

GOAL 1

**WHITE HOUSE
BLUEPRINT
EVIDENCE TO
ACTION BRIEFS**



**Increase Access to and
Coverage of Comprehensive
High-Quality Maternal Health
Services, Including Behavioral
Health Services**



Maternal Health
Learning & Innovation Center™
MaternalHealthLearning.org

**THE WHITE HOUSE BLUEPRINT
FOR ADDRESSING THE
MATERNAL HEALTH CRISIS**



The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action Brief highlights Goal 1 of the White House Blueprint.

Maternal Health Goal 1

Increase access to and coverage of comprehensive high-quality maternal health services, including behavioral health services.

CONTRIBUTION TO QUALITY OF LIFE

The [White House Blueprint](#) is a “whole-of-government approach to combating maternal mortality and morbidity” so that *all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe*.

As the White House Blueprint emphasizes: “The first step towards ending the maternal health crisis is to ensure that everyone can access and have affordable coverage of comprehensive health care services, regardless of where they live or how much they earn.”^{1, pg.21} Addressing gaps in insurance coverage both before and after pregnancy contributes to increased utilization of primary care services and increased access to behavioral and mental health services, which leads to a decreased risk of poor maternal and infant outcomes.

BASIC FACTS

Health insurance helps increase access to timely prenatal and postpartum care, which can lead to improved maternal and infant outcomes. Insurance coverage has been identified in a recent Centers for Disease Control and Prevention (CDC) report to be a key contributor to improving maternal mortality and “a prerequisite for access to quality health care before, during and after pregnancy.”³

In addition to comprehensive, continuous insurance coverage for the physical needs of individuals capable of becoming pregnant, to achieve equitable maternal health and well-being, behavioral health services must be covered by insurance. Untreated behavioral health conditions, such as post-traumatic stress, perinatal anxiety, and panic attacks, can impact the well-being of the baby and the family.⁴ Mental and behavioral health problems are the leading underlying cause of pregnancy-associated deaths, including suicides, and drug overdoses or poisoning.^{1, pg. 21}

To reduce coverage gaps, improve access to high-quality care, and address geographical barriers to health care access, the [White House Blueprint](#) commits to the following actions:



Action 1.1. **Work to ensure women have comprehensive, continuous maternal health insurance coverage during pregnancy, and for no less than one year afterwards**, by encouraging states to leverage the American Rescue Plan Act of 2021 state plan option to provide 12 months postpartum Medicaid and Children’s Health Insurance Program (CHIP) coverage. The Biden Administration also urges Congress to make 12 months of postpartum coverage mandatory for all state Medicaid and CHIP programs and to close the Medicaid coverage gap.

Action 1.2. **Serve as a model employer for maternal health care coverage** by strengthening coverage, benefits, and services around maternal care across the Office of Personnel Management (OPM) via the Federal Employees Health Benefits (FEHB) Program, Department of Health and Human Services (HHS) (including the Indian Health Service [IHS]), Department of Veterans Affairs (VA), and the Department of Defense (DoD).

Action 1.3. **Improve rural obstetric readiness at hospitals and IHS facilities** by developing guidelines and standards so facilities without obstetric units are still “obstetric ready,” expanding the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program to enhance access to maternal and obstetric care in rural communities, and providing free readily accessible online obstetrical trainings to HRSA-funded health centers and free clinics to support the delivery of competent preconception, prenatal, intrapartum, and postpartum care.

Action 1.4. **Strengthen risk-appropriate care in rural and urban areas** by encouraging states to implement the CDC Levels of Care Assessment Tool (CDC LOCATeSM), a web-based, standardized assessment of birthing facilities that allows states to see the distribution of the levels of care (e.g., basic care, specialty care) at facilities throughout the state.

Action 1.5. **Expand access to family planning services, including pre-pregnancy health and contraception**, by supporting Title X Family Planning Program providers, issuing guidance from the Military Health System requiring walk-in contraceptive clinics at all military medical treatment facilities, and ensuring all enrolled veterans of childbearing age receiving care at VA are assessed for pregnancy intention during a primary care visit.

Action 1.6. **Reduce uncontrolled hypertension** through an IHS pilot program to expand utilization of self-monitored blood pressure management equipment and through targeted interventions by VA to manage enrolled veterans of childbearing age with hypertension and other known risk factors for developing preeclampsia. Improve quality of care provided to pregnant and postpartum women with or at risk for hypertensive disorders of pregnancy by disseminating self-measured blood pressure monitoring tools and resources for obstetrical providers, primary care professionals, and the pregnant and postpartum women they serve.

Action 1.7. **Improve quality of care provided to pregnant and postpartum women with or at risk for hypertensive disorders of pregnancy** by disseminating self-measured blood pressure monitoring tools and resources for obstetrical providers, primary care professionals, and the pregnant and postpartum women they serve.

Action 1.8. **Facilitate continuity of care for service members and veterans** by identifying avenues to ensure pregnant service members are aware of their prenatal care options upon leaving active service.



Action 1.9. **Ensure veterans return to primary care after they deliver.** The Maternity Care Coordination Program, via the VA, will ensure veterans schedule a return to primary care visit within 12 weeks postpartum.

Action 1.10. **Strengthen supports and access to perinatal addiction services for individuals with substance use disorder (SUD)** by partnering with hospitals and community-based organizations to implement evidence-based interventions.

Action 1.11. **Keep mothers and their infants together** by developing resources for state, tribal, and local correctional facilities to create residential programs for pregnant and postpartum inmates, based on Bureau of Prisons programs.

Action 1.12. **Establish a National Maternal Mental Health Hotline for pregnant individuals and new mothers facing mental health challenges to increase access to mental health care.** “The National Maternal Mental Health Hotline is a 24-hour, toll-free hotline...with qualified counselors who can provide support in English and Spanish via voice and text.”

Action 1.13. **Appoint a head of women’s mental health and substance use.** “HHS will hire a dedicated Associate Administrator for Women’s Services in HHS’s Substance Abuse and Mental Health Services Administration (SAMHSA) to lead its efforts on promoting positive mental health during pregnancy and in the postpartum period.”

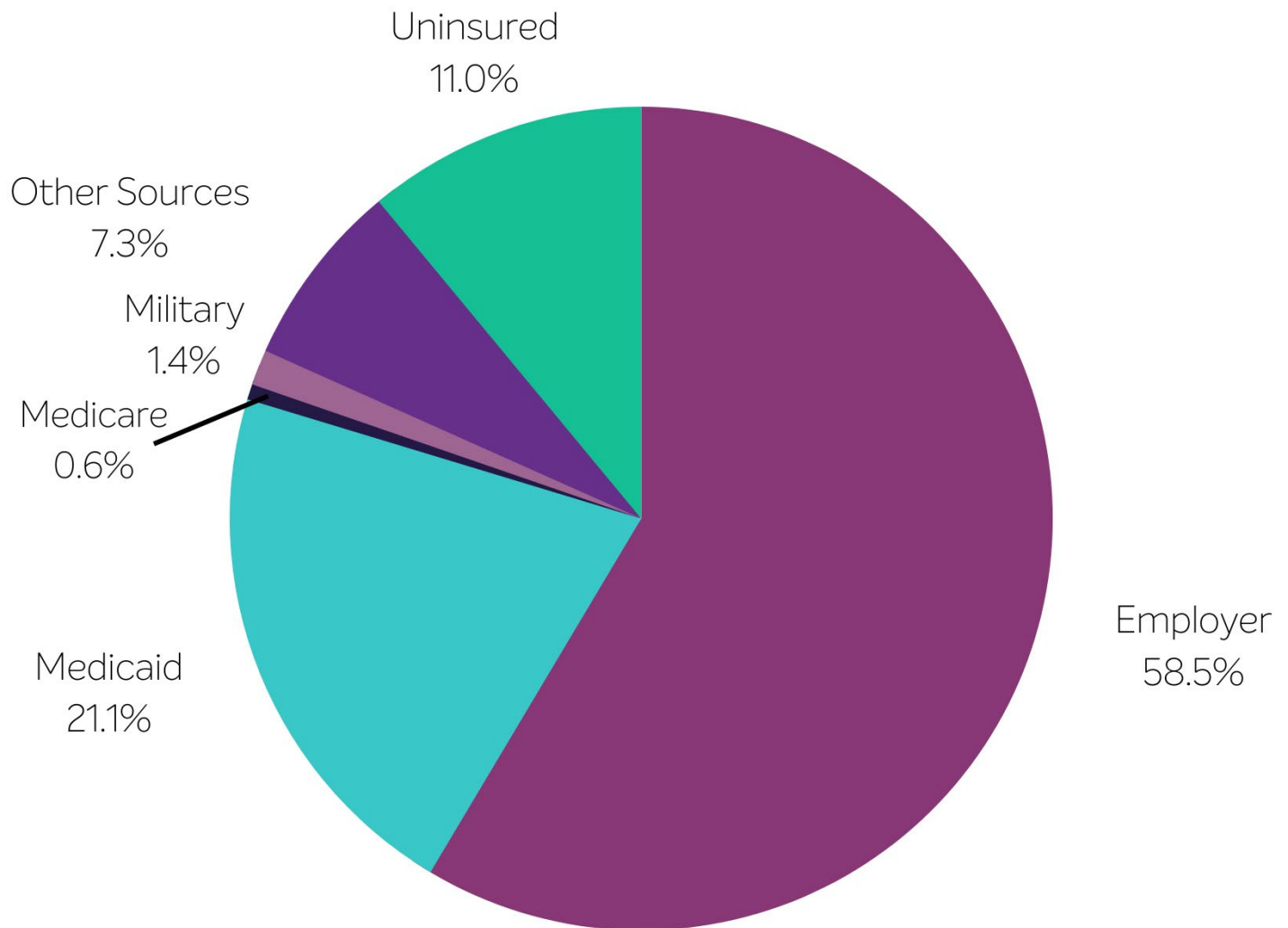
Action 1.14. **Expand capacity to screen, assess, treat, and refer for maternal depression and related behavioral disorders** by providing real-time psychiatric consultation, care coordination support, and training to frontline health care providers.

Action 1.15. **Integrate behavioral health supports in community settings** by training navigators and community health workers to identify behavioral health needs and link families to local resources, such as medical homes, school based and other community health centers, community-based organizations, and local community social supports.

HOW ARE WE DOING?

Below we highlight data related to Goal 1. Racial, ethnic, geographic, and socioeconomic disparities highlight where efforts should be focused to improve health outcomes related to the goal.

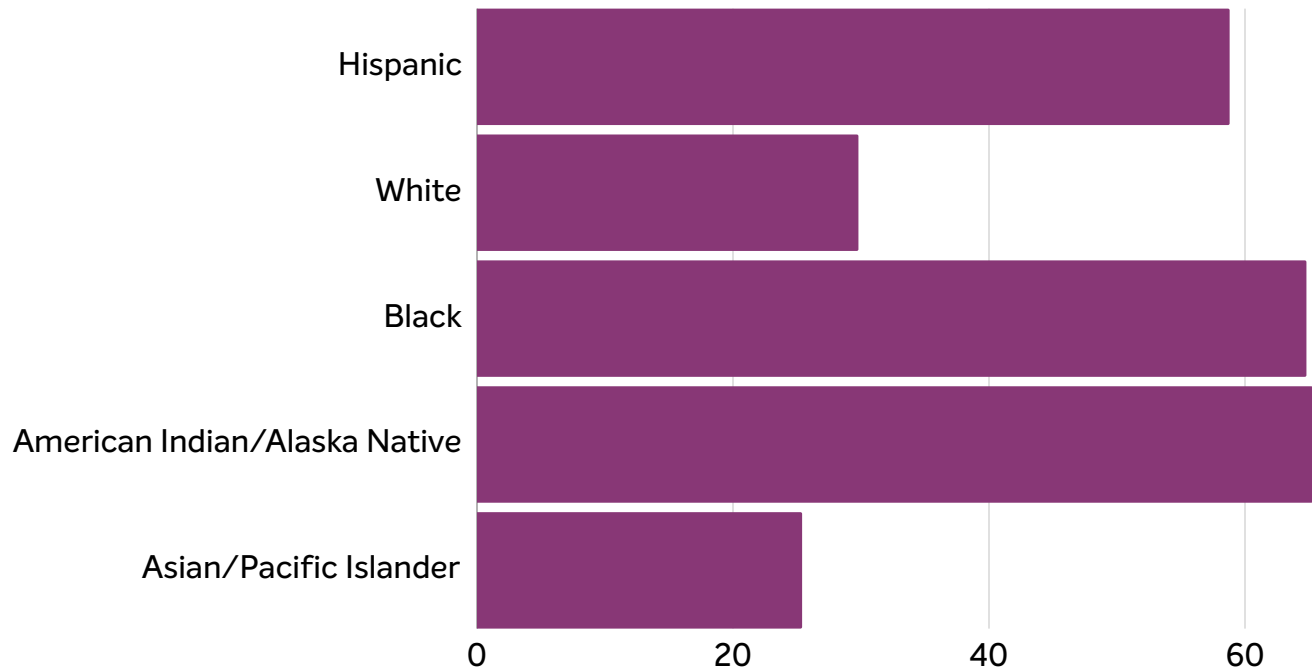
Figure 1: Percentage of Women Age 15 to 49 with Health Insurance



In the US, among women 15 to 49 years of age, 58.5% have insurance from their employer, 21.1% from Medicaid, 0.6% from Medicare, 1.4% from the military, and 7.3% from other sources. Just over 11% of women are uninsured.

Source: [Kaiser Family Foundation. Health Insurance Coverage. 2021.](#)

Figure 2: Percentage of Medicaid Coverage by Race/Ethnicity in the United States, 2018-2020

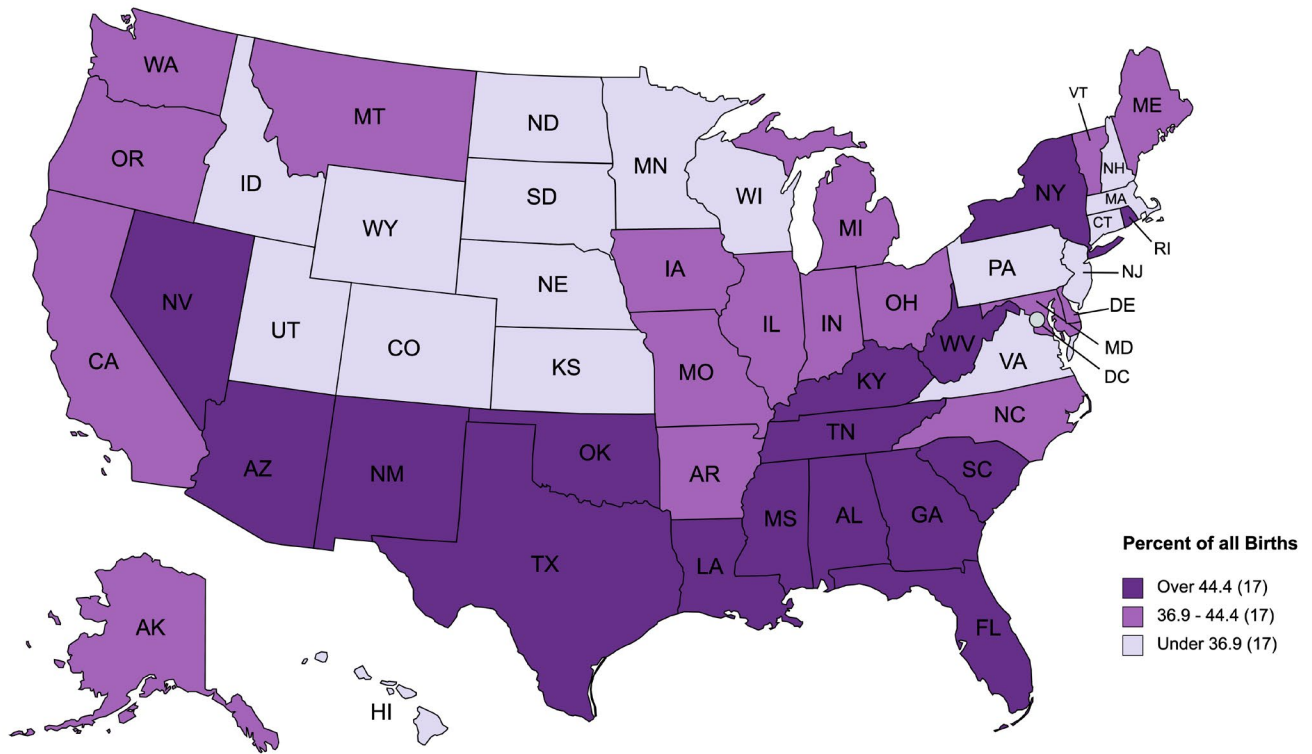


Between 2018 and 2020, Medicaid coverage was highest at the time of birth for American Indian/Alaska Native women (65.3%), followed by Blacks (64.8%), Hispanics (58.8%), Whites (29.8%) and Asian/Pacific Islanders (25.4%).

Source: [March of Dimes Peristats](#), 2018-2020.



Figure 3: Percentage of Births Covered by Medicaid, 2020



In 2020, Medicaid covered more than 44% of all births in the US. 44.4% of all births covered by Medicaid occur in 17 states (CA, OR, WA, MT, ME, IN, IL, IA, MO, AR, MI, OH, NC, DE, MD, VT, AK).

Source: [March of Dimes, Peristats](#), 2020.

STORY BEHIND THE DATA: FACTORS AFFECTING PROGRESS

Insurance coverage varies by race, ethnicity, socioeconomic status, and geography. (See Figure 1.) Lack of insurance coverage as well as insurance disruptions affect access to health services before, during, and after childbirth for women and those capable of becoming pregnant. Insurance disruptions occur as a result of changes in employment, marital status, income, and Medicaid eligibility.⁴ One of the most significant barriers affecting progress toward the goal of expanding access to and coverage of comprehensive high-quality maternal health services, including behavioral health services, is the lack of states that have expanded Medicaid and postpartum care for up to 12 months. In states without Medicaid expansion, coverage is limited from conception to 60 days after delivery.⁴ Considering that “over 80% of pregnancy-related deaths occur before delivery or within the postpartum period”⁵ and more than 11% of deaths occur between 42 and 365 days postpartum, expanding Medicaid coverage for up to 12 months postpartum is a crucial component of decreasing maternal mortality.

Medicaid is essential in providing care for maternal and behavioral health needs – it covers more.⁶ Medicaid covers more than 40% of all births in the US (see Figures 2 and 3). In 2019, among women of childbearing age, Medicaid covered 24% of those with mental illness and 30% of those with serious mental illness (SMI).⁶ While the expansion of Medicaid and/or the extension of postpartum care up to 12 months has demonstrated decreases in maternal mortality and morbidity,^{4,6} without adequate access to health care providers and networks of providers, Medicaid expansion will continue to be insufficient.⁶

Women with Medicaid are more likely to



experience a gap in insurance compared with women with private insurance. “Nearly half of women in Medicaid non-expansion states and nearly 1 in 3 women in Medicaid expansion states experienced an insurance disruption from preconception to postpartum.”⁶ There are also important disparities to note. Authors of a cross-sectional analysis of survey data from 107,921 women in 40 states found that “disruptions in perinatal insurance coverage disproportionately affect Indigenous, Hispanic, and non-Hispanic Black women. Differential insurance coverage may have important implications for racial-ethnic disparities in access to perinatal care and maternal-infant health.”²

The [White House Blueprint](#) outlines 15 actions under Goal 1 that aim to improve maternal and infant health outcomes by increasing access to and coverage of comprehensive high-quality maternal health services, including behavioral health services.

WHAT CAN BE DONE TO ADDRESS THE ISSUE?

The [White House Blueprint](#) identifies actionable steps to address Goal 1. In addition, experts from the maternal and child health (MCH) field have identified innovative, evidence-informed strategies from several databases and national repositories.

Maternal and Child Health Innovations

MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program's Innovation Hub](#), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what’s working” in the MCH field; the [Robert Wood Johnson Foundation's What Works for Health](#) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.

- [Eligibility-expanded insurance coverage/ Medicaid eligibility](#). Adopt protocols to ensure all persons in maternal health programs are referred for enrollment in health insurance at public and private health care facilities. (MCHbest)
- [Expansion of access to prenatal care](#). Expand access to prenatal care to increase coverage and improve health outcomes for immigrant women and their infants. (MCHbest)
- [Intensive case management for pregnant & parenting teens](#). Provides pregnant or parenting teens with services based upon their needs (e.g., counseling, connections to health care or social services, academic

support, etc.) in school or community settings. (RWJF)

- [Patient navigators](#). Provide culturally sensitive assistance and care coordination and guide patients through available medical, insurance, and social support; also known as systems navigators. (RWJF)
- [Value-based insurance design](#). Support the shift to value-based insurance design for all health insurance models within a state. (MCHbest)

Resources from the [Evidence Center's MCH Digital Library](#)

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, white papers, and more with seminal and historic resources. The following may support Goal 1.

- March of Dimes. [Nowhere to go: Maternity care deserts across the U.S.](#) 2022.
- Executives for Health Innovation. [Maternal health disparities: Challenges, trends, and the way forward.](#) 2022.
- [Maternal health: Hospital-based obstetric care in rural areas.](#) 2022.
- [Rural maternal health toolkit.](#) 2021.
- [Promising practices to reduce maternal mortality in New Jersey.](#) 2021.
- Association of Maternal and Child Health Programs. [Addressing Mental Health in BIPOC Communities: Key Cultural Considerations for MCH.](#) 2021.
- Association of Maternal and Child Health Programs and Association of State and Territorial Health Officials. [Maternal Mental Health Systems Change & IMD Exclusion Waivers.](#) 2021.
- Association of State and Territorial Health Officials and Association of Maternal and Child Health Programs. [Integrating Mental](#)

[and Primary Care for Perinatal People](#). 2021. Association of Maternal and Child Health Programs.

- U.S. Maternal and Child Health Bureau. [The case for integrated behavioral health care for mothers, children, and adolescents](#). 2020.

Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit maternalhealthlearning.org/Blueprint for more details.



REFERENCES

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The MHLIC is available for consultation, coaching, and technical assistance to support your implementation of any innovations to improve maternal mortality and morbidity. For more information, visit <https://maternalhealthlearning.org/connect>.

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