Create **payment incentives for hospital-level interventions** that promote high-quality care.[b] ▪ Support **efforts to increase the diversity of the provider workforce** to improve racial and ethnic concordance between patients and providers. ▪ **Design Medicaid policy statements and communications** with members and providers that address enrollees' language needs and are culturally competent and respectful.
Data and oversight	▪ Plan robust **data collection and evaluation** for initiatives to not only monitor progress overall but reduce inequities.[c]
MCO contracting	▪ **Employ MCO procurement and contracting mechanisms** that require or build in financial incentives for tracking and reducing disparities.
Leveraging existing federal avenues and mandates	▪ **Take advantage of federal options** that capitalize on legislators' interest in improving maternal health care, such as through targeted Section 1115 waivers and the ARPA postpartum extension or CHIP unborn child funding. ▪ Leverage **state Medicaid quality strategies** as a road map for improving care. ▪ Encourage state action and training opportunities to **increase the size and geographic distribution of the perinatal workforce.**
Care delivery transformation	▪ Encourage **evidence-based antibias training** for all providers (including Medicaid providers and their front office staff).

Source: Key informant interviews conducted in late 2021 through summer 2022.

Notes: WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. SNAP = Supplemental Nutrition Assistance Program. MCO = managed-care organization. ARPA = American Rescue Plan Act. CHIP = Children's Health Insurance Program.

[a] As part of the managed-care rule, MCOs must conduct at least two performance improvement projects per year, one administrative and one clinical. The projects are evaluated by the state's external quality review organization and reported to the Centers for Medicare & Medicaid Services via an annual technical report. MCOs also run pilot projects outside of the mandatory performance improvement projects and may offer additional value-added services (distinct services above what is mandatory) to compete for members.

[b] Examples may include maternal safety bundles or birthing-friendly hospital designations.

[c] This may require auditing race and ethnicity data in Medicaid enrollment data for accuracy and completeness.

Conclusion

Like states across the nation, some southern states are adopting policies that could expand access to care and improve maternal outcomes, such as extending postpartum coverage and adding to the perinatal services Medicaid covers. But even though key informants in the southern states we studied described interest in improving maternal outcomes as generally high, interest in explicitly designing policies to close equity gaps is more mixed.

The policy solutions interviewees described also highlight the need for more research to understand which policies can specifically improve maternal health equity. Accurate, high-quality, and timely data are required to know if the suggested policies and practices can actually advance equity. It is possible that policies that seem beneficial will not improve outcomes, and policies that improve outcomes in aggregate could also allow established disparities to remain in place. If more complete data were available on enrollees, MCOs and providers were held accountable with data collection mandates, and program and policy changes were routinely evaluated, Medicaid programs would be able to monitor racial and ethnic health care disparities and would be in a much stronger position to evaluate the impacts of changes in policy and practice. This would also permit greater accountability to enrollees and taxpayers. But incomplete data, a lack of funding, and that data collection and evaluation are less prioritized than other goals limit efforts to evaluate policies' efficacy, overall and for various racial and ethnic groups. For example, the strategic use of data and public-private partnerships were associated with a reduction in maternal mortality in California as maternal mortality rates rose nationally, suggesting that data-driven approaches can improve outcomes.[20]

Moreover, consistent with our findings, other evidence shows that few states' maternal health initiatives are directly addressing equity, and the extent to which general changes could close equity gaps is unclear (Khanal 2021). Some evidence suggests tailored, person-centered solutions or community-based models could both improve overall outcomes and address inequities (Sudhinaraset et al. 2021; Zephyrin et al. 2021), illustrating that promotion of these care models may be useful when coupled with efforts to widen Medicaid eligibility and access to care. And even with more robust data collection and evaluation plans, many informants recognized that measuring the success of initiatives overall and in closing equity gaps is difficult and takes time; as one state Medicaid agency representative explained, "One should not expect to be able to show impacts of a policy change right away."

Finally, key informants indicated that broad policy changes may be needed to dramatically improve maternal health equity. Universal adoption of Medicaid expansion under the ACA, for example, could

help narrow racial maternal health gaps (Eliason 2020). But in the two nonexpansion study states (Georgia and Texas), informants were not optimistic about expansion being adopted under current conditions.

The federal government has been increasingly promoting initiatives to address maternal health, such as the White House Blueprint for Addressing the Maternal Health Crisis released in June 2022 and the Black Maternal Health Momnibus,[21] a package of 12 bills seeking to address the maternal health crisis. But broader actions across sectors beyond the health care system would also be needed to address underlying racial and ethnic disparities in wealth and income and disparities in environmental and occupational risks that contribute to health disparities.

With approximately 700 women dying each year to pregnancy-related causes and many more experiencing maternal morbidity (Petersen et al. 2019), improving maternal health and narrowing inequities are crucial priorities. This is especially critical given the *Dobbs v. Jackson Women's Health Organization* decision that has already restricted abortion access in almost half of states, which is expected to disproportionately affect Black women.[22] The benefits of improving maternal health would accrue not only to Medicaid-covered women and other people who get pregnant and give birth but to their infants and families, given the strong association between parental and child health and well-being (Murphey et al. 2018). Broad, sustained, multisector action—including employing various Medicaid policies—and evaluation of the effectiveness of such efforts are urgently needed to improve outcomes and reduce long-standing inequities.

Notes

[1] Elisha Brown, "Where Abortion Would Remain Accessible in a Post-Roe South," *Facing South*, May 12, 2022, https://www.facingsouth.org/2022/05/where-abortion-would-remain-accessible-post-roe-south.

[2] "Maternal Mortality by State, 2018," US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, accessed October 27, 2022, https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf.

[3] Jens Manuel Krogstad, "Hispanics Have Accounted for More Than Half of Total U.S. Population Growth since 2010," Pew Research Center, July 10, 2020, https://www.pewresearch.org/fact-tank/2020/07/10/hispanics-have-accounted-for-more-than-half-of-total-u-s-population-growth-since-2010/; and Christine Tamir, "The Growing Diversity of Black America," Pew Research Center, March 25, 2021, https://www.pewresearch.org/social-trends/2021/03/25/the-growing-diversity-of-black-america/.

[4] Robin Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities," AAMC News, October 31, 2017, https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities.

[5] Authors' tabulations based on "Births Financed by Medicaid," Kaiser Family Foundation, accessed October 18, 2022, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] Six states use CHIP in addition to Medicaid for pregnancy-related coverage (Brooks et al. 2021). The Medicaid policies we discuss here could also apply to CHIP, but we refer to Medicaid throughout for simplicity.

[7] "Preconception Care (Position Paper)," American Academy of Family Physicians, accessed October 18, 2022, https://www.aafp.org/about/policies/all/preconception-care.html.

[8] "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, accessed September 20, 2022, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

[9] "State Policies to Improve Maternal Health Outcomes," Commonwealth Fund, November 19, 2020, https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-policies-improve-maternal-health-outcomes; "Maternal Mortality Review Committees," Guttmacher Institute, October 1, 2022, https://www.guttmacher.org/state-policy/explore/maternal-mortality-review-committees; "Medicaid Reimbursement Policies for Immediate Postpartum Long Acting Reversible Contraceptives (LARCs)," Kaiser Family Foundation, July 1, 2021, https://www.kff.org/womens-health-policy/state-indicator/medicaid-coverage-of-intrauterine-devices-iuds-implants-and-reimbursement-policy/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; "Medicaid Postpartum Coverage Extension Tracker," Kaiser Family Foundation, October 20, 2022, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/; and "Doula Medicaid Project," National Health Law Program, accessed October 27, 2022, https://healthlaw.org/doulamedicaidproject/.

[10] We only conducted case studies in states with pregnancy-related Medicaid, not pregnancy-related CHIP, though the insights here are likely applicable for states with CHIP pregnancy programs. Louisiana and Texas offer CHIP-funded "unborn child" coverage that is limited to covering fetuses as "targeted low-income children" before birth, but none of the study states uses CHIP funding for comprehensive pregnancy-related coverage that is similar to Medicaid (Brooks et al. 2020).

[11] Emily M. Johnston, "Research Shows Access to Legal Abortion Improves Women's Lives," *Urban Wire* (blog), Urban Institute, May 27, 2022, https://www.urban.org/urban-wire/research-shows-access-legal-abortion-improves-womens-lives.

[12] Brown, "Where Abortion Would Remain Accessible in a Post-Roe South."

[13] Reproductive health advocates and legal scholars are concerned that this ruling will embolden states to limit access to contraception. Justices Breyer, Sotomayor, and Kagan noted that the right to terminate a pregnancy arose out of the right to purchase contraception per *Griswold v. Connecticut* (1965) and *Eisenstadt v. Baird* (1972). In a concurring opinion, Justice Thomas advocated for overruling *Griswold v. Connecticut*, *Lawrence v. Texas*, and *Obergefell v. Hodges*, which would place restrictions on contraception, same-sex intimacy, and same-sex marriage. See Dobbs v. Jackson Women's Health Organization, No. 19-1392, slip op. (Sup. Ct. 2022).

See also Elisabeth Jacobs, Andrew Boardman, and Archana Pyati, "Roe v. Wade's Reversal Poses a Disproportionate Threat to Black Women's Economic Mobility," *Working Knowledge* (blog), WorkRise, June 28, 2022, https://www.workrisenetwork.org/working-knowledge/roe-v-wades-reversal-poses-disproportionate-threat-black-womens-economic-mobility; and Cody Mello-Klein, "Overturning Roe v. Wade Will Put Even More of an Economic Burden on Women, Northeastern Economist Says," *News@Northeastern*, Northeastern University, June 27, 2022, https://news.northeastern.edu/2022/06/27/roe-v-wade-economic-impact-women/.

[14] "State Policies to Improve Maternal Health Outcomes," Commonwealth Fund.

[15] As noted above, though stakeholders mentioned these initiatives and policy options for their potential to improve maternal health care, the extent to which these changes would directly affect outcomes or whether or how they could affect racial and ethnic equity is unclear. Further, the initiatives and policy options mentioned are not an exhaustive list; additional policies not included could be important for addressing outcomes and inequities.

[16] "Medicaid Postpartum Coverage Extension Tracker," Kaiser Family Foundation.

[17] As of July 2022, only 12 states, including 4 of the 17 southern states, have maternal mortality review committees that explicitly review morbidity cases or investigate trends of maternal morbidity as a part of their scopes of work. Moreover, only 10 states, including only 4 southern states, have maternal mortality review committees that investigate or consider racial disparities when conducting reviews; see "Maternal Mortality Review Committees," Guttmacher Institute. This could represent a missed opportunity in the effort to improve maternal outcomes overall and maternal health equity specifically.

[18] Most Medicaid enrollees are served by an MCO that functions as an intermediary between the state Medicaid agency and direct service providers (MACPAC 2021). The state Medicaid agency often contracts with multiple MCOs, which then compete for members; MCOs are paid a fixed amount per member every month. The MCO contract, the legal agreement between the Medicaid agency and the MCO, also incorporates multiple ways the Medicaid agency can hold the MCO accountable for members' care. The contract may include provisions for alternative payment models, whereby a portion of the money used to care for members must be earned and evidenced by meeting targets for standardized quality measures, making Medicaid programs' MCO policies also relevant to the quality of maternal health care.

[19] "CMS Framework for Health Equity," Centers for Medicare & Medicaid Services, last modified October 14, 2022, https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity.

[20] Rachel Mayer, Alison Dingwall, Juli Simon-Thomas, Abdul Sheikhnureldin, and Kathy Lewis, "The United States Maternal Mortality Rate Will Continue to Increase without Access to Data," *Health Affairs Forefront*, February 4, 2019, https://www.healthaffairs.org/do/10.1377/forefront.20190130.92512/.

[21] "Black Maternal Health Momnibus," Black Maternal Health Caucus, accessed October 27, 2022, https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus.

[22] Fabiola Cineas, "Black Women Will Suffer the Most without Roe," *Vox*, June 29, 2022, https://www.vox.com/2022/6/29/23187002/black-women-abortion-access-roe; "Abortion Policy in the Absence of Roe," Guttmacher Institute, October 1, 2022, https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe; and Jacobs, Boardman, and Pyati, "Roe v. Wade's Reversal Poses a Disproportionate Threat to Black Women's Economic Mobility."

References

ACOG (American College of Obstetricians and Gynecologists). 2018. "ACOG Committee Opinion No. 736 Summary: Optimizing Postpartum Care." *Obstetrics & Gynecology* 131 (5): 949–51. https://doi.org/10.1097/AOG.0000000000002628.

Brooks, Tricia, Allexa Gardner, Jennifer Tolbert, Rachel Dolan, and Olivia Pham. 2021. *Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey*. San Francisco: Kaiser Family Foundation.

Brooks, Tricia, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan. 2020. *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*. San Francisco: Kaiser Family Foundation.

Burroughs, Emily, Ian Hill, Kimá Joy Taylor, Sarah Benatar, Jennifer M. Haley, Eva H. Allen, and Sarah Coquillat. 2021. "Maternal Health Inequities during the COVID-19 Pandemic: Challenges, Promising Advances, and Opportunities to Promote Equitable Care." Washington, DC: Urban Institute.

Callaghan, William M., Andreea A. Creanga, and Elena Kuklina. 2012. "Severe Maternal Morbidity among Delivery and Postpartum Hospitalizations in the United States." *Obstetrics & Gynecology* 120 (5): 1029–36. https://doi.org/10.1097/aog.0b013e31826d60c5.

CMS (Centers for Medicare & Medicaid Services). 2019. "Improving Access to Maternal Health Care in Rural Communities." Baltimore: CMS.

Declercq, Eugene, and Laurie Zephyrin. 2020. "Maternal Mortality in the United States: A Primer." New York: Commonwealth Fund.

Eliason, Erica L. 2020. "Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality." *Women's Health Issues* 30 (3). https://doi.org/10.1016/j.whi.2020.01.005.

Gonzalez, Dulce, Genevieve M. Kenney, Marla McDaniel, and Laura Skopec. 2021. "Perceptions of Unfair Treatment or Judgement Due to Race or Ethnicity in Five Settings." Washington, DC: Urban Institute.

Heck, Jennifer L., Emily M. Jones, Diane Bohn, Shondra McCage, Judy Goforth Parker, Mahate Parker, Stephanie L. Pierce, and Jacquelyn Campbell. 2021. "Maternal Mortality among American Indian/Alaska Native Women: A Scoping Review." *Journal of Women's Health* 30 (2): 220–29. https://doi.org/10.1089/jwh.2020.8890.

Haley, Jennifer M., Emily M. Johnston, Ian Hill, Genevieve M. Kenney, and Tyler W. Thomas. 2021. *The Public Health Insurance Landscape for Pregnant and Postpartum Women*. Washington, DC: Urban Institute.

Hoyert, Donna L. 2022. "Maternal Mortality Rates in the United States, 2020." Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.

Johnston, Emily M., Jennifer M. Haley, Stacey McMorrow, Genevieve M. Kenney, Tyler W. Thomas, Clare Wang Pan, and Robin Wang. 2021. *Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care through a Postpartum Medicaid/CHIP Extension*. Washington, DC: Urban Institute.

Khanal, Priti. 2021. "Improving Maternal Health Outcomes: State Policy Actions and Opportunities." Hamilton, NJ: Center for Health Care Strategies.

MacDorman, Marian F., Eugene Declercq, Howard Cabral, and Christine Morton. 2016. "Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues." *Obstetrics & Gynecology* 128 (3): 447–55. https://doi.org/10.1097/aog.0000000000001556.

MACPAC (Medicaid and CHIP Payment and Access Commission). 2021. *MACStats: Medicaid and CHIP Data Book*. Washington, DC: MACPAC.

Mallick, Lindsay, Marie E. Thomas, and Edmond D. Shenassa. 2020. "The Role of Doulas in Respectful Care for Communities of Color and Medicaid Recipients." *Birth Issues in Perinatal Care.* https://doi.org/10.1111/birt.12655.

March of Dimes. 2020. *Nowhere to Go: Maternity Care Deserts across the U.S. 2020 Report*. Arlington, VA: March of Dimes.

———. 2021. *2021 March of Dimes Report Card*. Arlington, VA: March of Dimes.

Martin, Joyce A., Brady E. Hamilton, and Michelle J. K. Osterman. 2020. "Births in the United States, 2019." Washington, DC: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

McDaniel, Marla, Audrey Richardson, Dulce Gonzalez, Clara Alvarez Caraveo, Laura Wagner, and Laura Skopec. 2021. "Black and African American Adults' Perspectives on Discrimination and Unfair Judgment in Health Care." Washington, DC: Urban Institute.

Murphey, David, Elizabeth Cook, Samuel Beckwith, and Jonathan Belford. 2018. "The Health of Parents and Their Children: A Two-Generation Inquiry." Bethesda, MD: Child Trends.

Ndugga, Nambi, and Samantha Artiga. 2021. "Disparities in Health and Health Care: 5 Key Questions and Answers." San Francisco: Kaiser Family Foundation.

Petersen, Emily E., Nicole L. Davis, David Goodman, Shanna Cox, Nikki Mayes, Emily Johnston, Carla Syverson, et al. 2019. "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017." *Morbidity and Mortality Weekly Report* 68 (18): 423–29. http://dx.doi.org/10.15585/mmwr.mm6818e1.

Platt, Taylor, and Neva Kaye. 2020. "Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid." Washington, DC: National Academy for State Health Policy.

Saluja, Bani, and Zenobia Bryant. 2021. "How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States." *Journal of Women's Health* 30 (2): 270–73. https://doi.org/10.1089/jwh.2020.8874.

Shrider, Emily A., Melissa Kollar, Frances Chen, and Jessica Semega. 2021. *Income and Poverty in the United States: 2020*. Washington, DC: US Government Publishing Office.

Skopec, Laura, Dulce Gonzalez, and Genevieve M. Kenney. 2021. "Most Adults Who Feel Treated or Judged Unfairly by Health Care Providers Report Adverse Consequences." Washington, DC: Urban Institute.

Snyder, John E., Anne L. Stahl, Robin A. Streeter, and Michelle M. Washko. 2020. "Regional Variation in Maternal Mortality and Health Workforce Availability in the United States." *Annals of Internal Medicine.* https://doi.org/10.7326/M19-3254.

Stevenson, Amanda Jean. 2021. "The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant." *Demography* 58 (6): 2019–28. https://doi.org/10.1215/00703370-9585908.

Sudhinaraset, May, Amanda Landrian, Ginger M. Golub, Sun Y. Cotter, and Patience A. Afulani. 2021. " Person-Centered Maternity Care and Postnatal Health: Associations with Maternal and Newborn Health Outcomes." *AJOG Global Reports* 1 (1). https://doi.org/10.1016/j.xagr.2021.100005.

Taylor, Jamila, Cristina Novoa, Katie Hamm, and Shilpa Phadke. 2019. *Eliminating Racial Disparities in Maternal and Infant Mortality*. Washington, DC: Center for American Progress.

Vilda, Dovile, Maeve E. Wallace, Clare Daniel, Melissa Goldin Evans, Charles Stoecker, and Katherine P. Theall. 2021. "State Abortion Policies and Maternal Death in the United States, 2015 – 2018." *American Journal of Public Health* 111 (9): 1696–704. https://doi.org/10.2105/AJPH.2021.306396.

Zephyrin, Laurie, Shanoor Seervai, Corinne Lewis, and Jodie G. Katon. 2021. "Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity." New York: Commonwealth Fund.

About the Authors

Jennifer M. Haley is a senior research associate in the Health Policy Center at the Urban Institute. Her current work includes understanding ways to improve collection of race and ethnicity data for use by health plans and other stakeholders, monitoring insurance coverage trends during the pandemic, exploring how states and stakeholders can help promote continuous coverage, and assessing challenges to accessing the safety net for immigrant families. She holds an MA in sociology from Temple University.

Sofia Hinojosa is a research assistant at the Health Policy Center at the Urban Institute. Her research focuses on health equity, immigration policy, and strengthening safety-net programs. She also completed health policy fellowships at Carnegie Mellon University and the University of Michigan School of Public Health. Sofia graduated with honors from American University, where she earned a BA in Public Health and a certification on Community-Based Participatory Research.

Leandra Lacy is a training and technical assistance specialist in the Research to Action Lab at the Urban Institute. She supports the design and delivery of tailored technical assistance and the coordination and facilitation of peer learning for a variety of stakeholders. Lacy's background is in sexual and reproductive health research, education, programming, and capacity building. Her passions include STI/HIV prevention, maternal health, community health, racial equity, and health equity. She has a BA in women's studies from the University of North Carolina at Chapel Hill and an MPH in behavioral sciences and health education from Emory University.

Carla Willis is a principal research associate in the Health Policy Center at the Urban Institute. Her work focuses on Medicaid policy, payment incentives, and delivery system reform. She previously served as the director of performance, quality, and outcomes for the Georgia Medicaid program and holds a PhD in political science from The Ohio State University.

Statement of Independence

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org