



# 2021 STATE LEGISLATIVE AGENDA

## POLICY BRIEF

### MATERNAL HEALTH AND MEDICAID

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During the first trimester of pregnancy, healthcare providers can detect and treat problems, often before they negatively impact fetal development and maternal health (5). Fortunately, increased access to care has been found to increase utilization during early pregnancy. CDC data indicates significant increases in preconception health conversations with providers, folic acid consumption, and postpartum contraception when women have access to Medicaid (10).

Unfortunately, when pregnant persons are unable to access care, the potential adverse effects are serious (2,3).

Approximately 700 pregnant persons in the United States die each year because of pregnancy complications, and America is the only developed nation in which that rate annually increases (1,2). Systematic factors including lack of preventive care, gaps in care, and lack of care coordination, have been identified as leading contributory factors of prenatal and perinatal deaths (13). Maternal mortality is a national crisis with a range of contributing factors including inadequate access to Medicaid and prenatal/postnatal care. In 2018, a comprehensive literature review found that an increase in quality healthcare for women before, during, and after pregnancy is necessary to identify and/or manage chronic medical conditions (14).

In the nine years between 2007 and 2016, 6,765 pregnancy-related deaths in the U.S. were attributed to cardiovascular conditions, pre-existing medical conditions, chronic illnesses, and infections (12). The majority of these conditions could have been detected by skilled healthcare providers, so it is alarming to note that in 2018 nearly one in ten persons who gave birth in Nevada received late or no prenatal care (3). While this statistic is disheartening, it doesn't reflect additional disparities for Black, Indigenous and People of Color (BIPOC), rural areas, and/or low-income communities.

According to the Georgetown Center for Children and Families, Black and American Indian/Alaska Native women die from problems in pregnancy two to three times more than White women (1). Only one in three pregnant women residing in Laughlin, a small town of 7,502 in Clark County, receive early prenatal care (5). In Washoe County, one in five receive early care, which experts attribute to a disproportionate lack of care in its rural areas (6). Worldwide, low-income mothers are more likely to receive inadequate prenatal care and have preeclampsia, c-sections, hemorrhages, and preterm deliveries than their middle- and high-income counterparts (4). In the United States, uninsured women typically utilize Emergency Medicaid to deliver a baby in a hospital or birthing center (17).

Lawfully residing immigrant children in Nevada are currently covered by Medicaid through the ICHIA option (Immigrant Children's Health Improvement Act). If Nevada extends Medicaid to lawfully residing pregnant women who have been in the U.S. for less than 5 years, some of the pregnancies and deliveries that currently require Emergency Medicaid would be covered by traditional Medicaid. This is a more streamlined and cost-effective option for patients and the state Medicaid authority that would ensure more Nevadan women access to care. A lack of adequate prenatal care jeopardizes the health of birthing persons and their babies. Neonatal mortality rates directly correlate with not only socioeconomic status, but also birth weight, which can often be mitigated with appropriate prenatal care (9).

According to the Southern Nevada Health District, babies whose mothers did not receive prenatal care are three times more likely to have a low birth weight and five times more likely to pass away than their counterparts whose mother's received care (5). During the neonatal period (first month of life), birthweight is the greatest determinant of infant mortality—the lower a newborn's weight, the more likely they may suffer adverse health outcomes or pass away (9). The delivery of a full-term baby is something to strive for and celebrate, but it is not the end of the pregnancy experience. Supporting new mothers with medical homes and continuity of care improves health outcomes and reduces costs over time.

Presently, Nevada Medicaid covers those who have given birth for only 60 days postpartum. However, roughly 24% of pregnancy-related deaths occur between 6 weeks and one year postpartum (1). Scholarly research indicates that extending postpartum coverage is critical to reduce maternal deaths from treatable and preventable causes, especially for BIPOC birthing persons (1). Expanded postpartum care is also essential for the treatment of postpartum depression, anxiety, and other mood disorders which often take months to diagnose and total over \$14 billion in health spending if untreated (11). Submitting a Section 1115 waiver to CMS, like fellow expansion states Illinois and New Jersey, could extend Nevada Medicaid beyond 60 days postpartum here in Nevada and allow practitioners and new mothers to ensure their physical and emotional health (18).

Pre- and postnatal care are unique instances in which expanding coverage decreases not only adverse health outcomes, but also cost to Medicaid and taxpayers. In 2007, the Institute of Medicine calculated a preterm birth typically resulted in \$33,200 in healthcare expenditures, while a full-term birth resulted in a \$3,325 bill, a nearly \$30,000 difference (8). According to the CDC, approximately 10% of deliveries in the United States are preterm (less than 37 weeks of gestation) (15). If access to prenatal care allows for a decrease in preterm birth rates, there is opportunity for significant cost savings.

While Nevada Medicaid currently covers pregnancy-related care, the process to guarantee coverage could be streamlined. Presumptive eligibility (PE) allows “qualified entities,” including hospitals, health departments, and federally qualified health centers (FQHC), to determine eligibility and then immediately, temporarily enroll patients in Medicaid (1). Extending PE to pregnant women in Nevada would guarantee not only coverage for those presenting to the hospital in labor, but also those who visit an FQHC with high blood pressure at 28 weeks, or an emergency room with bleeding at 15 weeks. This would provide instant access to care and begin the process of applying for coverage that will last throughout the pre- and postnatal periods. Extending Medicaid to lawfully residing pregnant women would decrease administrative burden and increase access to prenatal and postnatal care. Twelve months of postpartum coverage could improve our abysmal maternal mortality rates and increase access to vital mental health services. Nevada Medicaid policies can do more to support women and their infants in the first year of life.

## **RECOMMENDATIONS FOR IMPROVEMENT:**

- Expanding Medicaid presumptive eligibility (PE) for pregnant women to receive early prenatal care by expanding the pool of providers allowed to process PE claims
- Expanding Medicaid coverage to include 12-month eligibility for post-partum care
- Eliminating the 5-year wait-period for lawfully residing pregnant women to be eligible for Medicaid

## REFERENCES & FURTHER READING GUIDE

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