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Addressing Social Determinants of Health for Pregnant and Postpartum Medicaid Beneficiaries

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, and age that affect a wide range of health and quality-of-life outcomes. Complex structural, environmental, and social factors have an impact on the health and well-being of pregnant and postpartum people. Factors such as food insecurity, housing instability, and chronic stress associated with experiencing interpersonal violence and poverty, can limit access to timely quality care and contribute to adverse maternal health outcomes. Recognizing the interconnectedness between unmet social needs and health and addressing SDOH has the potential to increase access to care and improve maternal health.

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The U.S. has the highest rate of maternal mortality among developed nations, with more than 80 percent of pregnancy-related deaths being preventable. Stark disparities in pregnancy-related mortality persist, with Black, American Indian and Alaskan Native, and non-Hispanic Native Hawaiian and Pacific Islander people at least two to four times as likely to die from a pregnancy-related cause than non-Hispanic White people. Severe maternal morbidity, defined as unexpected outcomes of labor and delivery that result in significant short- or long-term health consequences, has also increased in recent years and is estimated to affect more than 50,000 people each year. In addition, the U.S. infant mortality rate increased by 3 percent from 2021 to 2022, the first year-to-year increase in 20 years.

As part of longstanding efforts to reduce health disparities and advance maternal and infant health, states are increasingly developing holistic approaches to address the health and social needs of pregnant and postpartum people. This brief highlights state approaches to addressing SDOH and improving quality of care for pregnant and postpartum Medicaid beneficiaries.

Federal Priorities in Addressing SDOH for Pregnant and Postpartum People

SDOH is a federal priority and key strategy to combat the maternal mortality crisis and longstanding disparities in maternal and infant health outcomes.

White House

- The White House Blueprint for Addressing the Maternal Health Crisis outlines five federal maternal health priorities, including a goal to strengthen economic and social supports for people before, during, and after pregnancy, with a focus on actions to address housing insecurity, food insecurity and nutrition, environmental risks, economic insecurity, and personal safety.
- The White House U.S. Playbook to Address Social Determinants of Health lays out structural actions federal agencies are undertaking to break down silos in the health care system and support equitable health outcomes by improving the social circumstances of individuals and communities.

Health Resources and Services Administration (HRSA)

- In support of the goal to strengthen economic and social supports for people before, during, and after pregnancy, as outlined in the White House Blueprint for Addressing the Maternal Health Crisis, HRSA is making investments to increase access to basic social and health services and foster linkages among health care providers, social service organizations, state Medicaid programs, and health departments to improve pregnancy and postpartum care.
- HRSA launched the year-long Enhancing Maternal Health Initiative in 2024, which aims to strengthen, expand, and accelerate HRSA's maternal health work in partnership with mothers, grantees, community organizations, and state and local health officials. HRSA is bringing together grantees from 11 states and Washington, DC, to drive progress in maternal health and address the maternal mortality crisis.

Centers for Medicare & Medicaid Services (CMS)

- The CMS Maternity Care Action Plan identifies social support as a key gap for individuals receiving maternity care. The plan notes that CMS is identifying promising approaches for state Medicaid agencies to directly provide or link Medicaid members to appropriate social support services, including tenancy-related services, housing vouchers, nutrition services, and others.
- CMS released a state health official letter in 2021 on opportunities to address SDOH in Medicaid and CHIP. The letter outlines federal and managed care authorities that state Medicaid and Children's Health Insurance Program (CHIP) programs can use to address social needs. In 2023, CMS released a Medicaid and CHIP Health-Related Social Needs Framework, which outlines the health-related social needs (HRSN) services and supports allowable under specific Medicaid and CHIP authorities and provides considerations for each authority.
- CMS announced the Transforming Maternal Health (TMaH) Model in 2023. The model is a 10-year payment and care delivery model that aims to support participating state Medicaid agencies in developing and implementing a whole-person approach to pregnancy, childbirth, and postpartum care for women with Medicaid and CHIP coverage, including screening for and addressing health-related social needs.

Centers for Disease Control and Prevention (CDC)

- In partnership with states, territories, and local jurisdictions, the CDC launched a new phase of the Pregnancy Risk Assessment Monitoring System (PRAMS) core questionnaire in 2023 that includes questions addressing SDOH. The supplemental questionnaire also gathers information on experiences before, during, and after pregnancy, including on SDOH, experiences of discrimination, and respectful care to help inform program and policy to improve maternal health.

State Approaches to Addressing SDOH for Pregnant and Postpartum People

States are using a range of federal programs and cross-sector strategies to support SDOH efforts for pregnant and postpartum people. Medicaid plays a key role in perinatal health coverage as the largest single payer of pregnancy-related services, covering 41 percent of births nationally. As of May 2024, 46 states and DC have also extended Medicaid postpartum coverage from 60 days to 12 months to ensure continuity of coverage during the period of elevated health risk that follows childbirth. States can support the SDOH needs of pregnant and postpartum people through public insurance financing. Emerging areas of focus for addressing SDOH for the perinatal population include improving child care access, food and nutrition security, housing stability, interpersonal safety, and transportation access.

Access to High Quality Child Care

Access to reliable, high-quality child care is critical for families. Child care gives parents the ability to work to financially support their families, allows pregnant and postpartum people to attend medical appointments, and supports healthy developmental outcomes for children. Lack of child care is recognized as a significant barrier to accessing medical care. Logistical barriers related to the gender roles and expectations of pregnant and postpartum people as caretakers impact access to care, with 14 percent of women missing or delaying their own health care due to a lack of child care. Although this barrier affects all pregnant and postpartum people, those who are low-income are more likely to experience barriers in obtaining child care and accessing health care.

Indiana Family and Social Service Administration's Pregnancy Promise Program (PPP) is a part of the Center for Medicare and Medicaid Innovation Maternal Opioid Misuse Model. The model works to integrate behavioral health and opioid use disorder (OUD) treatment while providing care coordination and other supports to alleviate common barriers, such as transportation and child care. Indiana's PPP partnered with the Office of Early Childhood and Out-of-School Learning (OECOSL) to address barriers to child care for program participants. As a result, PPP participants are prioritized to receive federal child care vouchers from the Child Care and Development Fund, recognizing the parent's substance use treatment, mental health services, and postpartum follow-up care as the service need for child care. According to the PPP 2022 Annual Report, more than $84,000 in child care funding was used by PPP families within the first six months of launching the initiative. In 2023, 45 children benefited from child care funds resulting from parental participation in the PPP. The partnership between the OECOSL and PPP is a model for other states to connect parents with OUD to child care to support sustained treatment and recovery.

Food and Nutrition Security

Food and nutrition insecurity during pregnancy is linked to adverse perinatal health outcomes, such as high blood pressure, postpartum depression, and other pregnancy complications. Children from food-insecure households have a higher risk of developing acute and chronic health problems and are more likely to forego medical care. Black households (21.7 percent), Hispanic households (17.2 percent), households with children headed by a single woman (27.7 percent), and rural households (11.6 percent) experience much higher rates of food insecurity compared to the national average (10.5 percent). States are using a variety of policy approaches to finance services that support food and nutrition security and improve health outcomes.

Massachusetts is using a section 1115 demonstration waiver to provide services that address health-related social needs (HRSN) through the Flexible Service Program (FSP), including time-limited housing supports, nutrition education, medically tailored meals, and time-limited food assistance. Medicaid members eligible for services include pregnant individuals who are experiencing high-risk pregnancy or complications associated with pregnancy, including those who are up to 60 days postpartum, their children up to one year of age, and children born of the pregnancy up to one year of age. The specific nutrition supports provided through FSP include nutrition counseling and education, up to three home-delivered meals per day for up to six months, medically tailored or nutritionally appropriate food prescriptions for up to six months, and cooking supplies, including pots and pans, utensils, and refrigerators, when not available through other programs.

In February 2021, **Delaware's** Medicaid program began a state-funded postpartum food bank delivery pilot program. The intent of the program was to reduce burden on new moms and families, address heightened food insecurity, and alleviate stress of traveling outside the home during the COVID-19 pandemic. The state partnered with the Food Bank of Delaware to provide food and diapers, its Medicaid managed care organizations to administer the program, and its non-emergency medical transportation broker to deliver the items. Eligible postpartum Medicaid members received up to two shelf-stable food boxes, up to two boxes of diapers, and one pack of baby wipes per week for up to eight weeks postpartum. Delaware received overwhelmingly positive feedback from members and partners that participated in the program. The program also showed initial benefits in health outcomes, with 85 percent of postpartum members attending a postpartum visit and 95 percent of infants in the program going to at least one well-child visit.

In May 2024, CMS approved Delaware Medicaid's section 1115 demonstration waiver extension request, which formally pilots the Postpartum Nutrition Supports Initiative for over 8,800 postpartum members. The approval allows for coverage of two home-delivered meals per day or one medically appropriate shelf stable food box that does not constitute a full nutritional regimen, up to eighty diapers per week and up to one pack of baby wipes.

This benefit is for postpartum beneficiaries enrolled in Delaware's Diamond State Health Plan 1115 demonstration waiver for the first twelve weeks of the postpartum period, reaching low-income postpartum members with disproportionately high rates of food insecurity and inequitable adverse maternal and birth outcomes.

Housing Stability

Housing instability during pregnancy is associated with adverse perinatal outcomes, including preterm birth, low infant birthweight, neonatal intensive care unit admissions, and delivery complications. Many social factors can contribute to a pregnant person's ability to obtain and maintain housing, including economic instability and experiences of interpersonal violence. Infancy is a particularly vulnerable period for housing instability, as a person is most likely to experience homelessness in their first year of life. Housing instability during infancy is associated with poor health outcomes, including longer stays in neonatal intensive care units, emergency department visits, asthma diagnoses, and higher health care spending. Stable and safe housing is important for the health and well-being of parents and the growth and development of children.

Creating and sustaining housing programs for pregnant people and their families requires collaboration across federal, state, and local levels of government and sectors, including across behavioral health, housing, Medicaid, and public health agencies. Medicaid is an important resource for funding housing-related services, but effective health and housing initiatives often require braiding funds from additional sources to achieve the "three-legged stool" of supportive housing: affordable housing stock, rental assistance, and supportive services. Permanent supportive housing is an evidence-based model that provides affordable housing with voluntary support services that build tenancy skills and connect people to community-based health care, treatment, and employment services.

States can leverage a variety of Medicaid authorities, including through their state plans, waivers, and Medicaid managed care arrangements, to cover housing-related services for Medicaid beneficiaries. While federal law prohibits Medicaid from paying for housing itself, states are increasingly covering supportive services, and CMS has approved short-term rental assistance (up to six months) through section 1115 demonstration waivers. As of May 2024, 19 states have received approval for section 1115 demonstration waivers with housing support provisions, and additional states have demonstrations pending CMS review.

Arizona's section 1115 demonstration waiver extends longstanding waiver authorities and adds programs that provide health-related social needs services to certain populations experiencing life transitions, including pregnancy. Covered services include short-term post-transition housing for up to six months, including associated utility assistance, housing supports, pre-tenancy and tenancy sustaining services, and medically necessary home modifications. The services also include case management, outreach, and education, as well as infrastructure investments to support these services. The waiver also directs Medicaid

managed care organizations to make incentive payments to providers that meet certain targets related to improving health equity for targeted populations through addressing health-related social needs.

Interpersonal Safety

Interpersonal violence is associated with adverse maternal health outcomes, including poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight. Professional organizations, such as the American College of Obstetricians and Gynecologists, recommend providers screen for interpersonal violence as a part of routine health exams to review available prevention and referral options for pregnant and postpartum people. Guidance outlined in the Affordable Care Act requires Medicaid, contracted health plans, and private payers to provide reimbursement for interpersonal violence screening. States have been implementing a range of approaches to operationalize this requirement and leverage their Medicaid programs to provide targeted supports to pregnant and parenting people at risk of or experiencing interpersonal violence.

North Carolina is using a section 1115 demonstration waiver to support the Healthy Opportunities Pilots, including through reimbursement of SDOH screening and support services for interpersonal violence. These supports can be crucial for Medicaid members in a state where 47 percent of women have experienced interpersonal violence. The Healthy Opportunities Pilots support North Carolina Medicaid Managed Care members with one qualifying health condition and one qualifying social risk factor. North Carolina uses a screening questionnaire that is available in multiple languages through its Healthy Opportunities Pilots to identify interpersonal safety needs.

Reimbursement rates under the North Carolina Healthy Opportunities Pilots' interpersonal violence domain include:

- Interpersonal violence case management services, per member per month (PMPM) $221.96
- Violence intervention services, PMPM $168.94
- Evidence-based parenting curriculum, one class $22.60
- Home visiting services, one home visit $67.89
- Dyadic therapy, per occurrence $68.25

States are also leveraging opportunities to screen for interpersonal violence as part of dyadic treatment, often through the Early and Periodic Screening, Diagnosis, and Treatment benefit. For example, **West Virginia** incorporates screening for interpersonal violence in its Early and Periodic Screening, Diagnosis, and Treatment HealthCheck Program Preventive Health Screen. The screening, developed to be administered to a parent or caregiver, identifies if a child has witnessed or has been threatened with violence and/or abuse and if the caregiver has experienced physical, emotional, and/or sexual abuse.

Transportation Access

Among the Medicaid population, 2.5 million members (5.2 percent) delayed care due to transportation barriers in 2018, with women reportedly delaying care at a higher rate than men. Some pregnant and postpartum people need to travel far to access care, especially in areas with a shortage in maternal health care providers and hospitals. Nearly 50 percent of U.S. counties do not have a single practicing ob-gyn. As of 2018, half of rural U.S. counties did not have a hospital that provides obstetric services, and more than 2.2 million women of childbearing age live in maternity care deserts, where there are no hospitals or birth centers providing obstetric care. The COVID-19 pandemic exacerbated these transportation barriers, with at least 36 rural hospitals closing since 2020, further limiting access to obstetric services.

Some pregnant and postpartum Medicaid members require transportation assistance to attend medical appointments. State Medicaid agencies are required to administer the non-emergency medical transportation benefit to all Medicaid members, providing coverage for rides to and from medical appointments to those who may not otherwise have a means to accessing care. States determine the scope of the benefit through their Medicaid state plan, with most states covering trips in cars, vans, buses, and trains. Some states also cover transportation and lodging to out-of-state medical appointments.

Michigan's Maternal Infant Health Program (MIHP) is a statewide evidence-based home visiting program for Medicaid eligible pregnant people and infants up to 12 months of age. The program aims to identify racial or ethnic disparities in the postpartum care visit rate and strategies to improve health equity. Pregnant people, infants, and their families enrolled in MIHP receive care coordination, intervention services, and personalized care plans developed by MIHP providers, including nurses, social workers, nutritionists, lactation consultants, and infant mental health specialists.

MIHP providers use a Maternal Plan of Care transportation worksheet to assist eligible Medicaid members in accessing transportation services. The transportation plan of care prompts the home visitor to discuss options for transportation, which include those provided by a Medicaid health plan. There is an established referral process among the health plan, pilot clinics, and maternal infant health programs regarding transportation scheduling assistance and how to track the transportation services. The brief interventions used by home visitors include discussing transportation concerns, ensuring the Medicaid member has accurate contact information for Medicaid health plan transportation services, discussing the scheduling process for transportation services, developing an emergency transportation plan, and more. Pregnant people who participated in the program were 1.5 times more likely to receive appropriately timed postpartum care than those who did not participate.

California provides nonmedical transportation services to Medicaid members with full-scope Medi-Cal or who are pregnant up to 12 months postpartum. Nonmedical transportation under Medi-Cal is transportation by private or public vehicle for Medi-Cal enrollees, including Medi-Cal managed care members, who do not have another way to get to their appointment. Pregnant people seeking nonmedical transportation can access all covered Medi-Cal services, including reproductive health services (e.g., prenatal care, family planning services, abortion care). Members can also use nonmedical transportation services to pick up reproductive health-related prescriptions that cannot be mailed directly to members.

Arkansas Maternal Life360 HOME Services

An amendment to Arkansas' section 1115 demonstration waiver, "Arkansas Health and Opportunity for Me," approved in 2022, created Maternal Life360 HOMEs to provide social supports and services for individuals with high-risk pregnancies up to two years postpartum, regardless if an individual's Medicaid eligibility changes. Clinicians determine whether a patient is high risk, and Life360 home visitors screen for health-related social needs (HRSN) to inform delivery of supports.

The program builds upon the state's existing home visiting structure administered by the Arkansas Department of Health and supported by federal Maternal, Infant and Early Childhood Home Visiting funds. There are four evidence-based models in Arkansas eligible for reimbursement through Life360 HOMEs. Eligible Maternal Life360 providers must be a hospital that is a licensed general hospital in Arkansas or a border state and provides obstetrical services. Hospitals serving as Life360 HOMEs can partner with an organization(s) providing an evidence-based program, and the state will provide resources and tools to Life360 HOMEs to encourage partnerships.

Through the home visiting intervention, women will be assisted to connect with housing, food, education and training, and other services in their communities. Housing services may include linkages to tenancy-sustaining services and tenant rights education/eviction prevention, and coverage of one-time housing transition and moving costs. Additional supports that can be covered are non-medical transportation services and nutrition supports, including counseling, education, and meal preparation.

Home visiting services are reimbursed at a rate of $300 per member per month. Non-medical transportation is also reimbursable up to $50,000 annually and includes transportation to home visits and to non-medical appointments or to receive HRSN supports. Providers can receive up to two $50,000 start-up payments to develop staff capacity and infrastructure necessary to operate the program.

Key Considerations

States are using a range of federal programs, policy strategies, and cross-sector program approaches, including to leverage public insurance financing, assess health-related social needs, facilitate referrals to services, and support the workforce to address SDOH for pregnant and postpartum people. As states develop programs and initiatives that address SDOH, they can consider ways to ensure these approaches are advancing equity and improving quality of care for pregnant and postpartum Medicaid beneficiaries.

- **Health-Related Social Needs (HRSN) Screening and Assessment:** To identify unmet social needs of pregnant and postpartum people, states can consider approaches to screening for HRSN that ensure respectful care and privacy and are not burdensome to Medicaid members seeking care. States considering implementing universal HRSN screening in clinical settings can also consider providing screening training for providers and creating customizable screening questionnaires. Several states have leveraged Medicaid managed care contracting to incentivize or require screening and referral for unmet social needs.
- **Referrals to Programs that Address HRSN:** States are working to integrate referrals to services when screenings identify social needs in clinical settings to ensure pregnant and postpartum people are connected with appropriate health and social services. States can strengthen cross-sector partnerships to identify barriers and design approaches that facilitate referrals to needed services and enrollment in federal and community-based programs that provide food, housing, child care, and other supports. States can increase access to these services by leveraging the role of Medicaid managed care, pursuing integrated eligibility systems and policies, implementing closed-loop referral systems, engaging with community-based providers, and strengthening care coordination efforts for pregnant and postpartum people.
- **Data-Sharing and Systems Integration:** Data-sharing is a critical tool for improving health outcomes driven by social needs. Among state agencies, data exchange is central to informing policymaking, understanding priority target populations, shaping needed intervention approaches, and conducting cost analyses for interventions. Data-sharing at the local level can be critical in improving coordination between state health and social services systems and community-based organizations to improve access to services and outcomes. States can consider a range of approaches to data-sharing and systems integration to address siloed systems and complex privacy laws at the state, federal, and local level and across the health and social services sectors.

- **Supporting the Perinatal Health Workforce:** Expanding the perinatal health workforce to include community-based providers can increase access to care for pregnant and postpartum people and help connect them to social services. States can consider providing Medicaid coverage for services provided by community health workers, doulas, midwives, and home visitors. States can leverage opportunities to support the growth and development of this workforce. States can consider requiring cultural competency training for community-based and clinical providers to ensure pregnant and postpartum receive equitable, respectful care.
- **Strengthening Cross-Sector Partnerships:** States can collaborate across agencies, including public health and Medicaid, to strengthen efforts to provide whole-person care to pregnant and postpartum people and improve maternal health outcomes. States can also engage with community-based organizations to maximize the impact of services that address SDOH.

Additional Resources

- White House Blueprint for Addressing the Maternal Health Crisis
- White House The U.S. Playbook to Address Social Determinants of Health
- CMS Maternity Care Action Plan
- CMS Coverage of Health-Related Social Needs Services in Medicaid and the Children's Health Insurance Program
- CMS A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights
- NASHP Health and Housing Resource Center
- NASHP Q&A: Getting More Bang for the Buck in Oklahoma's Food Security Initiative

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