RESEARCH REPORT

Promoting Continuous Coverage during the Postpartum Period

Lessons Learned from Medicaid Coverage Transitions and the Public Health Emergency

Emily M. Johnston  Jennifer M. Haley  Tyler W. Thomas

September 2021
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.
Contents

Acknowledgments v

Executive Summary vii

Promoting Continuous Coverage during the Postpartum Period: Lessons Learned from Medicaid Coverage Transitions and the Public Health Emergency 1
  Methods 6
  Findings 8
  Postpartum Coverage Transitions before and during the Continuous Enrollment Requirement 9
  Barriers to and Facilitators of Continuous Postpartum Coverage before and under the Continuous Enrollment Requirement 13
  Looking Ahead: Postpartum Transitions Following Expiration of the PHE and under Proposed and Planned Postpartum Extensions 17
  Discussion 23

Notes 26

References 28

About the Authors 29

Statement of Independence 30
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 Tricia Brooks, Emily Eckert, Ian Hill, Genevieve M. Kenney, and staff at the Centers for Medicare & Medicaid Services; and for comments, suggestions and questions that resulted from discussions with members of a community advisory board organized and overseen by Myriam Hernandez-Jennings of Community Catalyst and Kimá Taylor of the Urban Institute.
Executive Summary

The US has been facing a maternal morbidity and mortality crisis in which more than half of maternal deaths occur after delivery (Petersen et al. 2019), underscoring the importance of comprehensive health insurance coverage during the first year postpartum. However, eligibility for pregnancy-related Medicaid/Children’s Health Insurance Program (CHIP) coverage ends 60 days after pregnancy ends (Haley et al. 2021). At that point, state Medicaid programs must assess potential eligibility through other Medicaid pathways, and many postpartum people lose coverage. Legislation passed during the COVID-19 pandemic established a continuous enrollment requirement that has temporarily prevented states from disenrolling people from Medicaid during the public health emergency (PHE), which was initially declared in March 2020, in exchange for a temporary federal matching rate enhancement. But this requirement will end following the end of the PHE; though the exact date is not yet determined, it is not expected to end before early 2022. Pregnancy-related coverage will then again end 60 days after the end of pregnancy, and many people whose coverage had been extended during the PHE will face redetermination of Medicaid eligibility and the risk of becoming uninsured.

For this study, we spoke with national maternal health leaders and stakeholders in four states in the spring of 2021 to understand how states assessed eligibility for other Medicaid pathways when pregnancy-related Medicaid coverage ended before the pandemic, how the continuous enrollment requirement during the PHE has changed postpartum coverage, and what steps could increase coverage continuity during the postpartum period following the end of the PHE, including in states that have proposed one-year postpartum Medicaid/CHIP extensions.

Many key informants reported that before the public health emergency’s continuous enrollment requirement, Medicaid eligibility systems did not always facilitate coverage transitions that allowed postpartum people to remain insured. They therefore suggested steps the federal government, state
Medicaid/CHIP agencies and managed-care organizations, and community-based stakeholders could take to minimize postpartum coverage gaps when normal eligibility processes, including redetermination procedures, resume after the PHE ends. First, the federal government could consider the following:

- **Extending the redetermination catch-up period to 12 months after the PHE expires.** As of the time of our interviews, guidance indicated states must process redeterminations within 6 months of the PHE’s end, but extending this period would avoid overwhelming state systems and help stagger renewals to avoid a glut of redeterminations at the same time in subsequent years.
  
  » On August 13, 2021, the Centers for Medicare & Medicaid Services (CMS) issued updated guidance that extended the catch-up period for pending eligibility and enrollment actions from six months to 12 months after the month in which the PHE ends.²

- **Providing further guidance to states.** States need instruction on how to handle eligibility transitions, including shifting eligibility pathways, after the PHE ends. The federal government could also clarify whether any rules or interpretations have changed under the new administration.
  
  » The updated CMS guidance also revises earlier guidance by rescinding the option for states to avoid “repeat redeterminations” by using eligibility actions completed within six months of a post-PHE termination date. Instead, states may not terminate Medicaid coverage until they have completed an eligibility redetermination after the PHE ends.

- **Providing federal support.** Federal funding could support navigators, enrollment assisters, community health workers, and others who help people facing redetermination processes navigate systems, understand their coverage options, enroll in coverage, and access needed care.

Key informants also suggested state governments and Medicaid/CHIP agencies could take the following steps:

- **Effectively communicating expiration of the continuous enrollment requirement and supporting coverage transitions.** These should be communicated both to postpartum enrollees losing Medicaid coverage when the PHE ends and people who will lose coverage after 60 days postpartum after the PHE ends. This could be done by
  
  » informing enrollees about upcoming redetermination procedures in understandable language;
  
  » using multiple modes, including texting, online portals, and paper mail, to reach enrollees who need to verify their eligibility;
» providing information to those losing Medicaid eligibility about other publicly subsidized coverage options, such as Marketplace coverage;
» connecting enrollees losing Medicaid to navigators, enrollment assisters, community health workers, and others providing assistance to minimize coverage losses; and
» engaging social service agencies and community organizations to share information with their clients about the expiration of the continuous enrollment requirement and other sources of health insurance coverage.

- **Proactively updating enrollees’ contact information before Medicaid eligibility ends.** Doing so helps Medicaid/CHIP agency workers reach enrollees for information needed at redetermination.

- **Facilitating transitions to Marketplace coverage for those losing Medicaid eligibility but eligible for premium subsidies.**

- **Supporting access to and use of postpartum health care.** For postpartum people with coverage, reducing barriers related to child care, transportation, low health literacy, and work can support health care access and use.

In addition, key informants highlighted the importance of social service and community-based organizations, health care providers, and managed-care organizations

- sharing information about Medicaid transitions and coverage options,
- providing navigation and enrollment assistance,
- and helping clients navigate the health care delivery system and overcome barriers to seeking care.

This study also surfaced strategies for minimizing postpartum coverage gaps in states adopting postpartum Medicaid/CHIP extensions, including

- programming state eligibility systems well before the extension;
- notifying enrollees, providers, and other key stakeholders of the extension;
- simplifying redetermination processes;
- aligning redetermination processes for postpartum people and their infants at one year postpartum; and
- promoting access to and use of needed health care services during the new eligibility period.

Though this research focuses on maximizing coverage among those who are eligible for publicly subsidized insurance, stakeholders' concerns about major gaps in access to affordable coverage also
emerged, particularly for immigrants and people living in states that have yet to expand Medicaid. We also heard concerns about how postpartum health care services are structured, given the competing demands on new parents’ time, suggesting broader reforms are necessary to ensure both health and health-related social needs are met for all postpartum people.
Promoting Continuous Coverage during the Postpartum Period: Lessons Learned from Medicaid Coverage Transitions and the Public Health Emergency

Compared with other adults, pregnant people can access Medicaid/Children’s Health Insurance Program (CHIP) coverage at much higher income levels in most states, ranging from 138 to 380 percent of the federal poverty level (FPL). In nearly every state, pregnancy-related coverage has been broadly defined to include comprehensive health benefits, including postpartum care and care unrelated to pregnancy, and has minimal cost sharing (Haley et al. 2021). But pregnancy-related Medicaid/CHIP coverage expires 60 days after pregnancy ends, at which point states must assess a person’s eligibility for other Medicaid eligibility pathways or other insurance affordability programs, like the Marketplace (CMS 2021). If postpartum people are eligible for another Medicaid pathway, they should transition to that coverage to avoid having their Medicaid coverage terminated. But little research or data indicate how states redetermine eligibility to identify those eligible under another pathway, so it is unclear how successful these coverage transitions are.

Those losing pregnancy-related coverage are most likely to qualify for Medicaid through adult or parent pathways. But, as noted, the income eligibility thresholds for these pathways are typically much lower than those for pregnancy-related coverage. The median eligibility threshold for adults is 138 percent of FPL in states that have adopted Medicaid expansion under the Affordable Care Act (hereafter called “expansion states”), but it is below 50 percent of FPL in states that have not expanded. 

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.
Medicaid (hereafter called “nonexpansion states”; Brooks et al. 2020). People with incomes above their state’s adult or parental Medicaid thresholds may be eligible solely for Medicaid family planning benefits, if offered in their state, which are limited to specific reproductive health services. Outside Medicaid, publicly subsidized coverage is available through the Affordable Care Act’s Marketplaces for people with incomes between 100 and 400 percent of FPL who do not have an affordable employer-sponsored insurance offer. However, outside of the temporary increase in subsidies recently enacted in the American Rescue Plan (Rae et al. 2021), this coverage can require considerable cost sharing and applicants may face enrollment hurdles. Moreover, new parents in nonexpansion states with incomes below the FPL are in the “coverage gap,” meaning their incomes are too high to qualify for Medicaid at their states’ very low eligibility thresholds but too low to qualify for subsidized Marketplace coverage. Therefore, though some may qualify for limited family planning benefits, they are ineligible for comprehensive publicly subsidized coverage. These people may enroll in employer coverage if it is available to them and affordable. Otherwise, they will likely become uninsured when their pregnancy-related Medicaid coverage is terminated 60 days postpartum.

Because of these eligibility rules, about 1 in 4 of the 440,000 women estimated to be uninsured in the first year postpartum annually appeared to be eligible for Medicaid but not enrolled in 2016 through 2018 (Johnston, Haley, et al. 2021). This suggests many people who have Medicaid/CHIP coverage for prenatal care and delivery are not being appropriately transitioned to other coverage for which they qualify when their pregnancy-related coverage ends.

However, the federal response to the COVID-19 pandemic has temporarily shifted the postpartum coverage landscape (figure 1). The Families First Coronavirus Response Act, passed in March 2020, includes a continuous enrollment requirement, wherein states must maintain continuous enrollment for people enrolled in Medicaid during the public health emergency (PHE) to receive enhanced federal matching funds. Thus, people whose coverage would have otherwise been terminated following a renewal or redetermination, including some whose pregnancy-related Medicaid coverage would otherwise expire after 60 days postpartum, will stay enrolled until after the PHE ends (box 1). This requirement therefore offers temporary continuous Medicaid coverage to many people who might have otherwise become uninsured during the crisis (Buettgens and Green, forthcoming). But following the expiration of the PHE, states will have to complete outstanding renewals and redeterminations for all Medicaid enrollees, including those who maintained pregnancy-related coverage postpartum during the PHE. States must also grapple with decisions about maintaining optional flexibilities in enrollment procedures and other processes adopted during the pandemic, such as accepting self-attestation of eligibility criteria when appropriate and streamlining enrollment procedures.
FIGURE 1
Postpartum Coverage Transitions before and under the Families First Coronavirus Response Act’s Continuous Enrollment Requirement

Before the continuous enrollment requirement

Coverage During Pregnancy

Pregnancy-Related Medicaid Coverage

60 Days After Pregnancy Ends

Transition to Nonpregnancy-Related Medicaid Pathway

Pregnancy-Related Medicaid Coverage

Termination of Medicaid Coverage

Coverage After 60 Days Postpartum

ACA Expansion Medicaid

Parental Medicaid

Marketplace Coverage

Employer Coverage

Uninsured
Under the *continuous enrollment requirement*

**BOX 1**

**The Continuous Enrollment Requirement**

Under the Families First Coronavirus Response Act, states receive enhanced federal matching funds if their Medicaid programs do not reduce eligibility standards and maintain continuous enrollment for people enrolled during the PHE. This means some postpartum people whose pregnancy-related Medicaid coverage would otherwise have expired 60 days after their pregnancy ended can temporarily stay enrolled in Medicaid during the PHE. However, these provisions do not apply to all enrollees with pregnancy-related coverage, such as those covered by CHIP and some noncitizens.\(^a\)

This continuous enrollment requirement will expire at the end of the month in which the PHE ends. The administration has indicated the emergency period will last at least through the end of 2021 and that they will give 60 days’ notice of its pending expiration.\(^b\) So, we expect the continuous enrollment requirement to last through at least January 2022, though the exact date is unknown at the time of this

---

Source: Urban Institute.

Note: ACA = Affordable Care Act. People with incomes above their state’s adult or parental Medicaid thresholds may be eligible for a Medicaid family planning program, if offered in their state. But such programs are limited to specific reproductive health services and are not comprehensive coverage. Therefore, we do not include family planning–only coverage in the figure.
writing. At the time of the interviews for this study, federal guidance indicated states would have 6 months to complete pending eligibility renewals. New guidance issued on August 13, 2021, extended the catch-up period for pending eligibility and enrollment actions from 6 to 12 months after the month in which the PHE ends.

\[a\] Centers for Medicare & Medicaid Services, "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies" (Baltimore: Centers for Medicare & Medicaid Services, 2021).


Notably, the American Rescue Plan Act of 2021 also gives states the option, starting in April 2022, to extend pregnancy-related Medicaid/CHIP coverage for a year (rather than 60 days) following the end of pregnancy by submitting a state plan amendment. In our prior research, we found that if all states were to adopt this optional new provision, approximately 123,000 uninsured new mothers could become newly eligible for Medicaid/CHIP coverage during the first year postpartum (Johnston, Haley, et al. 2021). This provision also permits states to extend postpartum coverage without having to apply and gain federal approval for a Section 1115 waiver, the other means of extending such coverage. Extending postpartum coverage through a Section 1115 waiver potentially allows customization of the length of the extension, the eligible population, and/or the benefits provided. Nearly half of states had explored this option in 2019 and 2020, and three states (Illinois, Georgia, and Missouri) had received federal approval for their extensions as of June 2021 (Haley et al. 2021). As of August 2021, more than a dozen states have declared intentions to submit a waiver or state plan amendment under the American Rescue Plan.

Understanding Medicaid transitions processes both before and during the PHE, as well as barriers to and facilitators of smooth transitions, can inform efforts to ensure coverage continuity for postpartum people when the PHE expires, under resumption of normal processes, and under postpartum extensions. In this report, we present findings from key informant interviews with national experts and case studies in four states (Georgia, Illinois, Missouri, and New Jersey). Through these, we
sought to examine the Medicaid eligibility determination process for postpartum people before the PHE, how the continuous enrollment requirement may be changing continuity of coverage for postpartum people, and challenges to maintaining continuous Medicaid coverage for postpartum people during and after the PHE. We further assess how these insights can inform efforts to maintain subsidized coverage for those who qualify after the PHE. We also highlight what these findings suggest about potential opportunities for and barriers to ensuring continuous coverage under future postpartum Medicaid extensions through state-level Section 1115 waivers or adoption of the American Rescue Plan’s 12-month postpartum extension option.

Methods

Between March and May 2021, we conducted 4 interviews with national experts on maternal coverage policies and 18 interviews with stakeholders in Georgia, Illinois, Missouri, and New Jersey. We selected these states from among those with proposed postpartum Medicaid extensions before the American Rescue Plan option was available, and we sought to include both Medicaid expansion and nonexpansion states in various geographic regions. We spoke with state officials who work in Medicaid agencies and represent maternal health programs. To hear about the experiences of pregnant and postpartum people from those who serve them, we also spoke with maternal health stakeholders including legal aid representatives, advocates, nonclinical health center staff, representatives of community-based organizations and maternal health consortiums, providers, researchers, and health insurance navigators.

We conducted semistructured interviews using protocols tailored by key informant type: national expert, state official, and state maternal health stakeholder. All protocols included questions about how eligibility for nonpregnancy-related Medicaid pathways was assessed before the continuous enrollment requirement, including how coverage transitions worked, how information was communicated to beneficiaries, and what resources were provided to those losing Medicaid coverage. Our protocols also included questions about how the continuous enrollment requirement was operationalized in each state, including the technical process for stopping terminations, communication to beneficiaries about the continuous enrollment requirement, and whether beneficiaries and providers are aware of the change. Finally, our protocols explored concerns about and plans for the end of the public health emergency, resumption of normal eligibility processes, and potential implementation of postpartum Medicaid extensions. Throughout, we probed on barriers to and facilitators of continuous coverage and inequities in the Medicaid system. The research team recorded, transcribed, and analyzed interviews to
identify common themes and key insights and select illustrative quotes. Table 1 contains details about our interviews.

**TABLE 1**
Number of Study Interviews, by Interviewee Type and Location

<table>
<thead>
<tr>
<th>Federal/state government officials</th>
<th>Maternal health stakeholders and/or community partners</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>3 (maternal health policy experts)</td>
<td>4</td>
</tr>
<tr>
<td>Georgia</td>
<td>4 (advocates, legal services professionals, navigators, providers, and academic researchers)</td>
<td>5</td>
</tr>
<tr>
<td>Illinois</td>
<td>3 (advocates, nonclinical health center staff, and legal services professionals)</td>
<td>4</td>
</tr>
<tr>
<td>Missouri</td>
<td>3 (community health organization representatives and medical/legal professionals)</td>
<td>4</td>
</tr>
<tr>
<td>New Jersey</td>
<td>3 (advocates, providers, and representatives of health consortia)</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>

*Source:* Urban Institute interviews conducted between March and May 2021.

*Note:* In some interviews, more than one person represented the same organization.

Our research has several limitations. Because we interviewed a small number of stakeholders in a limited number of states, we have not captured some important experiences and perspectives, and our findings may not be generalizable to all postpartum people in the states studied or in all states. In addition, interviews reflect participants’ views at a point in time; when we conducted interviews in spring 2021, policies and procedures for the end of the PHE and future postpartum coverage extensions were still being planned, and perspectives and policies may have shifted since then, including following the release of new CMS guidance on August 13, 2021.11 We designed our interviews to understand the redetermination process occurring 60 days after the end of pregnancy, when a person no longer qualifies for pregnancy-related Medicaid. However, some respondents described the periodic renewal process, a regularly scheduled requirement for all Medicaid beneficiaries. Where possible, we have differentiated between redetermination and renewal in our findings (box 2). In addition, our discussions did not consider various other Medicaid/CHIP eligibility pathways, including disability-related categories, emergency Medicaid, and CHIP’s “unborn child” coverage, which often provides services for noncitizens who are ineligible for comprehensive Medicaid/CHIP because of their immigration status. Finally, we refer to pregnancy-related coverage as Medicaid, but findings about coverage transitions before and after the continuous enrollment requirement may also apply to
comprehensive pregnancy-related CHIP programs that are similar to pregnancy-related Medicaid (Haley et al. 2021).

**BOX 2
Medicaid Renewals and Redeterminations**

Redetermination of eligibility in the Medicaid program differs from periodic renewals. Redetermination occurs when a beneficiary experiences a change in circumstances, such as reaching 60 days after pregnancy ends or turning 19 years old. Redeterminations do not require a complete review of all eligibility information but instead focus only on a beneficiary’s change in circumstances.

Renewals occur regularly for all Medicaid beneficiaries, usually once every 12 months, and require a review of all eligibility information, including income. Beneficiaries enrolled in pregnancy-related Medicaid remain continuously eligible until 60 days postpartum and are therefore not subject to renewal while enrolled through this pathway.

For beneficiaries enrolled in pregnancy-related Medicaid who had Medicaid coverage before pregnancy, if their regularly scheduled renewal occurs during the pregnancy and postpartum periods, their renewal is delayed until after pregnancy-related eligibility ends 60 days postpartum. At that point, the state must conduct a full renewal rather than the standard redetermination conducted for most beneficiaries when postpartum coverage ends.


Input from the Urban Institute Health Policy Center’s Transforming Health and Health Care Systems project community advisory board informed the direction of this project, and the Urban Institute’s Institutional Review Board approved our study methods.

**Findings**

We present findings from our case studies as follows. First, we describe postpartum coverage transitions before the continuous enrollment requirement and how processes changed during the PHE. Next, we present barriers to and facilitators of continuous postpartum coverage before and under the continuous enrollment requirement. Finally, we present considerations and lessons learned for the
expiration of the continuous enrollment requirement, the return to normal eligibility processes, and potential future postpartum Medicaid extensions.

Postpartum Coverage Transitions before and during the Continuous Enrollment Requirement

In this section, we describe how state Medicaid programs and workers assessed eligibility for other coverage when pregnancy-related Medicaid coverage ended after 60 days postpartum before the PHE and how they communicated coverage changes to beneficiaries. We also discuss how eligibility assessments and communication to beneficiaries about coverage have changed under the continuous enrollment requirement.

HOW WAS ELIGIBILITY FOR OTHER COVERAGE ASSESSED AND COMMUNICATED WHEN PREGNANCY-RELATED MEDICAID EXPIRED BEFORE THE PHE?

Coverage through other Medicaid pathways. Federal rules require Medicaid programs to periodically renew Medicaid eligibility and redetermine eligibility in between renewals when an individual experiences a change in circumstances that may affect eligibility, including reaching 60 days after the end of pregnancy for those enrolled through the pregnancy-related Medicaid eligibility pathway (box 2). If a person is ineligible for the pathway they are enrolled in, they must be assessed for eligibility on other bases; people no longer eligible must be provided advance notice of loss of eligibility as well as fair hearing and appeals rights. State Medicaid agency representatives we spoke with consistently reported that their Medicaid systems automatically complete the redetermination process for such beneficiaries and described the process as follows:

- First, state Medicaid systems generate an eligibility determination based on information already available in the system from prior applications or renewals, such as income, citizenship status, and family size. The systems compare this information on file with eligibility requirements for available Medicaid eligibility pathways in the state to determine a beneficiary’s eligibility. Using a cascading approach, the systems first consider eligibility for full-benefit Medicaid before assessing eligibility for more limited programs, such as a Medicaid family planning program, if available in the state. State officials said this redetermination process begins before the end of 60 days postpartum to ensure a seamless transition between coverage pathways or provide time to seek alternative coverage for beneficiaries losing Medicaid.
Notably, the systems that contain Medicaid eligibility information were not always integrated with other data systems. Officials in one state explained that the Medicaid system is integrated with other medical and cash assistance programs but did not know the extent to which the Medicaid system checked other programs for information when assessing eligibility. Some state agency representatives specifically reported that their systems consider Supplemental Nutrition Assistance Program data in the redetermination process, if available.

If a person is found to be eligible for Medicaid, state systems automatically move the beneficiary into the new eligibility category and confirm continuing eligibility with the beneficiary, and coverage continues. One state official noted that transferring coverage might require a beneficiary’s signature, if one is not on record. A key informant in one state also noted that in some cases, beneficiaries may need to select a managed-care plan to complete enrollment in their new eligibility pathway.

If found ineligible for any Medicaid coverage, state systems terminate coverage and send a notice to the beneficiary explaining the termination and providing an opportunity to appeal the decision. State officials consistently described these systems as working well, noting their abilities to function without case worker involvement and to draw from beneficiaries’ information already on file.

Our key informants outside of state offices, however, were more critical of these transition processes and highlighted unnecessary churn and uninsurance resulting from a lack of seamless postpartum coverage transitions. Whereas state officials focused on the systems’ abilities to accurately assess Medicaid eligibility during redetermination, other stakeholders we spoke with were frustrated with the periodic renewals some beneficiaries face at the same time as postpartum redetermination (box 2). They also described missed connections between Medicaid and Marketplace coverage, explained failures in communication, and highlighted the challenge of limited Medicaid eligibility thresholds outside pregnancy, especially in nonexpansion states. We describe these in more detail below.

**Coverage outside Medicaid.** Subsidized health insurance coverage options for beneficiaries found ineligible for Medicaid are generally limited to the Marketplace. National experts said Medicaid redeterminations include an assessment of Marketplace eligibility and transfer of the account, if appropriate. However, key informants seldom found handoffs between Medicaid and the Marketplace to be “warm,” that is, facilitated by two programs communicating seamlessly with one another and informing the beneficiary of the transition. Instead, handoffs were “cold”; information was often electronically transferred between agencies without coordination, or beneficiaries were simply
provided information in a letter without next steps, follow-up, or a facilitated connection. In addition, enrollees whose renewal is denied for procedural reasons, such as not responding to requests for information, are not transferred to the Marketplaces.12

Consistent with what we heard from national experts, some key informants at the state level explained that when a person’s Medicaid is terminated, their case is transferred to the Marketplace. The Marketplace then sends a letter to the beneficiary, which one interviewee described as “not the greatest” at clearly informing beneficiaries and supporting smooth transitions to Marketplace coverage. Another key informant described referrals from Medicaid to the Marketplace quite negatively, saying, “I tried calling...and I just got a phone ringing...When I did find someone, they would say that they couldn't help. I don't see how people were able to get help.”

No state officials provided examples of warm handoffs or caseworker outreach from Medicaid offices to help beneficiaries losing Medicaid coverage complete Marketplace enrollment. However, some key informants shared that community organizations conducted outreach to help facilitate Medicaid-to-Marketplace transitions. In addition, key informants in nonexpansion states noted that Marketplace coverage is inaccessible for people in the coverage gap; among those losing Medicaid coverage postpartum, “many of the women don’t qualify [for Marketplace subsidies] because they may not reach that income threshold [of 100 percent of FPL],” according to one stakeholder.

**Communication about coverage.** In all states, people we interviewed described changes in Medicaid coverage occurring after 60 days postpartum being communicated to beneficiaries through mailed notices and letters, regardless of whether beneficiaries are found eligible for a new coverage pathway and/or have their benefits terminated. Interviewees in multiple states noted that some beneficiaries may be able to access these mailed letters through online accounts or electronic portals as well.

Key informants highlighted a range of limitations in communicating Medicaid coverage changes, however. For instance, frequent address changes mean many letters do not reach beneficiaries. And when beneficiaries do receive a letter, they may find the language overly complex and difficult to understand.

**HOW DID MEDICAID PROGRAMS IMPLEMENT THE CONTINUOUS ENROLLMENT REQUIREMENT FOR POSTPARTUM PEOPLE AND COMMUNICATE THE CHANGE TO THEM?**

**Changes in processes.** All of the state representatives we interviewed confirmed that terminations of Medicaid coverage had ceased during the PHE, but system changes to halt terminations varied. One state official reported a system override that halted the redetermination and renewal processes
completely. Another reported that their state is conducting redeterminations following the same pre-PHE process. However, instead of terminating coverage for beneficiaries who would have otherwise lost eligibility after 60 days postpartum if not for the PHE, the state is moving them to the parent Medicaid eligibility pathway. A third state initially also paused its system, including all assessments. But following additional guidance from the Centers for Medicare & Medicaid Services, the state began completing eligibility assessments while keeping beneficiaries enrolled regardless of the outcome.

Community-based stakeholders we interviewed were consistently aware that states were no longer terminating pregnancy-related Medicaid coverage after 60 days postpartum (with one notable exception of a provider who was unaware of the change before this study). They confirmed that postpartum people were indeed maintaining their coverage in the postpartum period, as required. One stakeholder shared, "From an advocacy standpoint, we’re not seeing the churn. We’re not getting as many calls from agencies asking about clients losing coverage."

*Communication about coverage.* Though states have halted terminations as required, many beneficiaries have received little communication about the newly implemented continuous enrollment requirement. Informants from two states noted that their offices are not sending notices of the continuous enrollment requirement but rather have stopped sending termination communication. These state officials chose not to communicate about the continuous enrollment requirement because they were uncertain about how long the PHE would last and wanted to avoid confusing beneficiaries. One said, "We wouldn’t send a notice out saying, 'You’re not eligible, but we’re keeping you on anyway.' We don’t want to upset anybody; we don’t want anybody asking for a fair hearing when it’s not really necessary right now." Another state official shared:

> I think there were some conversations about if we should send a letter and we felt like, because we didn’t know when the public health emergency was going to end, saying that you’re covered until the public health emergency ended would generate questions and phone calls. It would just kind of create more uncertainty, when we didn’t have an answer for them.

Another state did not send notices but posted information about the continuous enrollment requirement in the integrated eligibility system patient portal for beneficiaries to see. This information intended to inform beneficiaries that terminations and annual renewals were suspended. Informants from multiple states reported that they publicized the continuous enrollment requirement through provider forums, to managed-care organizations, in newsletters, on their websites, and through Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and other community-based social service providers.
Barriers to and Facilitators of Continuous Postpartum Coverage before and under the Continuous Enrollment Requirement

Here we discuss challenges with and facilitators of maintaining coverage for postpartum people before and under the continuous enrollment requirement. The challenges pertain to communicating with beneficiaries, ensuring new parents are supported in enrolling in coverage and accessing care, and overcoming structural barriers, like limited Medicaid eligibility outside pregnancy. However, generous Medicaid eligibility in expansion states, engaged providers and managed-care organizations (MCOs), and engaged social services and community-based providers can promote coverage continuity for postpartum people.

BARRIERS

Key informants described a range of barriers to successful postpartum coverage transitions for those losing pregnancy-related Medicaid coverage after 60 days postpartum before the PHE. They also reported barriers to promoting postpartum insurance coverage and access to care under the continuous enrollment requirement, and many barriers occurred in both periods. Several challenges pertain to communication, including the following:

- **Challenges reaching beneficiaries.** Informants we spoke with mentioned that address changes made it difficult to reach beneficiaries with mailed letters and ensure continuous coverage before the PHE. Enrollees did not always know that their Medicaid coverage was terminated, nor did they always receive information about appeals or other coverage options from state Medicaid offices. To try to address this barrier, a state representative noted that one employee is specifically tasked with keeping enrollees’ addresses updated, using information about address changes directly from enrollees and MCOs. One interviewee said, “If written notification is sent, many of the women don’t get it, because they move [or are] transient.”

- **Difficult-to-understand communication.** Stakeholders worried that Medicaid agencies’ communication to beneficiaries was not easily understandable. One shared, “We see even on the paperwork that they’ve mailed to people and upload to [the case management system], it’s really complex, really wordy, hard to understand…[The state has] a long way to go in terms of the language they use and making the process understandable.”

- **Limited health literacy.** Stakeholders also reported that beneficiaries’ limited health literacy made it harder for them to successfully navigate the Medicaid system before the PHE; many beneficiaries who received communication from the state Medicaid office struggled to understand it. One stakeholder shared, “Health literacy is such a huge thing…there’s a shame,
and not knowing, that's huge. We see that a lot; with our community health workers, mothers are bringing forms to them, bringing letters to them, and saying, 'I don't even know what this means.'

**Difficulties explaining the continuous enrollment requirement.** Some stakeholders identified the lack of communication to beneficiaries about the continuous enrollment requirement during the PHE as a barrier. As one said, "That's a really big concern for advocates on the ground. We've been trying to get the word out...I'd like to know if there is a reason why they [Medicaid agencies] may or may not be advertising this. Why is it falling on advocacy and community-based organizations to get that information out there?"

Some enrollees who noticed their coverage had not been reevaluated sought information. But overall, stakeholders worried that limited publicity about the continuous enrollment requirement would cause people who expected their coverage to have ended to not seek care. This, in turn, limits the continuous enrollment requirement's ability to promote access to care beyond 60 days postpartum. One stakeholder said, “[Enrollees] don't necessarily know that their coverage was extended...They're not going to be seeking care. It just may be that if they end up in an emergency room or end up somewhere for care and they run their card, they might find out that they still have coverage.”

Prioritizing coverage has been and is challenging for many beneficiaries, especially during the pandemic. We heard about the following specific barriers:

**Competing demands on new parents' time.** Key informants consistently shared that though people are often motivated to obtain coverage for pregnancy and delivery, new parents are not as focused on prioritizing their own health postpartum; instead, they focus on taking care of their infants. Therefore, navigating a complex system to maintain health insurance coverage can be a serious barrier to continuous coverage postpartum. One interviewee said, “What we found is moms are much more attuned to, ‘I'll take my baby to go the pediatrician, whatever it takes to ensure that my baby's taken care of, but for me, not so much.’...It's not that they don't care; it's just the question of, 'What's my priority? My priority is to make sure my baby's safe, and if it means another trip out for me, it may not be uppermost on my to-do list.’” Another interviewee shared, “We've heard from our family councils that after having a child, it's really hard to navigate that postpartum care because there are so many well-child visits that are needed, so many vaccines and immunizations that are needed...parent care falls to the wayside in that postpartum period.”
Additional pandemic-related difficulties. Interviewees described balancing seeking coverage with meeting other pressing needs as especially difficult during the pandemic, particularly for those who lack access to other affordable care (e.g., through clinics). One stakeholder said, “There’s a lot of messaging going on...in this pandemic that I don’t expect people to know everything and get everything. Insurance coverage is important, but getting a COVID test and getting food and getting a vaccine now may supersede that for some.”

The people we spoke with also mentioned barriers from before the PHE that will likely reemerge after the PHE expires:

- **Limited Medicaid eligibility outside pregnancy.** As discussed, extremely low income eligibility thresholds for parental Medicaid in nonexpansion states mean most postpartum people are ineligible for another Medicaid pathway when their pregnancy-related Medicaid ends. As one stakeholder shared, “Very few women are going to maintain coverage postpartum because of the drastic drop in the income eligibility. So, if you work at all, you’re not going to get coverage.” Some states offer limited Medicaid benefits to people with higher incomes through a Medicaid family planning program, but one key informant shared that their clients often “think it’s not really what they need or want” and do not enroll. Another key informant shared that some people “enroll and think they have full Medicaid, and when they find it’s this limited set of services, they’re upset, understandably.”

- **Burdensome periodic renewal process.** Among enrollees who faced full periodic renewal postpartum (rather than only a redetermination), the systems through which they had to reapply made maintaining coverage burdensome. Key informants described situations where documentation needed to be submitted by fax and where Medicaid agencies lost mailed documentation. They also mentioned barriers posed by web-based systems; such systems can be inaccessible for some without internet access, and if they are not made for mobile devices, they can also be inaccessible for people whose main internet source is their phone.

- **Barriers to Marketplace transfers and few resources to assist postpartum people with coverage transitions.** Key informants noted that Marketplace coverage is not as affordable as Medicaid even with premium subsidies, and many postpartum beneficiaries losing pregnancy-related Medicaid in nonexpansion states are also ineligible for subsidies because of the coverage gap. Moreover, one key informant described the transition period as “an area where a lot of women just don’t understand what the coverage options are at that point.” Interviewees explained that navigation systems that support enrollment in or renewal of Medicaid or Marketplace coverage or help people understand their coverage options are extremely limited.
or nonexistent in some communities, limiting beneficiaries’ options for receiving assistance with applications. Stakeholders also reported mixed availability of support from health care providers in the absence of navigators. Further, barriers to Marketplace enrollment are heightened for postpartum people balancing new parenting responsibilities. One interviewee said, "Navigating Medicaid and Marketplace eligibility is...a huge challenge, and there’s fewer navigators...and assisters out there to help people. Those are just really complicated systems, overly complicated, and people have a lot going on in their life when they have a new baby. It’s just a lot to deal with.”

FACILITATORS
Key informants also described systems and resources that have helped people maintain health insurance coverage or access to care during the postpartum period before and under the continuous enrollment requirement, including the following:

- **More generous Medicaid eligibility in expansion states.** Higher income eligibility thresholds for coverage outside of pregnancy promote continuous coverage by increasing the likelihood that a postpartum person losing pregnancy-related coverage is eligible for another Medicaid pathway. As one interviewee said, "Because we’re a Medicaid expansion state, most women stay on state Medicaid [after 60 days postpartum], even prepandemic.”

- **Engaged providers and Medicaid MCOs.** Some state representatives mentioned that Medicaid MCOs help eligible beneficiaries maintain coverage (or learn about the continuous enrollment requirement) and navigate the Medicaid system. People we spoke with said similar engagement by providers, particularly those working in federally qualified health centers or other community health centers, facilitated smooth coverage transitions. As one representative of a community health center described, “[We’re] determining eligibility every time a patient comes through the doors...If something is going on with coverage, they will know immediately, and the staff are really great at saying, ‘You lost coverage; let’s call the 800 number to your plan and see what happened.’ Oftentimes it's just they didn't receive documentation, and then we'll work with them to help them get all that together." State Medicaid office representatives also described providing education to provider organizations as part of their outreach strategies, highlighting the role providers can play in supporting their patients as they navigate coverage transitions.

- **Community and social service engagement.** Stakeholders shared that various state and community organizations, including local health departments, community health centers, WIC
offices, home visiting programs, and legal aid organizations, provide critical support navigating coverage transitions, particularly in the absence of official health insurance navigators.

HOW DO EXPERIENCES VARY FOR SUBGROUPS OF THE POSTPARTUM POPULATION?

Most commonly, stakeholders working in state Medicaid offices and in communities said immigrants were least likely to maintain subsidized coverage when pregnancy-related Medicaid ended before the PHE. Multiple states cover immigrants otherwise ineligible for Medicaid during pregnancy (through Medicaid, CHIP, or state-funded pathways) but end that coverage early in the postpartum period for people who have resided in the US legally for fewer than five years and those without documentation (Haley et al. 2021). Stakeholders also described greater challenges to maintaining coverage for nonnative English speakers who face language barriers, rural residents who experience limited provider and transportation access, and people living with instabilities like seasonal or fluctuating income or unstable housing. One stakeholder summarized who the system works best for: “The greater your health care literacy is, the better it works for you. People who during COVID became unemployed, but who are educated and have higher health literacy and English is their first language, and they are just used to managing all kinds of systems, then they can manage the Medicaid system better.”

Overall, interviewees reported that the pandemic’s health and economic effects varied across populations, and people who would have otherwise lost Medicaid postpartum benefitted most from the continuous enrollment requirement (i.e., those with incomes that would have made them ineligible for Medicaid outside of pregnancy). However, we heard few concerns about variation in experiences with continuous enrollment across groups defined by race, ethnicity, place of residence, or other characteristics, suggesting the policy has been implemented as required.

Looking Ahead: Postpartum Transitions Following Expiration of the PHE and under Proposed and Planned Postpartum Extensions

In this section, we explore how the postpartum Medicaid coverage landscape could change after the PHE ends. We discuss how state agencies planned to resume redeterminations at the time of our interviews in spring 2021 and how insights gleaned during the PHE can improve coverage transitions and access to care both following expiration of the PHE and under planned and proposed postpartum Medicaid extensions.
HOW WILL REDETERMINATIONS RESUME WHEN THE CONTINUOUS ENROLLMENT REQUIREMENT EXPIRES?

When states’ Medicaid redeterminations and renewals resume when the PHE ends, interviewees speculated that agencies will resume processes in place before the PHE. For instance, a person whose income is 120 percent of FPL who enrolled in pregnancy-related coverage before the pandemic in a Medicaid expansion state would have their eligibility reassessed and renewed in the expansion adult category (if they were not already moved to this category during the PHE). A comparable person in a nonexpansion state, however, would lose coverage because their income makes them ineligible; they would then need to be connected with other coverage options, such as subsidized Marketplace policies, to remain insured. Still, interviewees raised several questions about how these processes will resume:

- **How will states’ redetermination and renewal systems handle mass renewals?** Stakeholders were concerned about the possibility that all Medicaid beneficiaries will be due for periodic renewal simultaneously (following the end of the PHE) instead of throughout the year. Some were pessimistic about state systems’ capabilities to handle the anticipated volume of redeterminations and renewals; as one key informant stated, "I don’t think that’s going to work well."

- **Will some adults who should remain eligible erroneously lose Medicaid?** If state workers cannot reach beneficiaries to obtain verification documentation or enrollees cannot submit required paperwork within requested time frames, beneficiaries may lose Medicaid coverage.

- **Will the Biden administration provide more guidance on how states should handle eligibility transitions, and if so, when?** Stakeholders wondered if the federal government would share more information beyond that released under the prior administration and whether the administration would extend the period for resuming normal operations after the end of the PHE to allow more time for processing redeterminations and streamlining workflows (Musumeci and Dolan 2021, Rosenbaum, Handley, and Morris 2021). CMS issued new guidance on August 13, 2021 (box 1).

- **Will flexibilities adopted by states during the pandemic continue after the PHE?** Stakeholders specifically mentioned wanting to retain simplifications such as accepting self-attestation of eligibility criteria when appropriate and use of phone consent by trained assisters.

For states with an approved Section 1115 waiver to extend postpartum Medicaid eligibility or considering state plan amendments under the American Rescue Plan, interviewees expected that the
same Medicaid redetermination processes typically conducted 60 days postpartum would simply shift to 12 months postpartum. Stakeholders expected enrollees in MCOs would remain in the same MCO under extension. Thus, the challenges to maintaining coverage when pregnancy-related Medicaid/CHIP expires that existed before the PHE, though shifted until a later date, would remain under postpartum Medicaid extensions.

WHAT LESSONS LEARNED FROM THE CONTINUOUS ENROLLMENT REQUIREMENT COULD INFORM STRATEGIES TO PROMOTE COVERAGE RETENTION?

As states prepare for the end of the PHE and the continuous enrollment requirement, they will need to consider how to maintain Medicaid enrollment for people who qualified through the pregnancy-related pathway and remain eligible (under ACA expansion, parental, or other eligibility pathways). They will also need to connect people no longer eligible for Medicaid to other coverage options, such as the Marketplace.

Some state eligibility officials reported proactively asking enrollees to update their contact details so they may be reached for information needed to reassess their Medicaid eligibility. Others reported being eager to start planning but feeling uncertain whether federal guidance on conducting redeterminations will change. Specifically, some of these officials were concerned about catching up on many months of redeterminations in just six months, as CMS required at the time of the interviews (Musumeci and Dolan 2021); some also expressed interest in a longer catch-up period that would streamline workloads in future years. As one interviewee said, "We would like that time period to get all caught up on redeterminations to be 12 months, as will most states, because we don’t want a glut every year of when redeterminations happen." This happened on August 13, 2021, when CMS issued updated guidance extending the catch-up period from 6 to 12 months after the month in which the PHE ends.

Nationwide, some states are informing enrollees that redeterminations are being processed automatically or ex parte, and that they may no longer be eligible for Medicaid when the PHE ends and may receive a renewal form to determine whether they remain eligible (Manatt Health 2021; Musumeci and Dolan 2021). Several informants expressed the need for clear, understandable communication from state agencies, MCOs, and providers notifying enrollees about the end of the PHE before possible disenrollment so they can reapply or be connected to other coverage. They also said it is essential that such communication use plain language, or language "without all the legal talk," as one informant put it. One interviewee mentioned that communication will need to be especially clear in states also implementing or planning postpartum extensions, given the potential for confusion: “We did pass a six-
month postpartum extension. But maybe [a] woman wouldn’t necessarily distinguish that she had six months more of coverage [because of] COVID or the postpartum expansion."

Given the needs for enrollment support identified before the PHE, key informants also added that effective and widespread consumer assistance will also be needed to help families navigate the resumption of redeterminations and renewals. Overall, our case studies identified several policy recommendations to support continuous coverage when the PHE ends (table 2).

TABLE 2

Strategies to Promote Coverage Continuity for Postpartum Populations When the Continuous Enrollment Requirement Expires and Normal Eligibility Redetermination Procedures Resume

<table>
<thead>
<tr>
<th>Level of implementation</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal government</td>
<td>Extend the renewal catch-up period after expiration of the PHE from 6 to 12 months to avoid overwhelming state systems and stagger renewals to prevent a glut of simultaneous redeterminations in subsequent years.</td>
</tr>
<tr>
<td></td>
<td>- This policy change was implemented via updated guidance from CMS issued August 13, 2021.¹</td>
</tr>
<tr>
<td></td>
<td>Provide more guidance, beyond that already released, to states on how to handle eligibility transitions (including shifting eligibility pathways) after the PHE ends, and clarify whether any rules or interpretations have shifted under the new administration.</td>
</tr>
<tr>
<td></td>
<td>- The updated CMS guidance also revises earlier guidance by rescinding the option for states to avoid “repeat redeterminations” by using eligibility actions completed within six months of a post-PHE termination date. Instead, states may not terminate Medicaid coverage until they have completed a determination after the PHE ends.</td>
</tr>
<tr>
<td></td>
<td>Provide federal support to navigators, enrollment assisters, community health workers, and others providing consumer assistance to help people facing redetermination navigate systems, understand their coverage options, enroll in coverage, and access needed care.</td>
</tr>
<tr>
<td>State governments</td>
<td>Effectively communicate expiration of the continuous enrollment requirement and support coverage transitions among postpartum enrollees losing Medicaid coverage at the end of the PHE and at 60 days postpartum when the PHE ends by doing the following:</td>
</tr>
<tr>
<td>and Medicaid/CHIP</td>
<td>- Informing enrollees about upcoming redetermination procedures in clear, understandable language.</td>
</tr>
<tr>
<td>agencies</td>
<td>- Using multiple modes, including texting, online portals, and paper mail, to reach enrollees who need to verify their eligibility.</td>
</tr>
<tr>
<td></td>
<td>- Informing enrollees who may lose Medicaid eligibility about other publicly subsidized coverage options, such as subsidized Marketplace coverage.</td>
</tr>
<tr>
<td></td>
<td>- Connecting enrollees losing Medicaid to navigators, enrollment assisters, community health workers, and others providing consumer assistance to minimize coverage losses.</td>
</tr>
<tr>
<td></td>
<td>- Engaging other social service agencies and community organizations, such as WIC, SNAP, FQHCs, and legal aid, to share information about the PHE expiration and other coverage sources with their clients.</td>
</tr>
</tbody>
</table>
|                         | - Being especially clear that coverage is changing because of expiration of the PHE in states that have recently passed postpartum extensions, where it may be
Level of implementation | Strategies
--- | ---
 | confusing whether extended coverage owes to the continuous enrollment requirement or the extension. Doing this helps enrollees understand how long they will be covered.
 | Proactively updating enrollees’ contact information before Medicaid coverage ends, as some states are currently doing in preparation for the end of the PHE (Brooks et al. 2020), so enrollees can be reached for information needed at redetermination.

**Facilitate transitions to Marketplace coverage** for those losing Medicaid eligibility but eligible for premium subsidies.

**Support access to and use of postpartum health care** for those with coverage by reducing barriers to seeking care related to child care, transportation, low health literacy, and work.

**Social service and community-based organizations, health care providers, and MCOs**

At the end of the PHE or after 60 days postpartum when the PHE ends, **share information with clients** about redetermination processes and coverage options for those losing Medicaid.

**Provide navigation and enrollment assistance** to help clients losing Medicaid or facing redetermination navigate systems, understand their coverage options, enroll in coverage, and access needed care.

**Encourage and support clients’ access to and use of postpartum health care services** by explaining the benefits of accessing preventive and other needed care, assisting clients in navigating the health care delivery system, and helping clients overcome barriers to seeking care, such as child care, transportation, low health literacy, and work.

Source: Key informant interviews.

Notes: PHE = public health emergency. CHIP = Children’s Health Insurance Program. MCO = managed-care organization. WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. SNAP = Supplemental Nutrition Assistance Program. FQHC = federally qualified health center.


WHAT LESSONS LEARNED FROM THE CONTINUOUS ENROLLMENT REQUIREMENT COULD INFORM STRATEGIES TO PROMOTE COVERAGE RETENTION UNDER POSTPARTUM EXTENSION?

Interviewees supported various strategies for increasing coverage continuity when shifting redetermination processes to 12 months postpartum under proposed and planned extensions (table 3). For instance, simplifications to redeterminations, including not requiring enrollees to confirm their MCO or move to a different MCO (as is reportedly required when moving to a new eligibility pathway under current procedures in one study state) and aligning birthing parents’ redetermination periods with those of their infants would promote coverage continuity for enrollees and streamline state procedures. One stakeholder shared, “In our 1115 waiver we asked for continuous eligibility so the
mom and the newborn could be redetermined at the same time, which is just easier for the caseworker side as well.” Some people also emphasized the technical modifications to state eligibility processes and other systems that will be needed under an extension and suggested that states proactively plan such changes before implementing an extension.

TABLE 3
Strategies to Promote Coverage Continuity for Postpartum Populations Following Adoption of Postpartum Medicaid/CHIP Extensions

<table>
<thead>
<tr>
<th>Level of implementation</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| State governments and Medicaid/CHIP agencies | ▪ Clearly notify enrollees about the postpartum coverage extension and promote and support access to and use of needed health care.  
▪ Plan technical changes to state eligibility systems in advance.  
▪ Simplify redeterminations; for instance, do not require confirmation of MCO or movement to a different MCO for extended postpartum coverage.  
▪ Align redetermination periods for postpartum people and their infants at one year postpartum, which simplifies processes for enrollees and caseworkers and could minimize coverage losses.  
▪ Use information on benefits use under the continuous enrollment requirement to anticipate conditions under postpartum extensions and inform efforts to improve care access and utilization, accounting for likely differences in behavior between the two periods. |
| Providers and MCOs      | ▪ Ensure providers and practices anticipate and prepare for possible increases in demand among postpartum people. |

Source: Key informant interviews.  
Notes: CHIP = Children’s Health Insurance Program. MCO = managed-care organization.

Postpartum extensions may be better communicated to the public than the continuous enrollment requirement if the extensions are seen as a policy “win” and better publicized, according to one stakeholder. But still, it will be important to let enrollees know about the extension so they will use their benefits. As one stakeholder said:

The challenges will be...raising the awareness of this benefit and operationalizing this benefit. It’s not a benefit if people don’t know about it, it’s not a benefit if people can[not] access it...The challenges will probably remain, and in [our state] in particular, working with a very diverse population, and really making sure that you get to some of those most vulnerable hard-to-reach folks in a way that is user friendly and appropriate for them.

Finally, some interviewees suggested using data from the continuous enrollment period to forecast what to expect under a postpartum Medicaid extension. As one stakeholder said, “In a way, this is a piloted postpartum expansion for everybody. I think the state will get a lot of data—much-needed data—on access to care and how often people are seeking care in the postpartum period post 60 days.” But another stakeholder cautioned that limited knowledge of the continuous enrollment requirement...
and other pandemic-related conditions that limit care utilization could mean behavior during the PHE would not represent behavior under a postpartum Medicaid extension: “You have this informal postpartum Medicaid extension [under the PHE], and we would love to use the results of that to say it’s working. But if people aren’t taking advantage of it because of the fact that they don’t know it exists, then it’s an issue.”

Discussion

Maternal morbidity and mortality, including in the postpartum period (Petersen et al. 2019), and the importance of health insurance coverage to improving access to and use of needed care highlight the need for seamless coverage transitions when pregnancy-related Medicaid/CHIP ends. However, the state officials and maternal health stakeholders we interviewed highlighted several barriers in states’ typical Medicaid policies and procedures that could contribute to unnecessary coverage churn, including low eligibility thresholds for parents, especially in non-expansion states; cumbersome renewal systems; insufficient handoffs to other coverage options; unclear communication to enrollees; and limited enrollment support. Barriers to continuity of care and coverage disruptions are not new in the Medicaid program, nor are they limited to the postpartum period (Sugar et al. 2021). And though these issues affect other groups of Medicaid enrollees as well, they are particularly acute for the postpartum population, given that postpartum coverage ends after 60 days postpartum, during a medically and socially fragile time.

Many of these barriers have been temporarily eliminated because of the freeze on Medicaid disenrollment under the continuous enrollment requirement. However, limited or unclear communication about continuing coverage may be limiting gains in health care access and utilization. And interviewees were concerned about the potential for postpartum people to be incorrectly disenrolled from publicly subsidized coverage when the continuous enrollment requirement ends, currently slated for early 2022 (Wagner 2020). However, stakeholders also highlighted the potential for clear and widespread communication, effective outreach and consumer assistance, and streamlined state procedures to help ensure postpartum people are aware their coverage is ending so they can reapply or be connected to other coverage. Together with other steps the administration or Congress could take to unwind the PHE as smoothly as possible, such actions could help minimize coverage losses when the continuous enrollment requirement expires. Many interviewees also supported proposed or planned 12-month postpartum Medicaid/CHIP extensions and identified several recommendations that would improve coverage continuity under such extensions.
Though our study respondents emphasized the importance of continuous coverage, many also noted that coverage alone cannot ensure use of care. For instance, multiple study participants noted that low awareness of the continuous enrollment requirement could be limiting use of care; as one participant put it, there is “all this care that they [postpartum people] could be taking advantage of but can't because of the lack of awareness.” Thus, it is essential to clearly and effectively communicate that coverage is in place, eliminate barriers to accessing care, and support postpartum people in getting the care they need despite other pressing demands. Key informants also noted that enrollees are not always interested in maintaining Medicaid or seeking other subsidized health insurance because they have had poor experiences with Medicaid during pregnancy, such as a lack of obstetricians accepting Medicaid, poor treatment from program staff and providers, receiving low-quality care, and even experiencing backlogs and delays when trying to enroll during pregnancy. These suggest improvements to experiences enrolling in and using Medicaid coverage could also improve postpartum coverage experiences.

Several key informants looked beyond maintaining and extending coverage for postpartum people eligible for Medicaid under current rules and suggested measures that could further expand eligibility for postpartum coverage and care. In expansion states, such measures could address how some residents lose Medicaid postpartum because income eligibility limits for pregnancy-related coverage are almost always higher than those for parental coverage (Haley et al. 2021). In nonexpansion states, such measures could address the very low income eligibility limits for parents and the coverage gap. In addition, key informants in both expansion and nonexpansion states highlighted the lack of Medicaid eligibility (outside of pregnancy) for noncitizens residing in the US for fewer than five years and for undocumented immigrants. Research has found that nearly one-third of uninsured new mothers would likely be ineligible for subsidized coverage (Medicaid, CHIP, or premium tax credits to purchase Marketplace plans) even under a 12-month postpartum extension in every state, mostly because they would not meet the immigration requirements (Johnston et al. 2021). This indicates Medicaid coverage rates for postpartum immigrants can only be raised by removing waiting periods for documented noncitizens and eliminating the federal bar on using Medicaid funds to cover undocumented noncitizens.

Lessons learned during the PHE can inform improvements to coverage transitions following the end of the PHE and under future postpartum extensions. In addition, meeting the other health and social needs of the postpartum population could not only help address alarming rates of poor maternal outcomes but have positive long-term implications for maternal health. As one study participant summarized:
If we do things right during pregnancy and postpartum, meaning women have access to the care they need... in the broadest sense, like they get food, they have transportation, all the things you need to stay healthy... If we do that right during pregnancy and postpartum, we are teeing her up to be healthier across her lifespan.
Notes

1. We refer to a “60-day postpartum period” but acknowledge the requirement is that coverage is provided through the last day of the month in which a 60-day period, beginning on the last day of pregnancy, ends.


3. We refer to a “60-day postpartum period” but acknowledge the requirement is that coverage is provided through the last day of the month in which a 60-day period, beginning on the last day of pregnancy, ends.

4. Some people who appeared eligible for but not enrolled in Medicaid might have experienced a change in income between an eligibility assessment at 60 days postpartum and the time of the survey, or their eligibility or coverage status may be subject to measurement error.


10. At the time of the interviews, Missouri had not yet expanded Medicaid. Therefore, we consider Missouri a nonexpansion state in this analysis, but we note that the state implemented Medicaid expansion on August 10, 2021, with coverage retroactive to July 1, 2021. See “Status of State Medicaid Expansion Decisions: Interactive Map,” Kaiser Family Foundation, accessed August 11, 2021, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.


13. Key informants did not comment on the expansion of Marketplace subsidies in 2021 and 2022 included in the American Rescue Plan, which can improve the affordability of Marketplace plans (Banthin et al. 2021).


16 States can either use an enrollee’s original redetermination timeline or begin a new eligibility period during the PHE to determine when redetermination will occur again, which can help stagger renewals. See Musumeci and Dolan (2021).

References


About the Authors

**Emily M. Johnston** is a senior research associate in the Health Policy Center at the Urban Institute. She studies health insurance coverage, access to care, Medicaid policy, reproductive health, and maternal and infant health with a focus on the effects of state and federal policies on the health and well-being of women and families. Johnston holds a PhD in health services research and health policy from Emory University.

**Jennifer M. Haley** is a research associate in the Health Policy Center. Haley’s current work includes assessing ways states and communities can improve health equity in response to the COVID-19 pandemic, barriers to enrollment in publicly subsidized health insurance coverage, postpartum coverage gaps, and challenges to accessing the safety net for children in immigrant families. She also conducts research on other issues related to Medicaid, the Children’s Health Insurance Program, and coverage and care for children and families. Haley holds an MA in sociology from Temple University.

**Tyler W. Thomas** is a former research assistant in the Health Policy Center, where he used data from federal surveys to study insurance coverage and health care access, use, and affordability. Thomas holds BAs in biochemistry and public health from the University of Massachusetts Amherst.
**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.