URBAN INSTITUTE · ELEVATE · THE · DEBATE

Leveraging Georgia's Postpartum Medicaid Extension for Improved Maternal Health

Eva H. Allen, Jennifer M. Haley, and Sofia Hinojosa

May 2025

Georgia's maternal health landscape is at a critical crossroads. Recognizing the vital role that Medicaid plays in maternal health, Georgia leaders have implemented several key strategies over recent years, including, in 2021, becoming one of the first states in the nation to extend postpartum Medicaid coverage.

Georgia has some of the worst maternal health outcomes in the nation, with 37.9 pregnancy-related deaths per 100,000 live births between 2020 and 2022; this is nearly twice the national maternal mortality rate in the same period.[1] According to the state's Maternal Mortality Review Committee, the vast majority of maternal deaths occurred within one year after pregnancy, and 87 percent were likely preventable. In addition, Black women in Georgia are more than twice as likely to die from pregnancy-related causes than white women (Georgia Department of Public Health 2025).[2] Medicaid pays for nearly half of births statewide (Chan 2023), and nearly two-thirds (62 percent) of Georgia mothers who died from pregnancy-related reasons in 2021 were covered by Medicaid (Georgia Department of Public Health 2025).

Historically, pregnancy-related Medicaid/Children's Health Insurance Program (CHIP) coverage has expired at the end of the month following 60 days after the end of pregnancy. In 2021, Georgia extended postpartum Medicaid coverage from 60 days to six months after the end of pregnancy through Section 1115 demonstration authority.[3] Taking an option made available under federal legislation, Georgia lawmakers directed the Medicaid program to transition from a temporary six-month postpartum extension under the waiver to a permanent 12-month postpartum extension in

[1] "Maternal Mortality," Georgia Department of Public Health, accessed May 15, 2025, https://dph.georgia.gov/maternal-mortality; and Donna L. Hoyert, "Health E-stat: Maternal Mortality Rates in the United States, 2022," CDC, May 2, 2024, https://stacks.cdc.gov/view/cdc/152992.

[2] 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," so we use the terms "maternal" and "women" in this essay, but we acknowledge that not all people who are pregnant or give birth identify as such. We remain committed to using respectful, inclusive language.

[3] "Postpartum Extension Demonstration," Georgia Medicaid, accessed May 15, 2025, https://medicaid.georgia.gov/programs/all-programs/postpartum-extension.

November 2022.[4][5] With this extension, eligible individuals are entitled to 12 months of continuous coverage with comprehensive benefits (including pregnancy-related services and other services) regardless of why the pregnancy ends and regardless of changes in income that could otherwise make the person ineligible for Medicaid.[6]

This essay presents findings from interviews with key stakeholders and postpartum Medicaid members in Georgia (box 1) to assess the early implementation of the 12-month postpartum Medicaid extension and identify challenges and opportunities associated with improving access to care in the full postpartum year and lowering maternal health risks.

We find the following key takeaways from this assessment:

1. Administrative systems and processes may not be ensuring that all eligible enrollees are covered and able to access services.
2. It is unclear how knowledgeable Georgia Medicaid members and health care providers are about the extension.
3. Postpartum visit rates remain a priority, but little has changed in the delivery system to ensure access to comprehensive health care services in the full postpartum year.
4. Addressing broader maternity care challenges would strengthen postpartum care.

These findings align with prior research suggesting that implementing a postpartum extension alone, without accompanying improvements to the delivery system, will likely be insufficient to ensure substantial improvements in postpartum health (Allen et al. 2024; Forester and Cornelius 2024). Below we describe findings from our study in more detail along with actions the state Medicaid agency, care management organizations (CMOs), providers, and other organizations serving families in Georgia could take to ensure that the postpartum extension translates into better access to care, improvements in postpartum health outcomes, and reductions in maternal health disparities.

[4] *American Rescue Plan Act of 2021*, Public Law 117–2; Usha Ranji, Alina Salganicoff, Ivette Gomez, "Postpartum Coverage Extension in the American Rescue Plan Act of 2021," *KFF*, March 18, 202, https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/; *Consolidated Appropriations Act of 2023*, Pub Law 117–328.

[5] In November 2022, Georgia terminated its waiver and, under SB 338, adopted 12-month postpartum coverage through the state plan amendment option in Medicaid and PeachCare for Kids (Georgia's CHIP). See: "SB 338," Georgia General Assembly, accessed May 28, 2025, https://www.legis.ga.gov/legislation/61152.

[6] CMS guidance indicates that postpartum coverage eligibility, whether for 60 days or 12 months after the end of pregnancy, extends to the person "regardless of the reason the pregnancy ends," that is, even if the pregnancy did not result in live birth; see Daniel Tsai, "RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)," Medicaid.gov, December 7, 2021.

BOX 1

Research Methods

Between November 2024 and February 2025, the Urban Institute research team conducted nine interviews with 20 key stakeholders in Georgia, including state Medicaid and public health department staff, representatives of managed care plans, health care providers, consumer advocates, and staff from community-based organizations serving pregnant and postpartum women. Interviews explored how the postpartum extension is being implemented, motivations and goals for the postpartum extension, communications and outreach to Medicaid members and other stakeholders, the state's health care delivery system, and policies in place or under consideration to ensure access to comprehensive health care in the postpartum period.

In February 2025, we also conducted telephone interviews with eight postpartum women enrolled in Georgia's Medicaid program during pregnancy and within 12 months of their most recent birth about their experiences with Medicaid benefits and health care during and after pregnancy. Interviewed Medicaid members were between the ages of 28 and 38, and all lived in the Atlanta metropolitan area. Six identified as Black, one identified as multiracial, and one identified as Hispanic. Four interviewees were first-time mothers, and the other four had between two and four children, some of whom were also covered by Medicaid. We collaborated with the Healthy Mothers, Healthy Babies Coalition of Georgia, which advocates for improved access to health care for mothers and babies, to recruit Medicaid members for the study.

The research team took detailed notes on each interview and recorded and transcribed interviews when study participants granted permission. Team members analyzed interview notes to identify common themes and unique insights, and supplemented or corroborated these findings with publicly available information.

Given the small sample of interviewed Medicaid members and key stakeholders, some perspectives may be missing, and others may be overrepresented. In particular, since we interviewed Medicaid members who have engaged in Healthy Mothers, Healthy Babies' programs and live in the Atlanta metropolitan area, their perspectives may not accurately represent those of members who are less well-connected to maternal supports or live in other areas of the state.

Though our findings from the interviews with Medicaid members cannot be generalized to the entire population of Medicaid-enrolled postpartum women in Georgia, they align with findings from other studies (Allen at al. 2024; Forester and Cornelius 2024), and together both sets of interviews provide insights into early implementation, emerging trends, and areas for further exploration and policy consideration. Quotes included in this brief were edited for clarity.

The Urban Institute's Institutional Review Board reviewed and approved the research study protocols.

1. Administrative Systems and Processes May Not Be Ensuring All Eligible Enrollees Are Covered and Able to Access Services.

What We Found

Reports of inappropriate disenrollments among postpartum enrollees. State officials reported that following approval of the state's SPA, the Georgia Gateway system (an online, integrated eligibility system) was updated to support automatic extension of coverage for 12 months after the end of

pregnancy for both new applicants and existing enrollees. Key stakeholders generally had no concerns about whether eligible members were maintaining coverage and were unaware of any systemic issues where women eligible for postpartum coverage had been denied coverage or inappropriately disenrolled from the program before 12 months postpartum. Responsibility falls to CMOs to notify the state of any problems, and no CMOs referred to widespread problems, though one CMO representative shared that there have been a few cases of inappropriate disenrollment where the organization had to work with the state agency to get members reinstated.

However, of the eight Medicaid members we interviewed, three reported receiving notifications from the Medicaid agency that their coverage had been terminated; one lost coverage at 20 weeks pregnant, while the other two received termination notices at three and six months postpartum, respectively. Medicaid members who lost coverage expressed distress, confusion, and disappointment. One woman who lost coverage during pregnancy was able to get her insurance reinstated, but reported that it took considerable time and effort to visit a county office in person to resolve the issue. Of the two women who had coverage terminated prematurely in the postpartum period, one was not aware of the 12-month extension at all, while the other knew the termination notice was wrong and was planning to reach out to someone to get assistance, but had not yet had the time to do so.

Possible claims denials. In addition, though we did not detect widespread concerns about prior authorization or claim denials, one key stakeholder shared that they knew about a mental health services provider whose claims for delivering therapy and counseling services for depression under extended postpartum Medicaid were denied. This stakeholder was unsure if this was an error, such as because of a failure to obtain prior authorization, or if those services were not covered in the postpartum period. Only one CMO representative shared that their plan is "open access," meaning it does not require members to obtain a referral from their primary care provider for specialty care, so some enrollees may face additional barriers to accessing specialty services. Although a single stakeholder reported this, we learned that there is no systematic assessment of whether this is occurring on a routine basis, which suggests a need for more provider education about services covered by postpartum Medicaid and close monitoring of utilization and oversight of CMO claims processing.

"I thought I had [coverage] for a whole year, a whole 12 months after giving birth. But according to the notice I just got in the mail, I don't know why, but it says coverage would be terminated after this month. My doctor wants me to come for a six-month postpartum check-up in April, but I won't be covered at that point."
—Postpartum Georgia Medicaid member

Why It Matters

Temporary disruptions in Medicaid coverage, such as when people still eligible for the program lose coverage and reenroll, can often happen because of administrative errors or income fluctuations at the time of periodic eligibility renewals, when states verify enrollees' information (Sugar et al. 2021). States can use available data to automatically renew coverage, or may require enrollees to submit information and documents to confirm their eligibility for Medicaid, which sometimes presents barriers for enrollees to keep their coverage. These coverage gaps, also known as churn, lead to disruptions in care and an increased administrative burden for enrollees and states (Sugar et al., 2021). Prior research showed that pregnant and postpartum women with Medicaid had a higher risk of coverage gaps within six months of delivery compared with women with private insurance (Daw et al. 2017). The postpartum coverage extensions intend to improve continuity of care by providing continuous eligibility from pregnancy through 12 months after the pregnancy ends.[7] However, as the present study demonstrates, system glitches and administrative errors in either Medicaid or CMO systems may result in some women losing coverage during the postpartum period despite remaining eligible.[8]

Though we only heard of one instance of service claims for postpartum care being allegedly denied, cumbersome prior authorization processes and high rates of claim denials in Medicaid managed care more generally have been shown to lead to delayed or foregone care and contribute to provider burnout (MACPAC 2024; OIG 2023).[9] State Medicaid agencies are responsible for facilitating access to high-quality care for all covered services, such as by implementing federal requirements and stronger oversight of managed care to ensure that Medicaid coverage, including through the postpartum extension, translates to reductions in unmet health care needs and improvements in maternal health outcomes.[10]

These findings underscore the importance of broad awareness and education of Medicaid members and key stakeholders about the postpartum extension and available benefits.

Actions to Consider

- ***Ensure that eligibility system and enrollment processes function smoothly,*** including exchange of eligibility information between the Medicaid agency and CMOs, to prevent erroneous coverage

[7] Tsai, "RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)."

[8] Lawsuits pending in Florida allege that the Medicaid agency terminated coverage of eligible women; see Jackie Llanos, "Florida Wrongly Kicked Postpartum Women and Their Newborns out of Medicaid," *Florida Phoenix*, July 29, 2024, https://floridaphoenix.com/2024/07/29/florida-wrongly-kicked-postpartum-women-and-their-newborns-out-of-medicaid/.

[9] Billy Morgan, "The Cost of Administrative Burdens: Providers Stop Accepting Medicaid Due to Hassle, Lost Payments," The University of Chicago, July 12, 2021, https://harris.uchicago.edu/news-events/news/cost-administrative-burdens-providers-stop-accepting-medicaid-due-hassle-lost; Tanya Albert Henry, "Exhausted by Prior Auth, Many Patients Abandon Care: AMA Survey," AMA, July 18, 2024, https://www.ama-assn.org/practice-management/prior-authorization/exhausted-prior-auth-many-patients-abandon-care-ama-survey.

[10] "Medicaid and CHIP Managed Care Monitoring and Oversight Initiative," Medicaid.gov, accessed March 26, 2025, https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html.

losses or inaccurate notices for postpartum women. This could include system testing for various eligibility pathway scenarios, robust monitoring of system performance, sample case reviews, and investigations of inappropriate coverage terminations to identify and address system or process issues.

- ***Monitor and report enrollment and retention changes.*** One way to track the performance of eligibility systems could be by monitoring enrollment and retention in postpartum coverage, including by race/ethnicity, CMO, geography, and other characteristics, to the extent these data are available and reliable. For example, Georgia could consider renewing some of the monitoring the state conducted under its now-discontinued Section 1115 demonstration waiver (unlike Section 1115 waivers, SPAs do not require state evaluations).[11]
- ***Provide greater oversight of CMOs related to prior authorizations and claims denials***. A federal rule requires Medicaid managed care programs to reduce complexity and barriers to care by streamlining the prior authorization approval process, and even if the regulation were to be rolled back, the state could encourage or require similar actions.[12] Georgia could also consider removing referral requirements for specialist services and requiring all CMOs to establish an ombudsman program to assist in resolving member and provider concerns related to access to and coverage of services.[13]

2. It Is Unclear How Knowledgeable Georgia Medicaid Members and Health Care Providers Are About the Extension.

What We Found

Widespread enthusiasm for extended postpartum Medicaid in Georgia. Among those familiar with the postpartum extension, stakeholders and Medicaid members lauded the policy. Adoption of the extension was reportedly driven in part by a desire to address Georgia's poor maternal health outcomes, and stakeholders thought the extension could help increase access to care and ultimately "move the needle" on reducing maternal mortality and morbidity. Medicaid benefits were characterized as comprehensive, with one stakeholder describing Medicaid as superior to private insurance for pregnancy-related coverage. When asked what they liked most about Medicaid, postpartum enrollees we interviewed most often valued the protection from out-of-pocket costs. As one person indicated, "everybody should have pregnancy Medicaid… It's a great service and a stress reliever." On learning

[11] "Medicaid and CHIP Managed Care Monitoring and Oversight Initiative," Medicaid.gov, accessed May 15, 2025, https://medicaid.georgia.gov/document/document/postpartum-extension-revised-annual-monitoring-report-dy1/download.

[12] "CMS Finalizes Rule to Expand Access to Health Information and Improve the Prior Authorization Process," CMS, January 17, 2024, https://www.cms.gov/newsroom/press-releases/cms-finalizes-rule-expand-access-health-information-and-improve-prior-authorization-process.

[13] Georgia's ombudsman program appears to be currently required only of the foster care managed care program. See "Your Advocate for Quality Care," NC Medicaid Ombudsman, accessed May 1, 2025, https://ncmedicaidombudsman.org/.

coverage would extend for 12 months postpartum, one Medicaid member described being "thrilled," and another said she was "very happy."

Limited communication to providers and others who work with postpartum families. The Medicaid agency provides policy updates to CMOs and provider associations as part of regular meetings and relies on them to pass down the information to health care providers and Medicaid members. CMO representatives described educating obstetrics and gynecology (OB/GYN) practices about the postpartum extension, but not necessarily other types of providers, such as primary care physicians, dentists, and specialists. Providers we interviewed did not believe that information about the postpartum extension was reaching the broader health care community. For instance, based on conversations with colleagues and reports from patients, one provider shared that some specialists were not ordering follow-up tests for postpartum patients after delivery because they did not believe Medicaid would cover those services. Furthermore, key stakeholders thought communications with provider groups, where they occurred, aimed to raise provider awareness but may not include prompts to share information about extended postpartum coverage with patients.

Both the Medicaid agency and CMOs also reported educating eligibility workers and call center representatives who can provide information about coverage to members. Although there appeared to have been some initial outreach about the extension via other programs and community-based organizations that serve young families, it was unclear how extensive these efforts were or whether they continued. Finally, stakeholders did not report knowledge about mass communication campaigns about the extended coverage (such as via traditional or social media).

Limited understanding of member awareness and knowledge about Medicaid. No systematic information is available on how knowledgeable members and providers are about the extended postpartum coverage, as the state stopped all monitoring and evaluation activities that began under the 1115 demonstration.[14] Seven of the eight Medicaid members we interviewed were aware of the postpartum extension; most reported learning about it through letters from CMOs and some through case management. However, it is important to note again that our interview participants lived in the Atlanta metro area and appeared well-connected to education and other resources, so their knowledge levels may not represent those of other Medicaid members across the state. Some stakeholders believed that because of the lack of Medicaid expansion under the Affordable Care Act in Georgia, many members have limited understanding of health coverage and Medicaid benefits in general, and under the extension. They were particularly concerned that non-English speakers, immigrant families, first-time parents with no prior Medicaid experience, and those not strongly connected to the health care system or pregnancy case management may be unaware of extended postpartum coverage or have challenges navigating Medicaid benefits.

Three Medicaid members we interviewed were uninsured before pregnancy, and four reported being enrolled in Medicaid for the first time. Only three had an option for employer health insurance coverage, and the remainder were unsure what insurance they could obtain after their Medicaid

[14] "Postpartum Extension Demonstration," Georgia Medicaid.

coverage ended. No Medicaid members we interviewed specifically reported a lack of insurance or limited experience with health insurance or Medicaid coverage as a barrier to understanding benefits or navigating care, though many worried about access to care after their Medicaid ended, and some reported feeling stigmatized for having Medicaid. For example, one Medicaid member requested that her postpartum Medicaid coverage be terminated because she obtained employer coverage and was worried that maintaining Medicaid coverage would negatively impact how her colleagues would view her.

Communications about extension to Medicaid members primarily rely on print and mail. Like in most states, delivery of health care for most Georgia Medicaid members, including pregnant and postpartum women, is delegated to CMOs. The state Medicaid agency must review and approve CMOs' member communications. Our research found that outreach to members about the postpartum extension in Georgia has relied heavily on mail, such as letters and postcards. Examples of written notices about the postpartum extension we reviewed were not necessarily in plain, accessible language. For example, some materials used the word "waiver" to describe the extension, which may not have meaning for individuals unfamiliar with Medicaid policy terminology, and others cited statistics on maternal deaths, which may be alarming. Furthermore, the communications we reviewed largely focused on pregnancy-related and women's health services, but did not clearly state that full, comprehensive Medicaid benefits are covered, including specialty care and dental services.

In addition to written communications, some CMOs reported disseminating information about Medicaid postpartum coverage to members by texting, posting notices on their websites, incorporating messages through care coordination activities, and sometimes using in-person community outreach. For example, one CMO hosts community "baby showers" where information about Medicaid coverage and postpartum benefits is shared with attendees. When we asked postpartum Medicaid members how they would prefer to receive important information about Medicaid coverage and benefits, most would prefer email or text, followed by face-to-face interactions, mail, and phone.

Outreach about the postpartum extension was reportedly complicated by the rollout amid the unwinding of pandemic-related Medicaid continuous coverage (Georgia Department of Community Health 2022).[15] Widespread messaging about the need for all Medicaid members to complete renewal packets during unwinding made it harder for a message directed at continued coverage for postpartum members to break through, specifying that, for this group only, no action was required to continue coverage. Key stakeholders were unaware of any efforts to seek input from pregnant and postpartum Medicaid members on how they would prefer to receive information or how it could be conveyed in an accessible and understandable way.

[15] In March 2020, Congress enacted the Families First Coronavirus Response Act, which established a continuous coverage requirement in Medicaid that prohibited states from disenrolling beneficiaries throughout the COVID-19 public health emergency. This requirement ended in 2023, and states reassessed the eligibility of all enrollees, a process known as "unwinding" of the requirement.

"What I expect is happening is that people did not know that this service was available to them, and so especially if someone was not keeping prenatal care appointments, or they felt overall they were healthy and that service was not needed, I can venture to think that a lot of women were not aware that coverage exists postpartum."

"Knowledge is to some degree tied to engagement and experience. If they were pregnant before and have kids covered by Medicaid, that member is going to understand [postpartum coverage]. But if it's their first time being on Medicaid or there are language barriers, it's a little bit harder. The other piece to consider with communication is the mode or method by which we communicate. We're becoming an increasingly digital society in terms of text messages, emails, and social media. The way [Medicaid members] communicate impacts how they get information."
—Key stakeholders

Why It Matters

The first step to ensuring that extended postpartum Medicaid coverage can improve access to health care and maternal health is for postpartum enrollees and their health care providers to be aware that it is in place. High uninsurance rates among low-income women in Georgia (which is the second-to-last state in the US in percent of low-income women who are uninsured, at 32.2 percent)[16] likely complicate outreach about Medicaid postpartum extension. Medicaid eligibility pathways for adults in Georgia who do not qualify for coverage based on pregnancy or a disability are very limited (table 1). As a state that has not adopted the Affordable Care Act's Medicaid expansion, the Medicaid income limit for parents is just 29 percent of the federal poverty level in 2025, and adults who are not parents are ineligible for Medicaid regardless of income.[17] The state's Pathways to Coverage program is available for people with incomes up to 100 percent of the federal poverty level, but it has strict work requirements and burdensome enrollment processes, and enrollment is far below state projections (Chan 2024).[18] Otherwise, adults' only publicly supported coverage options are subsidized Marketplace plans (which

[17] "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level," KFF, accessed May 15, 2025, https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/.

[18] The Centers for Medicare & Medicaid Services is currently reviewing Georgia's Pathways demonstration waiver extension proposal which would expand qualifying activities to include caregiving by "parents and legal guardians who are primarily responsible for the daily care and well-being of a child younger than 6 years of age."

tend to include higher cost sharing than Medicaid) or limited family-planning-only services that do not include comprehensive health care access (Haley et al. 2021).

TABLE 1

Health Insurance Coverage for Women of Reproductive Age in Georgia Is Limited Outside of Pregnancy/Postpartum Periods

Characteristics of publicly supported health insurance coverage and related programs, 2025

Program	Income eligibility thresholds	Notes
Pregnancy-related Medicaid/CHIP, also known as Right from the Start	0–225 percent of FPL	Eligibility begins during pregnancy and lasts until 12 months after the end of pregnancy
Medicaid for parents	0–29 percent of FPL	Parents with incomes 30–100 percent of FPL fall into the "coverage gap" with no publicly subsidized health insurance coverage options
Medicaid for childless adults	None (no program)	Childless adults with incomes 0–100 percent of FPL fall into the "coverage gap" with no publicly subsidized health insurance coverage options
Pathways to Coverage[a]	0–100 percent of FPL and working or performing other qualifying activities for 80 hours/month at the time of application and each month of enrollment	Enrollment in the first year (4,231) fell far below state expectations, and many enrollees faced barriers to enrollment
Planning for Healthy Babies	0–216 percent of FPL	Not comprehensive insurance coverage; family planning services only
Georgia Access (subsidized Marketplace coverage)	100 percent of FPL and above (100–250 percent of FPL to qualify for cost-sharing subsidies)	Likely to include higher cost sharing than Medicaid

Sources: Tricia Brooks, Jennifer Tolbert, Anna Mudumala, Amaya Diana, Allexa Gardner, Aubrianna Osorio, and Shoshi Preuss, "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision," San Francisco: KFF, April 1, 2025; and Leah Chan, *Georgia's Pathways to Coverage Program: The First Year in Review*, Atlanta: Georgia Budget and Policy Institute, accessed May 28, 2025.

Notes: FPL = federal poverty level; CHIP = Children's Health Insurance Program. Enrollees also must meet immigration-related and other requirements. Georgia removed the five-year waiting period for pregnant lawful permanent residents in Medicaid in 2024. Additional eligibility pathways related to disability are available.

[a] The Centers for Medicare & Medicaid Services is currently reviewing Georgia's Pathways demonstration waiver extension proposal, which would expand qualifying activities to include caregiving by "parents and legal guardians who are primarily responsible for the daily care and well-being of a child younger than 6 years of age."

In 2019, 1 in 5 new mothers in Georgia were uninsured in the year after the end of pregnancy (Johnston et al. 2021). Thus, some women may not have had access to coverage before their pregnancies and may not be aware they qualify for Medicaid when pregnant, delaying access to prenatal care (Admon et al. 2021). On the other hand, women who had Medicaid for prior pregnancies might wrongly assume they can only qualify for the program during pregnancy and a short time following

delivery, as had been the case in Georgia before the adoption of postpartum coverage extension in 2021. Importantly, if women are not aware they are eligible for 12 months of postpartum Medicaid coverage, they may not access needed care or effectively advocate for themselves if coverage is terminated inappropriately.

Medicaid notices about coverage and other important information have notoriously been complex and confusing for many enrollees to understand (Winkle et al. 2022).[19] A recent example emerged during the COVID-19 pandemic, when Medicaid coverage was automatically extended for all enrollees during the public health emergency, but some people were unaware they were covered (Ding, Sommers, and Glied 2024). Reliance on mail as the primary means of communication with Medicaid enrollees likely means that people with housing instability and low literacy may not receive or understand the information (Winkle et al. 2022). In addition, if information about postpartum coverage does not clearly explain that full Medicaid benefits are available, enrollees may wrongly assume that the coverage only pertains to women's health services, that it only covers postpartum visits or complications from pregnancy, or that it is only for women who had live births or have postpartum depression (Allen et al. 2024).

Similarly, if health care providers operate under the belief that pregnancy-related coverage is terminated 60 days after delivery or do not understand that services outside of pregnancy-related care are covered, they may not make referrals for follow-up health care. Low levels of outreach about the postpartum extension to community-based organizations may also mean that trusted community members on whom families rely for information to navigate the postpartum period and early childhood may not have the knowledge to share about extended Medicaid coverage.

Promoting broad awareness about extended postpartum coverage among Medicaid members, providers, and other key sectors serving young low-income families should be guided by input and feedback from Medicaid enrollees, and use multiple modes and platforms. Many states, including Georgia, incorporated text messaging and social media outreach during unwinding of Medicaid continuous eligibility,[20] which suggests these strategies and tools could be improved upon and leveraged to communicate with enrollees about other important updates, including the postpartum Medicaid extension (Morales, Perrow, and O'Connor, 2024). Furthermore, evidence suggests that access to an in-person trusted source of information, such as a community outreach worker or health insurance navigator, supports enrollment and retention in Medicaid (ASPE 2021).

Actions to Consider

- ***Refine and expand communications about postpartum coverage***. Obtaining member feedback on messaging and communication methods would help ensure that information reaches intended

[19] Peyton Yee, "Effective Medicaid Renewal Notices Are Key to Getting It Right During Unwinding," *Say Ahhh!* (blog), May 3, 2023, https://ccf.georgetown.edu/2023/05/03/effective-medicaid-renewal-notices-are-key-to-getting-it-right-during-unwinding/.

[20] "Medicaid Unwinding," Georgia Department of Human Services, accessed April 21, 2025, https://dhs.georgia.gov/medicaid-unwinding.

recipients and is understood. For example, CMOs could refine communications with input from the member advisory committees (which every CMO is required to establish)[21] and care coordinators who interact directly with pregnant and postpartum members to ensure messages are simple, free of jargon, and delivered in multiple ways, such as texting, email, social media, radio ads, and flyers in provider offices. It would also be important to ensure that information about benefits clearly states that the full range of health care services is covered throughout the postpartum year, including care unrelated to pregnancy, such as specialist visits, dental care, and medications.

- ***Expand state Medicaid agency and CMO outreach to all Medicaid providers***, including maternity care providers (OB/GYNs, midwives, doulas, and other perinatal health workers), pediatricians, birth centers and hospitals, primary care and behavioral health care providers, specialists, dentists, and others. Given the overwhelming amount of information that providers receive, it may be helpful to regularly remind Medicaid providers about postpartum coverage via provider newsletters, bulletins, and meetings. Alongside increasing awareness, provider outreach could include guidance for how to discuss postpartum coverage with their patients.
- ***Engage public services agencies and community-based organizations serving young families*** to help spread information about extended postpartum coverage and the benefits that come with it to their providers and clients. Engagement could include talking points and flyers that agencies and organizations could use to more effectively assist low-income postpartum women in understanding Medicaid coverage and benefits and obtaining care.

3. Postpartum Visit Rates Remain a Priority, but Little Is Changing in the Delivery System to Ensure Access to Comprehensive Health Care in the Full Postpartum Year.

What We Found

Postpartum visit rates remain a priority for the state and CMOs. Rates of postpartum visits—check-ups in the weeks after the end of pregnancy to monitor postpartum women's recovery—are low in Medicaid and for other insurance (Attanasio et al. 2022; CMS 2022). For example, one CMO representative stated that only about 30 percent of new mothers covered by this plan attend a postpartum visit between seven and 84 days after delivery.[22] The state agency and CMOs believed the postpartum extension was an opportunity to have more time to engage women in care, and stakeholders described various efforts to improve postpartum visit rates, including through care coordination, text reminders, and financial incentives. One stakeholder thought that part of the reason for low postpartum visit rates overall (not just in Medicaid) was a lack of coherence and coordination by public health agencies, health plans, and providers in messaging why postpartum visits are important. Moreover, some mentioned the

[21] https://medicaid.georgia.gov/document/publication/gf-contract-generic-002pdf/download

[22] This specific period aligns with HEDIS measure of postpartum care as a receipt of postpartum services on or between seven and 84 days after delivery. See "Prenatal and Postpartum Care (PPC)," NCQA, accessed May 15, 2025, https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/.

need for more resources to improve postpartum visits, such as telehealth appointments, reliable child care, and doula or nurse visits at home after delivery.

All eight Medicaid members we interviewed had had at least one postpartum visit, and four had two or more check-ups within six weeks of giving birth. This is an encouraging finding given that the American College of Obstetricians and Gynecologists recommends that postpartum care is ongoing and includes multiple encounters (ACOG 2018), but it is not necessarily representative of women across the state.

Members reported the need for more attention to mental and emotional wellness as part of postpartum care. Some interviewees reported that they did obtain a postpartum visit, but that it was not all that helpful, specifically highlighting the lack of attention to mental health. When asked what information was shared by their provider about postpartum health and wellness, most participants did not recall much beyond information about scheduling a postpartum visit, depression screening (which some deemed superficial), and contraception. Many Medicaid members expressed that more attention, education, and referrals to mental health resources would have been helpful during and after pregnancy.

Some CMOs reported efforts to address mental health and substance use concerns in their maternity care population through case management and virtual therapy, but the reach of these interventions may be limited given that behavioral health concerns are likely underreported, and perinatal mental health and substance use providers are in short supply in Georgia.[23] One CMO representative noted that the Medicaid agency asked CMOs to provide support to mothers who do not have live births because they still qualify for the full 12 months of coverage. In response, this CMO trained its staff and care coordinators on providing support for pregnancy loss.

"I wish maybe at the OB's office they had taken more time to offer mental health resources to me, or inform me, talk to me, and let me know the whole scope of things that could occur in my emotions and my mental health after delivery. More than just having me fill out a sheet. …Things like that would be so helpful to beat mom guilt, to beat mom shame, to not beat yourself up about things that maybe are not in our control."
—Postpartum Georgia Medicaid member

---

[23] "Maternal Mental Health Environmental Scan," Healthy Mothers, Healthy Babies Coalition of Georgia, accessed March 27, 2025.

Lack of a usual source of care among postpartum Medicaid members could present barriers to ongoing care after pregnancy. Several key stakeholders shared that because of limited access to health insurance outside of pregnancy, many pregnant and postpartum Medicaid enrollees in Georgia might not have an established primary care provider and regular access to care. For some, obtaining pregnancy Medicaid coverage may be one of the first times they are seeing a doctor as an adult. Providers and other stakeholders observed that hypertension, diabetes, depression, and anxiety are common conditions during pregnancy that can compromise the health of mothers and babies. Not having an established primary care provider makes it more challenging to ensure chronic disease management and ongoing care in the postpartum period. Furthermore, one stakeholder noted strained relationships between OB/GYNs and primary care providers, observing that OB/GYNs reportedly do not have incentives to refer patients to primary care providers because then they would lose patient volume. A few stakeholders suggested that pediatricians could play a role in coordinating care for postpartum mothers, but others raised concerns that pediatricians may not be comfortable screening mothers for depression and other health problems because of reimbursement challenges and shortages of providers to refer patients to for follow-up care and treatment. Half of the interviewed Medicaid members said they would prefer continuing to see their OB/GYN or midwife after pregnancy, and some also wanted more support from community health workers and doulas during pregnancy and the postpartum period.

No changes to metrics or requirements in response to the extension, though a new performance unit will reportedly focus on maternal health. The state Medicaid agency and CMOs reported no policy changes or additional responsibilities for CMOs to support expanded access to care in the full 12-month period postpartum, or to reduce maternal health disparities. Similarly, CMOs were not making changes in provider contracts or payment models to encourage providers to better coordinate care or ensure follow-up care for their patients in the postpartum year. However, Medicaid officials we interviewed shared that the agency is planning to launch a new performance management unit charged with identifying and implementing policy changes to improve outcomes of Medicaid enrollees. According to state officials, maternal health will be the first major area of focus for this unit, and strategies under consideration include data analyses to better understand and prevent causes of maternal deaths. Reportedly, the performance management unit may be charged with developing and testing a new care management model for pregnant and postpartum women, similar to the "cocoon model" that integrates health care with social and emotional supports (Forna et al. 2023).

Why It Matters

Though most maternal deaths occur in the postpartum year,[24] the predominant approach to maternity care in the US has been heavily focused on pregnancy and birth, with just a single postpartum visit recommended at about six weeks after delivery. Despite considerable attention from the Medicaid program and CMOs on improving postpartum visit rates, just before the state first implemented the six-month postpartum extension under the 1115 waiver, only about 30 percent of Georgia Medicaid enrollees who had a baby between May and July 2021 received postpartum care (Georgia Department

[24] "Four in 5 Pregnancy-related Deaths in the U.S. Are Preventable," CDC, September 19, 2022, https://archive.cdc.gov/www_cdc_gov/media/releases/2022/p0919-pregnancy-related-deaths.html.

of Community Health 2022).[25] In line with interviewed members' perspectives that their providers did not pay adequate attention to their mental and emotional health and well-being during or after pregnancy, a recent national survey found that 70 percent of US women wanted to receive more information about postpartum mental health before giving birth.[26]

Furthermore, lack of insurance and a usual source of care among many Georgia Medicaid enrollees before pregnancy may make it challenging to re-establish postpartum women with a primary care provider and ensure appropriate follow-up care for behavioral and physical health conditions in the postpartum year. A recent analysis of Medicaid claims data suggests that more than three-quarters of enrollees nationally who maintained Medicaid enrollment for 12 months after giving birth had at least one outpatient health care encounter outside of a postpartum visit, but fewer than 67 percent of Georgia enrollees had such a visit (Smith et al. 2025). Medicaid postpartum coverage includes a wide range of benefits outside of women's health services and primary care, including mental health, specialist services, and dental care. These findings could mean that more outreach, education, and supports are needed, including from community-based providers such as doulas and community health workers, to ensure that postpartum Medicaid enrollees in Georgia receive comprehensive health care throughout the year following the end of pregnancy.

Most Medicaid enrollees nationwide, including in Georgia, receive care through risk-based managed care organizations (Hinton and Raphael 2024). As such, contracted health plans play a key role in ensuring access to and quality of health care services for pregnant and postpartum Medicaid members (Grimm 2023).[27] Some state Medicaid agencies are increasingly using managed care contracting to incentivize greater investments in maternal health, but these requirements may not yet incorporate the full postpartum year, and little is known about the impacts of these contract requirements on maternal health outcomes (Bailit Health 2024a). For example, a recent assessment found little publicly available information on Medicaid managed care organizations' performance on maternal health measures (Schneider et al. 2023). Another study reported that New Mexico changed the state's managed care contracting in response to the postpartum extension by redefining the postpartum period as the full 12 months and expanding the set of performance measures for postpartum health, including deductions in capitation rates for plans that do not meet targets—an approach that could be replicated in Georgia (Allen et al. 2024).

[25] "Postpartum Care: Improving Postpartum Care," Medicaid, accessed March 26, 2025, https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/postpartum-care.

[26] "70% of Women Wish They Knew More About Postpartum Mental Health before Giving Birth, with Higher Percentages in Minority Communities: MetroPlusHealth Survey," *MetroPlusHealth*, May 3, 2023, https://metroplus.org/press/70-of-women-wish-they-knew-more-about-postpartum-mental-health-before-giving-birth-with-higher-percentages-in-minority-communities-metroplushealth-survey/.

[27] Rosenbaum, Sara, Anne Rossier Markus, Caitlin Murphy, Rebecca Morris, Maria Casoni, and Kay Johnson, "The Road to Maternal Health Runs Through Medicaid Managed Care," *The Commonwealth Fund* (blog), May 22, 2023, https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care.

Actions to Consider

- ***Incorporate more education about postpartum health and mental/emotional wellness as part of prenatal care.*** Maternity care providers and pregnancy care coordination programs could include more education about what to expect after the end of pregnancy as part of standard prenatal care, including educating expectant and new mothers about potential mental health problems in the postpartum period and linking them to professional services and/or support groups.[28] Health care providers, home visiting, and care coordination programs could offer targeted health education to families throughout the full postpartum year (Herval et al. 2019).
- ***Expand access to perinatal behavioral health.*** The postpartum extension provides an opportunity for Georgia's Medicaid program to shore up access to perinatal mental health services, such as through payment and delivery system reforms to increase the supply of providers and promote the integration of behavioral health with OB/GYN, primary, and pediatric care (Burak et al. 2024).
- ***Redefine postpartum care as including services needed throughout the entire year, as well as community-based supports.*** The American College of Obstetricians and Gynecologists suggests that postpartum care should be an ongoing process that includes multiple check-ins beyond the comprehensive physical examination four to six weeks after delivery (ACOG 2018). This type of care could be supported by multimodal check-ins via phone/telehealth to ease access barriers, and employ multidisciplinary teams that include doulas, nurse home visitors, and a community-based peer workforce (e.g., the Resource Mother peer workforce featured in box 2). Medicaid coverage for doulas and expansion of reimbursement for home visiting services could promote access to postpartum supports to more members (Thompson and Hasan 2023).
- ***Monitor utilization of services in the postpartum year and use data to close gaps and reduce disparities***. Utilization data could be an important indicator to assess whether and how often women covered by Medicaid are accessing health care services in the 12 months after the end of pregnancy. Given long-standing racial and ethnic disparities in maternal and child health outcomes, Georgia could publicly report CMO-level performance data stratified by race/ethnicity and other key characteristics, where data allow, for relevant Core Set/Healthcare Effectiveness Data and Information Set (HEDIS) measures, such as postpartum visits and postpartum depression screening.[29] Where data on member characteristics are available, stratifying by key characteristics such as race/ethnicity, geography, and others could help identify populations or communities that are falling behind and deliver more resources or targeted interventions to those communities.
- ***Clarify expectations for CMOs to support continuity of care in the full year after the end of pregnancy.*** One stakeholder suggested that primary care connections could be established as part of prenatal care to ensure a woman has a designated place to obtain primary care services after pregnancy. For example, Ohio's Comprehensive Maternal Care model includes an

[28] "Perinatal Mental Health Resources," Healthy Mothers, Health Babies Coalition of Georgia, accessed March 27, 2025.

[29] "HEDIS and Performance Measurement," NCQA, accessed May 27, 2025, https://www.ncqa.org/hedis/.

incentive metric for mothers' primary care visits within 12 weeks of giving birth, which could support smoother transitions from OB-GYN care to primary care and support access to preventive health care.[30] Similar incentive metrics could be included in CMO contracts to promote preventive care and specialist care follow-ups.[31]

4. Addressing Broader Maternity Care Challenges Could Strengthen Postpartum Care

What We Found

Health care provider shortages. Key stakeholders reported that maternity care provider shortages in Georgia are a major obstacle to improving maternal health, and we did not hear of major new initiatives to address maternity care shortages driven by the postpartum extension. Over a third (34.6 percent) of Georgia counties are "maternity care deserts," without a single maternity care provider or facility to deliver a baby (Fontenot et al. 2023). Concerns about provider shortages extended beyond maternity care to other types of providers postpartum women may need, such as therapists, psychiatrists, and specialists, particularly in rural areas. Moreover, some stakeholders shared that provider shortages extended beyond the Medicaid program.

Though the Medicaid members we interviewed for this study lived in the Atlanta metro area with a relatively larger supply of providers than other areas of the state and were well-connected to community resources, given their contact with Healthy Mothers, Healthy Babies, many still reported challenges finding providers who accept Medicaid and are conveniently located. The most frequently cited barriers to care during the postpartum period among Medicaid members we interviewed were limited provider networks, inaccurate directories, and long wait lists or long distances to providers who accept Medicaid patients, particularly for mental health services and specialty care.

State Medicaid officials reported efforts to address health care provider shortages through provider payment increases and expansion of telehealth.[32] However, these will not likely be sufficient to ensure postpartum members can access high-quality care in the year following the end of pregnancy. One key informant noted that family physicians who are trained in obstetrics are in a good position to help fill maternity care gaps in underserved areas and promote continuity of care in the postpartum period, including providing health care services under one roof for both women and infants.[33] But this stakeholder also lamented the fact that few family physicians pursue obstetrics training, partly because

[30] Comprehensive Maternal Care," Ohio Department of Medicaid, accessed on April 8, 2025, https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/cmc.

[31] Rosenbaum et al. "The Road to Maternal Health Runs Through Medicaid Managed Care."

[32] "DBHDD, DCH Announce Approval of Historic Medicaid Provider Rate Increases," Georgia Department of Community Health, accessed May 28, 2025, https://dch.georgia.gov/announcement/2024-07-11/dbhdd-dch-announce-approval-historic-medicaid-provider-rate-increases.

[33] Sarah Jane Tribble, "Can Family Doctors Deliver Rural America From its Maternal Health Crisis?" *KFF Health News*, January 2, 2024, https://kffhealthnews.org/news/article/family-doctors-rural-america-maternal-health-crisis-south/.

of bias and opposition from OB/GYNs and birthing hospitals (opposition which also reportedly extends to midwives).

Concerns about bias and unfair treatment. Alongside finding conveniently located and available providers, a few Medicaid members reported that some providers they saw did not seem to be of high quality and that they had experienced mistreatment or feeling judged for their personal characteristics, such as race and age, during pregnancy or in other health care encounters. For some, it was important to be seen by an OB/GYN and/or midwife of color because they were specifically concerned about mistreatment based on their race or ethnicity. Several described considerable time and effort they spent researching and visiting offices to identify prenatal, pediatric, and primary care providers they could trust. However, stakeholder interviews did not identify any new initiatives under the postpartum extension to address bias and mistreatment.

Silos between systems serving postpartum women. Several stakeholders noted that relationships and information or data exchange between CMOs and non-Medicaid community-based programs, such as community-based doula initiatives and Title V and other public programs focused on maternal and child health (e.g., early childhood home visiting), have not been strengthened under the postpartum extension. For example, a lack of coordination and limited ability to exchange patient information could lead to fragmented care and inefficiencies, such as when the same woman receives offers of postpartum care coordination from multiple organizations. Better coordination and integration of Medicaid and other public programs that serve young families, including data exchange agreements, could more effectively leverage resources for promoting access to health care and other supports during critical months following the end of pregnancy.

"What I like the least about Medicaid is that it is limiting, because not all providers will accept Medicaid."

—Postpartum Georgia Medicaid member

Need for a wider reach of CMOs' care coordination programs to better support postpartum members. All CMOs in Georgia offer pregnancy care coordination services, and CMOs also reported introducing new innovations and programs as part of postpartum care, such as deploying community-based peer support specialists and using virtual platforms for case management (box 2). However, several stakeholders believed maternity care coordination services were underused, and not all members eligible for care coordination took advantage of it. Care coordination services are not universally available to all pregnant and postpartum enrollees or offered throughout the full postpartum year. For example, only one CMO reported expanding the program to all eligible members as part of the postpartum expansion rollout, while others typically offered care coordination services only to members with high-risk

pregnancies or cut off care coordination after 84 days postpartum rather than the full postpartum year.[34]

The Medicaid members we interviewed who received care coordination found it helpful, and two reported being checked on by a care coordinator specifically after delivery. One member was very pleased to receive a home visit by a registered nurse who gave her a "mini-physical" examination and inquired about her mental health and other needs. Several members also reported receiving tangible supplies from their CMOs, most frequently breast pumps but also including diapers, baby clothes, and personal care products.

"The thing I love about my CMO is that while I was pregnant, I was given a nurse who would check in on me and assist me with resources. That was life-changing to me, and it was so helpful."
—Postpartum Georgia Medicaid member

BOX 2

Georgia Care Management Organization Postpartum Care Innovations

Peach State Health Plan expanded the Resource Mother program. Resource Mother is a postpartum care coordination program offered by the Peach State Health Plan care management organization. Peach State representatives reported that, originally, this program focused on families with low birthweight infants, but the plan decided to expand the program to all postpartum members. The program deploys trained community-based peer support specialists to provide home visits and supports to postpartum individuals, including education on Medicaid benefits and covered services and assistance with scheduling postpartum visits and baby well visits. Resource Mother specialists also screen mothers for health and social needs and help them access available community resources.

CareSource introduced postpartum telehealth visits as part of virtual care coordination. CareSource introduced an opportunity for members to receive a telehealth postpartum visit from a registered nurse as part of care coordination encounters. In practice, a care coordinator would provide a warm handoff to a registered nurse who would then proceed to deliver a postpartum check-up to a member. CareSource representatives noticed that this telehealth postpartum visit often resulted in a member attending an in-person postpartum visit with their regular provider. To address child care barriers, CareSource has a program called Safe Families for Children, which provides training and credentialing similar to foster parent requirements to individuals who can then provide child care for mothers with older children at home but no one to leave them with when they go to deliver or have postpartum visits.

Amerigroup entered new partnerships to support postpartum enrollees. Amerigroup has contracted with a virtual care coordination provider, Pomelo Care, to support 24/7 access to prenatal and

[34] This specific period aligns with HEDIS measure of postpartum care as a receipt of postpartum services on or between 7 and 84 days after delivery. See "Prenatal and Postpartum Care (PPC)," NCQA.

postpartum supports, particularly in rural and underserved areas. Pomelo Care uses a multidisciplinary team of experts, including clinicians, midwives, mental health therapists, nutritionists, doulas, and lactation consultants to provide on-demand support via text, phone, or video chat. As Amerigroup representatives shared, nearly half of all calls to Pomelo Care come after working hours, which likely means that some unnecessary emergency department visits were avoided through this intervention. The plan also piloted a program in partnership with Uber Eats, which provided health education and nutritional counseling to pregnant and postpartum members who were also eligible to receive $300 for completing their postpartum visit.

Source: Stakeholder interviews.

Unmet social needs continue to pose barriers to improved postpartum health and well-being. Some stakeholders indicated that though postpartum extensions improve access to health care, they do not solve the many other challenges in postpartum women's lives. Challenges meeting nonhealth needs, such as for housing, nutrition, education, jobs, community safety, transportation, and child care, were cited by numerous stakeholders as undermining postpartum health and families' well-being. Some also noted that a lack of paid time off and parental leave, including for pregnancy loss, were barriers to improving postpartum health outcomes. One stakeholder asked, "Are people getting the services so that they are able to really bounce back from a pregnancy, not only from a health perspective, but from a social determinants of health perspective as well?" CMOs were lauded by some stakeholders for their efforts to address structural barriers to accessing health care, such as transportation. But care coordination fell short in some cases in helping to address unmet social needs because of limited community resources. For example, one Medicaid member said they needed help with housing, but their CMO care coordinator was unable to help them beyond sharing referrals to other programs. Postpartum women we interviewed also shared that Medicaid coverage or benefit topics were not discussed during care coordination encounters, and they did not typically consider their care coordinator as someone who could problem-solve health insurance or benefits questions. This may mean women who are facing challenges with coverage continuity during the postpartum year or who are looking for coverage following the expiration of Medicaid do not have the education or resources to assist them.

Limited Medicaid eligibility outside of pregnancy and the postpartum period. Finally, some Medicaid members we interviewed were uninsured prior to pregnancy and had no clear plans for health insurance or health care after their postpartum coverage ended. Given that Medicaid income thresholds for parents are much lower than for pregnancy-related Medicaid, it is likely that many may no longer qualify and may need to seek other insurance coverage.

"I can't really talk to you about good nutrition during your postpartum period if you're not sure how your family's going to eat, or who's going to help you care for your children. Those are the things that I think are impacting this space. So, coverage for postpartum is incredibly important, but coverage without consideration of those other huge needs, I don't know what it gets accomplished. Because I can tell you that you have coverage for a year, but if you don't have a car to get to work or doctor's office, or you don't have a job to cover your utilities, having coverage is the least of your concerns."
—Key stakeholder

Why It Matters

Medicaid coverage on its own will likely have limited impacts on maternal health if enrollees are unable to access care because of limited provider networks and other barriers to care. Addressing health care provider shortages, particularly for maternal and mental health, is an urgent priority in Georgia (Fontenot et al. 2023). Although the state agency has increased provider rates over recent years, it is a broader problem in Medicaid that provider reimbursements are lower than for other types of coverage, which negatively affects access to and quality of care.[35] Fragmented care and siloed systems that serve pregnant and parenting women and young children further undermine maternal health and the well-being of families.[36]

Several evidence-based care models exist that could boost postpartum care systems. Extensive evidence suggests that midwifery-led care promotes better birth outcomes at lower costs than traditional physician-led care (Attanasio, Alarid-Escudero, and Kozhimannil 2019; Dubay et al. 2020; Sandall et al. 2016; Vedam et al. 2018). However, access to midwifery in Georgia is currently limited, in part because not all types of midwives are legally authorized to provide care (Black Mamas Matter Alliance 2022). Emerging evidence also supports the case for expanding coverage and Medicaid reimbursement for doula services and perinatal community health workers, who can effectively support

[35] Cindy Mann and Adam Striar,"How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost," *The Commonwealth Fund* (blog), August 17, 2022, https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact; Tiffany N. Ford and Jamila Michener, "Medicaid Reimbursement Rates Are a Racial Justice Issue," *The Commonwealth Fund* (blog), June 16, 2022, https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue.

[36] Steven Ross Johnson, "Maternal Mortality Crisis Fueled by Fragmented Care," *Modern Healthcare*, June 15, 2019, https://www.modernhealthcare.com/safety-quality/how-fragmented-care-fuels-maternal-mortality-crisis.

people during the full continuum of care from pregnancy through the postpartum year (Meghea et al. 2023; Mosley et al. 2023).[37]

Several postpartum Medicaid members we interviewed reported experiencing judgment and other forms of mistreatment in health care settings, and they were keenly aware of disproportionate risks of medical injury or death that women of color face in the perinatal period. A large national study found that about 1 in 6 women in the US reported experiencing some form of mistreatment during pregnancy or delivery, with women of color more likely to be exposed to mistreatment than white women (Vedam et al. 2019). These experiences contribute to mistrust of the medical system and low engagement in care and could also be the reason why some women are not returning for their postpartum visits (Gonzalez et al. 2023).[38] Recognizing and eliminating unconscious bias in health care while addressing structural barriers to care, such as limited provider networks, could help more women access high-quality care in the postpartum year (Green et al. 2021).

Care coordination has long been regarded as an important tool to improve access and utilization of health care services, but uptake of maternity care coordination programs by Medicaid enrollees is reportedly low, at 20 to 25 percent (Allen et al. 2024). Medicaid members we interviewed who received home visits and phone calls in the postpartum period valued the services and felt cared for. Ensuring that more eligible members are engaged in care coordination throughout the 12-month postpartum period could promote better access to care and resources and improve the well-being of mothers and children covered by Georgia Medicaid.

Uninsurance before and in between pregnancies restricts access to preventive health care, which could contribute to poor health outcomes during and after pregnancy for both women and infants, particularly for people of color who are more likely to be uninsured than white people (IOM 2002; Solomon 2021; Tolbert, Drake, and Damico 2023; Yagi et al. 2022). Evidence from the Affordable Care Act Medicaid expansion shows that women in states that expanded Medicaid have more access to preventive care and better outcomes during and after pregnancy, including lower rates of hospitalizations and maternal mortality, compared with women living in nonexpansion states (Searing and Ross 2019; Steenland and Wherry 2023). This suggests that adoption of Medicaid expansion could reduce coverage gaps, improve access to care, and contribute to better maternal health in Georgia. Members' uncertainty about their coverage after the end of the postpartum year also highlights the need for education and navigation assistance to help them understand insurance options and transition to other available coverage after the postpartum period.

[37] "Doula Medicaid Project," National Health Law Program, accessed on March 27, 2025, https://healthlaw.org/doulamedicaidproject/.

[38] Joan Harrigan-Farrelly, "For Black Women, Implicit Racial Bias in Medicine May Have Far-Reaching Effects," *U.S. Department of Labor Blog*, February 7, 2022, https://blog.dol.gov/2022/02/07/for-black-women-implicit-racial-bias-in-medicine-may-have-far-reaching-effects; and Annie Waldman, "Lost Mothers: How Hospitals are Failing Black Mothers," *ProPublica*, December 27, 2017, https://www.propublica.org/article/how-hospitals-are-failing-black-mothers.

Although health insurance and health care access are critically important to the health and well-being of postpartum women and their families, health outcomes are also influenced by factors outside of the health care system. For example, for families living in poverty, constant stress from not having enough resources to make ends meet has detrimental effects on health and well-being.[39] Though the health care sector has been increasingly exploring ways to better address patients' needs outside of clinical care, other policy changes would be needed to improve the availability of essential resources such as living wage jobs, affordable and quality housing, adequate food, transportation, and child care (Bailit Health 2024b; Kenney et al. 2019).[40]

Actions to Consider

- ***Expand Georgia's Medicaid health care workforce.*** The Medicaid agency could consider greater investments that would help expand training and scope of practice for family physicians to provide prenatal and delivery health care services in rural communities and thus ensure greater continuity of care for patients who will not need to find a different provider when pregnant.[41] Bills were introduced in Georgia in February 2025 that would expand access to midwifery care through recognition of certified professional midwives and pilot doula services in Medicaid, though they did not become law.[42] Doulas can also provide support to new mothers throughout the postpartum year, and the state could cover doula care, as has been done in New Mexico.[43] The state could also leverage managed care provider coverage requirements and network adequacy standards to promote greater access to a wide range of providers, including behavioral health and specialties (OIG 2024). Encouraging or requiring all CMOs to support health care workforce development, such as through scholarships for health profession students, could help boost postpartum provider availability. Increasing provider payment rates and implementing value-based payments models for perinatal care could also encourage more providers to participate in Medicaid (CMS 2019), which, in turn, would increase the number and range of providers members can see in the postpartum year.

[39] Peter J. Cunningham, "Why Even Healthy Low-Income People Have Greater Health Risks Than Higher-Income People," *The Commonwealth Fund* (blog), September 27, 2018, https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks; Aric A. Prather, "Stress Is a Key to Understanding Many Social Determinants of Health," *Health Affairs Forefront* (blog), February 24, 2020, https://www.healthaffairs.org/do/10.1377/forefront.20200220.839562/.

[40] "Prenatal-to-3 State Policy Roadmap," Prenatal-to-3 Policy Impact Center, accessed April 9, 2025, https://pn3policy.org/pn-3-state-policy-roadmap-2024/.

[41] "Family Medicine-Obstetrics Fellowship Program," Memorial Health, accessed March 27, 2025, ht"tps://hcahealthcaregme.com/locations/memorial-health/family-medicine-obstetrics-fellowship/.

[42] Legislature promotes midwifery access to improve maternity care and outcomes, accessed March 27, 2025 https://citizenportal.ai/articles/2448317/Georgia/Legislature-promotes-midwifery-access-to-improve-maternity-care-and-outcomes ; https://legiscan.com/GA/bill/HB263/2025

[43] "Doula Services," New Mexico Health Care Authority, accessed March 27, 2025.

- ***Promote high-quality, patient-centered care.*** This could include provider training to address bias[44] and efforts to improve the diversity of the maternal health workforce (Allen et al. 2022; Harrison et al. 2023). CMOs could consider including more information about the quality of providers in their networks, such as patient ratings. For example, the Irth App collects reviews of maternity care providers from patients of color.[45] In addition, more transparency about and accountability for clinicians and hospitals where patients report that they have been discriminated against and mistreated based on their race and ethnicity or other characteristics could help rebuild trust with health care systems for women who experience mistreatment that keeps them from seeking health care after pregnancy (Creveling and Hasan 2023).
- ***Support continuity of care and coordination of services in the postpartum year.*** Investments in an electronic health exchange could promote better coordination and bi-directional referrals between maternity care and primary care providers and specialists during the postpartum year. The Medicaid agency could also help families during this period by fostering strengthened connections and information exchange between CMOs and other programs delivering care and services to young families, such as public health initiatives, the Special Supplemental Nutrition Program for Women, Infants, and Children, home visiting programs, and community-based providers.[46]
- ***Expand eligibility for health care coordination to more pregnant and postpartum members in the full year postpartum***. Encouraging or requiring CMOs to offer pregnancy care coordination to more members, not just those with high medical or social risks, could increase the share of postpartum members who receive education about their health and connections to supports beyond medical care throughout this critical period. In addition, enabling access to care coordination in the full postpartum year could help more members access health care and other supports.
- ***Facilitate system navigation and transitions to other coverage.*** At the end of the 12-month postpartum period, women become eligible for Planning for Healthy Babies, but some may qualify for more comprehensive coverage. Georgia could include more education about available insurance options (e.g., the Pathways to Coverage program and Georgia Access, the state's health insurance Marketplace) as part of termination notices and require that CMOs provide supports for navigating the health insurance system to members.
- ***Expand Medicaid under the Affordable Care Act.*** Expanding adults' access to coverage could facilitate access to care before becoming pregnant and early entry into prenatal care, which could facilitate improved health outcomes for mothers and babies. It could also support mothers' access to care after the postpartum year and between pregnancies.
- ***Consider broader policy changes and strategies that support maternal and child health.*** The 2024 Prenatal-to-3 State Policy Roadmap outlines evidence-based policies and strategies that help

[44] Stephanie Teleki, "Challenging Providers to Look within Themselves: A New Tool to Reduce Bias," *Health Affairs Forefront* (blog), *https*://www.healthaffairs.org/content/forefront/challenging-providers-look-within-themselves-new-tool-reduce-bias-maternity-care.

[45] "Iorth: Birth Without Bias," Irth, accessed May 15, 2025, https://irthapp.com/.

[46] "Annual Medicaid MCO Survey: Maternal and Perinatal Health," Institute for Medicaid Innovation, 2023.

young families thrive, such as instituting paid family and medical leave, increasing state minimum wages, and implementing a state earned income tax credit for low-income workers.[47]

Conclusion

The Medicaid/CHIP postpartum extension in Georgia is an important step toward addressing the state's maternal mortality and morbidity crisis. Key stakeholders and Medicaid members interviewed for this study valued the extended coverage and the opportunities it brings to provide health care and other supports to women and their infants in the critical months after pregnancy. Our assessment of the state's early implementation of the extension finds apparent enrollment and eligibility errors that could undermine the potential positive benefits of the extension and limited information about how knowledgeable members and providers are about the extension and the benefits it includes. In addition, our findings suggest that while the focus on improving postpartum visit rates is high, little else has changed in the delivery system to ensure access to care in the postpartum year. We learned that challenges such as operational limitations, insufficient communication, limited provider networks and fragmented systems of care, inadequate supports for mental and emotional health of pregnant and postpartum women, and systemic problems such as high rates of uninsurance among low-income women continue to pose barriers to optimal postpartum health. We offer a range of strategies and policy options for Georgia's Medicaid agency, CMOs, providers, policymakers, and other key stakeholders to consider that would address these challenges and strengthen the potential of the postpartum extension to improve maternal health in Georgia.

Eva H. Allen is a senior research associate, Jennifer M. Haley is a principal research associate, and Sofia Hinojosa is a research analyst in the Health Policy Division at the Urban Institute.

References

ACOG (American College of Obstetricians and Gynecologists). 2018. "ACOG Committee Opinion 736: Optimizing Postpartum Care." *American College of Obstetrics and Gynecology* 131 (5): e140–50.

Admon, Lindsay K., Jamie R. Daw, Tyler N. A. Winkelman, Katy Backes Kozhimannil, Kara Zivin, Michele Heisler, and Vanessa K. Dalton. 2021. "Insurance Coverage and Perinatal Health Care Use among Low-Income Women in the US, 2015–2017," *JAMA Network Open* 4 (1): e2034549. https://doi.org/10.1001/jamanetworkopen.2020.34549.

Allen, Eva H., Kimá Joy Taylor, Zara Porter, LesLeigh D. Ford, and Faith Mitchell. 2022. *Building and Supporting a Black Midwifery Workforce in Oklahoma: Findings and Recommendations from an Expedited Review*. Washington, DC: Urban Institute.

Allen, Eva H., Jennifer M. Haley, Alaisha Verdeflor, and Kasey Dudley. 2024. "Improving Maternal Health and Well-Being through Medicaid/CHIP Postpartum Coverage Extensions." Washington, DC: Urban Institute.

ASPE (Assistant Secretary for Planning and Evaluation). 2021. "Reaching the Remaining Uninsured: An Evidence Review on Outreach and Enrollment." Washington, DC: ASPE.

[47] "Prenatal-to-3 State Policy Roadmap," Prenatal-to-3 Policy Impact Center.

Attanasio, Laura B., Fernando Alarid-Escudero, and Katy B. Kozhimannil. 2019. "Midwife-Led Care and Obstetrician-Led Care for Low-Risk Pregnancies: A Cost Comparison." *Birth* 47 (1): 57–66. https://doi.org/10.1111/birt.12464.

Attanasio, Laura B., Brittany L. Ranchoff, Michael I. Cooper, and Kimberly H. Geissler. 2022. "Postpartum Visit Attendance in the United States: A Systematic Review." *Women's Health Issues*, 32 (4): 369–75. https://doi.org/10.1016/j.whi.2022.02.002.

Bailit Health. 2024a. *Compendium of Medicaid Managed Care Contracting Strategies to Promote Health Equity*. Princeton, NJ: State Health and Value Strategies.

———. 2024b. *Addressing Health-Related Social Needs Through Medicaid Managed Care*. Princeton, NJ: State Health and Value Strategies

Black Mamas Matter Alliance. 2022. "Issue Brief: Expanding Midwifery Licensure in Georgia." Atlanta: Black Mamas Matter Alliance, Policy Department.

Burak, Elisabeth, Anne Dwyer, Tanesha Mondestin, and Kay Johnson. 2024. *State Medicaid Opportunities to Support Mental Health of Mothers and Babies During the 12-Month Postpartum Period."* Washington, DC: Georgetown Center for Children and Families.

CMS (Center for Medicare & Medicaid Services). 2019. "Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP." Baltimore: CMS.

———. 2022. "Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set." Presentation. Baltimore: CMS.

Chan, Leah. 2023. "Georgia Health Budget Primer for State Fiscal Year 2024." Atlanta: Georgia Budget and Policy Institute.

———. 2024. *Georgia's Pathways to Coverage Program: The First Year in Review.* Atlanta: Georgia Budget and Policy Institute.

Creveling, Emily, and Anoosha Hasan. 2023. "Medicaid Financing of Midwifery Services: A 50-State Analysis." Washington, DC: National Academy for State Health Policy.

Daw, Jamie R., Laura A. Hatfield, Katherine Swartz, and Benjamin D. Sommers. 2017. "Women in the United States Experience High Rates of Coverage 'Churn' in Months Before and After Childbirth." *Health Affairs* 36 (4): 598–606. https://doi.org/10.1377/hlthaff.2016.1241.

Ding, Dong, Benjamin D. Sommers, and Sherry A. Glied. 2024. "Unwinding and the Medicaid Undercount: Millions Enrolled in Medicaid during the Pandemic Thought They Were Uninsured." *Health Affairs* 43 (5): 725–31. https://doi.org/10.1377/hlthaff.2023.01069.

Dubay, Lisa, Ian Hill, Bowen Garrett, Fredric Blavin, Emily M. Johnston, Embry Howell, Justin W. Morgan, et al., 2020. "Improving Birth Outcomes and Lowering Costs for Women on Medicaid: Impacts of 'Strong Start for Mothers and Newborns,'" *Health Affairs* 39 (6): 1042–50. https://doi.org/10.1377/hlthaff.2019.01042.

Fontenot, Jazmin, Ripley Lucas, Ashley Stoneburner, Christina Brigance, Erin Jones, Kelly Hubbard, Motoko Oinuma et al. 2023. *Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity in Georgia*. Arlington, VA: March of Dimes.

Forester, Diana, and Chelsea Cornelius. 2024. "Initial Findings on Implementation of 12-Month Postpartum Health Coverage in Texas." Austin, TX: Texans Care for Children.

Forna, Fatu, Ericka Gibson, Philidah Seda, Annette Miles, Grace Sobers, Isata Ward, and Kate Koplan. 2023. "A Cocoon Pregnancy Care Model to Reduce Maternal Morbidity and Mortality." *NEJM Catalyst* 4 (2), https://doi.org/10.1056/CAT.22.0342.

Georgia Department of Public Health. 2025. 2019-2021 Maternal Mortality Report. Atlanta: Georgia Department of Public Health.

Georgia Department of Community Health. 2022. *Georgia Postpartum Extension: 1115 Demonstration in Georgia.* Atlanta: Georgia Department of Community Health.

Gonzalez, Dulce, Michael Karpman, Genevieve M. Kenney, and Marla McDaniel. 2023. "To What Extent Are Parents and Children Exposed to Bias and Unfair Treatment in Health Care? National Findings from 2022." Washington, DC: Urban Institute.

Green, Tiffany L., Jasmine Y Zapata, Heidi W Brown, and Nao Hagiwara. 2021. "Rethinking Bias to Achieve Maternal Health Equity: Changing Organizations, Not Just Individuals." *Obstetrics and Gynecology*, 137 (5): 935–40. https://doi.org/10.1097/AOG.0000000000004363

Grimm, Christi A. 2023. *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns about Access to Care in Medicaid Managed Care*. Washington, DC: OIG.

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.

Harrison, Eoana, Faith Mitchell, Leandra Lacy, Kimá Joy Taylor, and Lauren Fung. 2023. *Understanding Training and Workforce Pathways to Develop and Retain Black Maternal Health Clinicians in California*. Washington, DC: Urban Institute.

Herval, Álex Moreira, Danielle Peruzzo Dumont Oliveira, Viviane Elisângela Gomes, Andrea Maria Duarte Vargas, and Bernhard Schaller (editor). 2019. "Health Education Strategies Targeting Maternal and Child Health: A Scoping Review of Educational Methodologies." Medicine 98 (26): e16174. https://doi.org/10.1097/md.0000000000016174.

Hinton, Elizabeth, and Jada Raphael. 2024. "10 Things to Know About Medicaid Managed Care." San Francisco: KFF.

IOM (Institute of Medicine Committee on the Consequences of Uninsurance). 2002. "6, Health-Related Outcomes for Children, Pregnant Women, and Newborns." in *Health Insurance is a Family Matter*. Washington (DC): National Academies Press (US).

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.

Kenney, Genevieve M., Timothy A. Waidmann, Laura L. Skopec, and Eva H. Allen. 2019. *What Would It Take to Reduce Inequities in Healthy Life Expectancy?*. Washington, DC: Urban Institute.

MACPAC (Medicaid and CHIP Payment and Access Commission). 2024. "Denials and Appeals in Medicaid Managed Care." Washington, DC: MACPAC.

Meghea, Christian I., Jennifer E. Raffo, Xiao Yu, Ran Meng, Zhehui Luo, Peggy Vander Meulen, Celeste Sanchez Lloyd, Lee Anne Roman. 2023. "Community Health Worker Home Visiting, Birth Outcomes, Maternal Care, and Disparities Among Birthing Individuals with Medicaid Insurance." *JAMA Pediatrics*, 177 (9): 939–46. https://doi.org/10.1001/jamapediatrics.2023.2310.

Mosley, Elizabeth A., Allysa Lindsey, Daria Turner, Priya Shah, Ayeesha Sayyad, Amber Mack, and Ky Lindberg. 2023. "I Want…To Serve Those Communities…[But] My Price Tag Is…Not What They Can Afford: The Community-Engaged Georgia Doula Study." *Perspectives on Sexual and Reproductive Health* 55(3): 200–9. https://doi.org/10.1363/psrh.12241.

Morales, Melissa, Kenzie Perrow, and Kaylee O'Connor. 2024. "Optimizing SMS Strategies for Outreach to Medicaid and Marketplace Enrollees." Princeton, NJ: State Health and Value Strategies.

OIG (Office of Inspector General). 2024. *States Could Better Leverage Coverage and Access Requirements To Promote Maternal Health Care Access in Medicaid Managed Care*. Washington, DC: OIG.

Sandall, Jane, Hora Soltani, Simon Gates, Andrew Shennan, and Declan Devane. 2016. "Midwife-Led Continuity Models versus Other Models of Care for Childbearing Women." *Cochrane Database of Systemic Reviews* (4): CD004667. https://dx.doi.org/10.1002%2F14651858.CD004667.pub5.

Schneider, Andy, Tanesha Mondestin, Ella Matthews, and Eni Akinniyi. 2023. *Medicaid Managed Care, Maternal Mortality Review Committees, and Maternal Health: A 12-State Scan.* Washington, DC: Georgetown University Center for Children and Families.

Searing, Adam, and Donna Cohen Ross. 2019. "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies." Washington, DC: Georgetown University Health Policy Institute.

Smith, Laura Barrie, Claire O'Brien, Keqin Wei, Timothy A Waidmann, and Genevieve M Kenney. 2025. "Medicaid-Covered Health Care Visits During the Postpartum Year: Variation by Enrollee Characteristics and State." *Health Affairs Scholar* 3 (2). https://doi.org/10.1093/haschl/qxaf019.

Solomon, Judith. 2021. "Closing the Coverage Gap Would Improve Black Maternal Health." Washington, DC: Center on Budget and Policy Priorities.

Steenland, Maria W. and Laura R. Wherry. 2023. "Medicaid Expansion Led to Reductions in Postpartum Hospitalizations." *Health Affairs* 42 (1): 18–25. https://doi.org/10.1377/hlthaff.2022.00819.

Sugar, Sarah, Christie Peters, Nancy De Lew, and Benjamin D. Sommers. 2021. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." Washington, DC: ASPE.

Thompson, Veronica, and Anoosha Hasan. 2023. *Medicaid Reimbursement for Home Visiting Services*. Washington, DC: NASHP.

Tolbert, Jennifer, Patrick Drake, and Anthony Damico. 2023. "Key Facts About the Uninsured Population," San Francisco: KFF.

Vedam, Saraswathi, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, et al. 2018. "Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes." *PLOS ONE* 13 (2): e0192523. https://doi.org/10.1371/journal.pone.0192523.

Vedam, Saraswathi, Katherin Stoll, Tanya Khemet Taiwo, Nicholas Rubashkin, Melissa Cheyney, Nan Strauss, Monica McLemore, et al. 2019. "The Giving Voice to Mothers Study: Inequity and Mistreatment during Pregnancy and Childbirth in the United States." *Reproductive Health* 16: 77. https://doi.org/10.1186/s12978-019-0729-2.

Winkle, Suzanne, Jennifer Wagner, Farah Erzouki, and Jennifer Sullivan. 2022. "States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity." Washington, DC: Center on Budget and Policy Priorities and CLASP.

Yagi, Brian F., Jamie E Luster, Aaron M Scherer, Madeline R Farron, Judith E Smith, and Renuka Tipirneni. 2022. "Association of Health Insurance Literacy with Health Care Utilization: A Systematic Review." *Journal of General Internal Medicine* 37 (2): 375–89. https://doi.org/10.1007/s11606-021-06819-0.

Acknowledgments

This publication was funded by the Georgia Health Initiative. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

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 www.urban.org/fundingprinciples.

The authors thank the key stakeholders and Medicaid enrollees interviewed for their important insights; Emily Johnston and Genevieve M. Kenney for helpful feedback; and Sarah LaCorte for editorial assistance.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org