



SHO# 21-007
**RE: Improving Maternal Health
and Extending Postpartum
Coverage in Medicaid and the
Children's Health Insurance
Program (CHIP)**

December 7, 2021

Dear State Health Official:

Medicaid is the largest single payer of pregnancy-related services and covers over 42 percent of births nationally.¹ The Children's Health Insurance Program (CHIP) also covers pregnant adolescents and, in some states, low-income pregnant individuals with income over the Medicaid income limit. Together, Medicaid and CHIP play a critical role in ensuring access to care for pregnant and postpartum individuals, improving the quality of maternal health care, and addressing disparities in health outcomes and pregnant and postpartum care. Sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) give states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP beginning April 1, 2022. The purpose of this State Health Official (SHO) letter is to provide guidance to states on implementation of this new state option.

The newly extended postpartum coverage option offers states an opportunity to provide care that can reduce pregnancy-related deaths and severe maternal morbidity and improve continuity of care for chronic conditions such as diabetes, hypertension, cardiac conditions, substance use disorder, and depression. More than half of pregnancy-related deaths occur in the 12-month postpartum period, and 12 percent occur after six weeks postpartum. Significant and persistent disparities exist in pregnancy-related morbidity and mortality. Black and American Indian/Alaska Native individuals are up to five times more likely than White individuals to die from pregnancy-related complications and more likely to have a preventable death.² There are also disparities in rates of postpartum follow-up care for conditions associated with morbidity and mortality. Black individuals who had gestational diabetes were found to have among the lowest postpartum diabetes screening rates despite having the highest risk for progression to chronic diabetes.³ More generally, individuals who have a lower level of education, individuals who are Black or Hispanic, and individuals with co-existing morbidities, such as mental health

¹ Medicaid covers 42.1 percent of births nationally; National Center for Health Statistics, Birth Data (updated June 14, 2021). Available at <https://www.cdc.gov/nchs/nvss/births.htm>.

² Petersen, E. E., N.L. Davis, D. Goodman, et al. "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017." *Morbidity and Mortality Weekly Report*, vol. 68, no. 18, 2019, pp. 423–429. Exact rates differ by demographic data.

³ Herrick, C. J., Puri, R., Rahaman, R., Hardi, A., Stewart, K., & Colditz, G. A. (2020). Maternal Race/Ethnicity and Postpartum Diabetes Screening: A Systematic Review and Meta-Analysis. *Journal of women's health* (2002), 29(5), 609–621. Available at <https://doi.org/10.1089/jwh.2019.8081>.

conditions, have lower rates of postpartum care.⁴ Extended postpartum coverage presents an opportunity for states to improve postpartum care and address these disparities. States that have expanded Medicaid eligibility to provide coverage beyond 60 days postpartum report an increase in postpartum care visits, continuity in coverage, and enhanced engagement of individuals in health care.⁵

Background

Many pregnant individuals qualify for Medicaid on the basis of their pregnancy through the eligibility group for pregnant individuals described at 42 C.F.R. § 435.116. Pregnant individuals may also be eligible on another basis, for example, as a parent or caretaker relative or on the basis of disability status. States also have the option to extend coverage to lawfully residing pregnant individuals and children, if they otherwise meet eligibility requirements under the state’s program (commonly referred to as “the CHIPRA 214 option”). Under current law, pregnant Medicaid beneficiaries are eligible under the state plan for at least pregnancy-related services through the end of the month in which the 60-day period, beginning on the last day of pregnancy, ends (referred to as the “60-day postpartum period”).⁶ This continuous eligibility applies through the end of the 60-day postpartum period regardless of the eligibility group in which the beneficiary is enrolled, and is not affected by changes in income that would otherwise result in a loss of eligibility.⁷

Pregnant individuals also may be eligible for coverage in CHIP. Pregnant adolescents eligible as a “targeted low-income child” in CHIP can receive prenatal and postpartum care along with other child health assistance. States also have the option to extend CHIP eligibility to “targeted low-income pregnant women” through the end of the 60-day postpartum period, similar to Medicaid⁸, and to elect the CHIPRA 214 option for this population under section 2107(e)(1)(O) of the Act. In addition, states have the option to extend child health assistance to “unborn children” who meet other applicable eligibility criteria for coverage under the CHIP state plan, thereby providing coverage to pregnant individuals who themselves are not eligible for Medicaid or CHIP. Unlike postpartum coverage for targeted low-income pregnant individuals, postpartum coverage for pregnant individuals who received services during pregnancy on behalf of their unborn child is limited.

State Plan Option to Provide 12 Months Postpartum Coverage

The ARP provides Medicaid and CHIP agencies a new state plan option to provide 12 months of continuous postpartum coverage, regardless of any changes in circumstances, in Medicaid and CHIP (hereafter referred to as the “extended postpartum coverage option” or “extended postpartum coverage”). Section 9812 of the ARP adds a new section 1902(e)(16) of the Social

⁴ Jones, E.J., T.L. Hernandez, J.K. Edmonds, and E.P. Ferranti. “Continued Disparities in Postpartum Follow-Up and Screening Among Women with Gestational Diabetes and Hypertensive Disorders of Pregnancy: A Systematic Review.” *Journal of Perinatal Neonatal Nursing*, vol. 33, no. 2, 2019, pp.136–148.

⁵ Gordon, S.H., B.D. Sommers, I. Wilson, O. Galarraga, and A.N. Trivedi. “The Impact of Medicaid Expansion on Continuous Enrollment: A Two-State Analysis.” *Journal of General Internal Medicine*, vol. 34, no. 9, 2019, pp. 1919–1924.

⁶ Section 1902(e)(5) of the Social Security Act; 42 C.F.R. § 435.170

⁷ Section 1902(e)(6) of the Social Security Act; 42 C.F.R. § 435.170; CMCS Informational Bulletin, “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” (December 2020). Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>

⁸ Section 2112(d)(2)(A) of the Social Security Act

Security Act (the Act) to provide this authority in Medicaid, which is extended to CHIP through a new subparagraph (J) at section 2107(e)(1) of the Act, added by section 9822 of the ARP. When the state elects this option in Medicaid, it must also make the same election in a separate CHIP, as established under subparagraph (C) of section 1902(e)(16), as referenced in section 2107(e)(1)(J) of the Act. The option is currently limited to a 5-year period beginning on April 1, 2022.

The 12-month postpartum period begins on the last day of a beneficiary’s pregnancy and extends through the end of the month in which the 12-month period ends. Similar to the current 60-day postpartum period, under the extended postpartum coverage option, individuals are entitled to the extended postpartum coverage regardless of the reason the pregnancy ends. States that do not elect the extended postpartum coverage option must continue to provide coverage for pregnant individuals in Medicaid through the 60-day postpartum period as currently required.

States that elect to provide the extended postpartum coverage option are encouraged to educate beneficiaries about the availability of continuous extended postpartum coverage, including posting information on the state agency website and collaborating with providers and stakeholders in their state to provide outreach and education about the new option. States may use Medicaid and CHIP administrative matching funds for beneficiary and provider education and outreach. In addition, states are encouraged to update their notices to ensure pregnant individuals and beneficiaries are aware they are eligible for continuous extended postpartum coverage. States are reminded that program information on Medicaid and CHIP must be provided in plain language and in a manner that is accessible to individuals who have limited English proficiency or are living with disabilities, as required at 42 C.F.R. §§ 435.905(b) and 457.110(a).

Eligibility for Extended Postpartum Coverage

In states that elect the 12-month extended postpartum coverage option, beneficiaries who are eligible for and enrolled in Medicaid or CHIP while pregnant, including lawfully residing children and pregnant individuals covered under the state option provided for at sections 1903(v)(4)(A)(i) and 2107(e)(1)(O) of the Act (commonly known as the “CHIPRA 214” option), are eligible for continuous coverage for the duration of the extended postpartum period. Sections 1902(e)(16) and 2107(e)(1)(J) of the Act authorize 12 months of continuous extended postpartum coverage to individuals who “while pregnant” are eligible for and have received coverage under the Medicaid or CHIP state plan or a demonstration project. As a result, states cannot cover under the extended postpartum coverage option individuals who were not enrolled in Medicaid or CHIP in the state at some point during pregnancy. Note that, for Medicaid, the 12 months of extended postpartum coverage under this option applies to individuals who were pregnant and received Medicaid-covered services while pregnant during a period of retroactive eligibility granted under section 1902(a)(34) of the Act and 42 C.F.R. § 435.915(a).

The extended postpartum coverage option under the state plan is available to Medicaid beneficiaries enrolled in the group for pregnant individuals at 42 C.F.R. § 435.116 as well as pregnant individuals enrolled in any other categorically or medically needy eligibility group. States must ensure they are able to provide continuous extended postpartum coverage for

individuals enrolled in Medicaid on a basis that is not related to pregnancy status but who report a pregnancy or whom the state identifies as pregnant (e.g., based on claims data).

In states that cover children and/or pregnant individuals in a separate CHIP, if the state elects the extended postpartum coverage option in Medicaid, pregnant adolescents eligible as “targeted low-income children” and individuals eligible as “targeted low-income pregnant women” who are enrolled in the separate CHIP must also receive the extended postpartum coverage.

Section 9822 of the ARP did not change postpartum care for all pregnant individuals enrolled in CHIP, maintaining existing limitations.⁹ The 12-month extended postpartum coverage under section 2107(e)(1)(J) of the Act is only available to “targeted low-income children” who are pregnant or “targeted low-income pregnant women.” Pregnant individuals receiving CHIP services who do not meet the definition of either targeted population may not receive extended postpartum coverage under the ARP option. States should reach out to their CHIP Project Officer with any questions or technical assistance needs regarding coverage for such individuals.

States must submit a Medicaid and CHIP state plan amendment (SPA) to adopt the extended postpartum coverage option. In states that do so, the following populations must be provided continuous enrollment through the end of the 12-month postpartum period:

- Current beneficiaries who are pregnant as of the effective date of the SPA or who enroll based on pregnancy or become pregnant after the SPA is effective;
- Current beneficiaries who were enrolled in Medicaid or CHIP while pregnant and who are no longer pregnant when the SPA becomes effective, but who are still within a 12-month postpartum period; and
- Individuals who apply for Medicaid after their pregnancy ends, but who received Medicaid-covered services in the state while pregnant on or after the effective date of the SPA, if such services were received during a period of retroactive eligibility granted under section 1902(a)(34) of the Act and 42 C.F.R. § 435.915(a), provided that they would have been eligible when they received such services if they had applied.

When a state first implements the extended postpartum coverage option, there may be some individuals who were enrolled in Medicaid or CHIP while pregnant and are still less than 12 months postpartum, but whose coverage was terminated prior to the effective date of the extended postpartum coverage option in the state. While not required, states may choose to:

- 1) Identify these individuals and reinstate their coverage, provided they continue to be state residents. These individuals would be eligible for coverage with continuous eligibility in the group from which they were disenrolled for the remainder of their 12-month postpartum period; or

⁹ For individuals receiving pregnancy-related care who may not otherwise be eligible for Medicaid or CHIP, states may only provide postpartum care if (1) the post-birthing individual would otherwise satisfy all eligibility requirements for CHIP except age, as described at section 2112(f)(2) of the Act; (2) the postpartum coverage is included as part of a bundled payment for prenatal care and labor and delivery benefits (CMS SHO #02-004; available at https://healthlaw.org/wp-content/uploads/2018/09/cms_release_on_prenatal_care_for_fetuses.pdf); or (3) the state has implemented a health services initiative (HSI) to provide postpartum coverage.

- 2) Approve coverage for any such individuals who submit a new application within their 12-month postpartum period and provide them with continuous eligibility for the remainder of their 12-month postpartum period.

In Medicaid, under both options, retroactive eligibility would be available, consistent with 42 C.F.R. § 435.915(a), to provide coverage for the three months prior to the date of reinstatement or reapplication if the beneficiary had received Medicaid services, at any time during that three-month period, and would have been eligible for Medicaid at the time they received the services if they had applied. In CHIP, states may develop a reasonable methodology in their state plan to determine the effective date of eligibility and avoid gaps in coverage for this population, consistent with 42 C.F.R. § 457.340(g), including providing retroactive eligibility.

Continuous Eligibility During Pregnancy and the Extended Postpartum Period

Pregnant individuals who are eligible for extended postpartum coverage in Medicaid and CHIP are entitled to continuous eligibility through the last day of the month in which the 12-month postpartum period ends.¹⁰ Unlike the continuous eligibility provided under section 1902(e)(6) of the Act, which ensures pregnant Medicaid beneficiaries continue to be eligible through the end of the 60-day postpartum period despite changes in *income*, the continuous coverage afforded under section 1902(e)(16) of the Act ensures such coverage despite *any* changes in circumstances, similar to the continuous coverage provided to children, at state option, under section 1902(e)(12) of the Act. Individuals receiving extended postpartum coverage remain eligible regardless of changes in circumstances that may affect eligibility such as a change in income, household composition, or categorical eligibility (e.g., reaching an age milestone or loss of Supplemental Security Income (SSI) for individuals eligible for Medicaid based on receipt of SSI). For example, eligibility continues through the duration of the extended postpartum coverage period for pregnant adolescents in CHIP turning 19 and pregnant individuals enrolled in the Medicaid mandatory group for children under age 19 described at 42 C.F.R. § 435.118 at the time that they would ordinarily age out of eligibility under that group.

We have determined that, despite the broad coverage protection afforded under the statutory language, states are expected to apply the same narrow exceptions applied to continuous eligibility for children under 42 C.F.R. § 435.926(d)(2) through (d)(5) to the continuous 12-month postpartum coverage provided under section 1902(e)(16) of the Act. Thus, states providing extended postpartum coverage must ensure that pregnant and postpartum individuals eligible under the extended postpartum coverage option, who would otherwise lose eligibility due to a change in circumstances, remain enrolled in Medicaid or CHIP until the end of the 12-month postpartum period, unless:

- the individual requests voluntary termination;
- the individual ceases to be a state resident;
- the agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual; or
- the individual dies.

¹⁰ American Rescue Plan Act of 2021, Pub. L. 117-2, §§ 9812 and 9822

CHIP regulations at 42 C.F.R. § 457.342 allow for two exceptions to continuous eligibility in addition to those in 42 C.F.R. § 435.926(d): (1) non-payment of premiums, and (2) becoming eligible for Medicaid. However, section 2107(e)(1)(J) of the Act, which applies 1902(e)(5) and (16) of the Act to CHIP, explicitly requires that individuals who were eligible while pregnant remain eligible under the state plan through the end of the 12th month after the end of the pregnancy regardless of any changes. Therefore, the additional exceptions to continuous eligibility at 42 C.F.R. § 457.342 do not apply during the pregnancy and extended postpartum period under the option provided under section 2107(e)(1)(J) of the Act.¹¹

Renewals for Individuals Eligible for Extended Postpartum Coverage

For individuals first enrolled at the end of their pregnancy, the regular renewal required under 42 C.F.R. § 435.916 may coincide with the end of the extended 12-month postpartum period. For most, however, the 12-month postpartum period will end after their regularly-scheduled renewal date. The availability of continuous coverage for 12 months post-pregnancy under the extended postpartum coverage option renders any regular renewal scheduled before the end of the 12-month postpartum period unnecessary. Rather, the Medicaid and CHIP agency must conduct the renewal at the end of the individual’s extended 12-month postpartum period in accordance with renewal regulations at 42 C.F.R. §§ 435.916 and 457.343.¹² Because agencies do not need to complete renewals or redeterminations based on changes in circumstances until the end of the extended postpartum period, beneficiaries remain enrolled in the eligibility group in which the beneficiary was enrolled during pregnancy through the end of the 12-month postpartum period.

We recognize that, absent a state’s election to provide 12 months of continuous postpartum coverage, some individuals enrolled in the group for pregnant individuals would be redetermined as eligible for the adult group at the end of the 60-day postpartum period and meet the definition of “newly eligible” in 42 C.F.R. § 433.204(a)(1) for purposes of claiming the increased federal medical assistance percentage (FMAP) described in section 1905(y) of the Act. The availability of increased FMAP for such individuals is discussed below.

Benefits

States electing the extended postpartum coverage option must provide full benefits to all pregnant and postpartum individuals, as described at sections 1902(e)(16)(B) and 2107(e)(1)(J) of the Act. There may be some beneficiaries who become pregnant after enrolling in the adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 C.F.R. § 435.119. Coverage provided under an Alternative Benefit Plan (ABP) under section 1937 of the Act is considered full benefits for purposes of the extended postpartum option. States must inform beneficiaries of any differences in coverage between the ABP and the benefits available to

¹¹ While eligibility for Medicaid is not an exception to continuous eligibility during pregnancy and the extended postpartum period under ARP, it may be beneficial for a pregnant or postpartum individual to request voluntary termination of CHIP eligibility to enroll in Medicaid. As such, beneficiaries who become Medicaid eligible need to be informed about the differences between the programs, including cost sharing, benefits, provider networks, and their eligibility for extended postpartum coverage, so they can make an informed decision.

¹² See CMCS Informational Bulletin “Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” (December 2020) for more information on making accurate redeterminations of eligibility. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>

individuals eligible as pregnant women (including any differences in benefits, premiums, and cost sharing).

While most states provide full coverage to all pregnant Medicaid beneficiaries, some states limit the coverage available to beneficiaries who are enrolled in the group for pregnant individuals described at 42 C.F.R. § 435.116 and have income above a threshold specified by the state.¹³ States that have elected to provide only services related to pregnancy or a condition that may complicate pregnancy and to COVID-19 vaccines (and their administration) must submit a SPA to remove this coverage limitation while the extended postpartum coverage option is in effect.

Under CHIP, the state must continue to provide the same scope of child health assistance as defined in section 2110(a) of the Act and pregnancy-related assistance as defined in section 2112(d) of the Act during the extended postpartum period. At a minimum, states must continue to provide comprehensive benefits consistent with the benefit coverage option elected in the CHIP state plan, as described in section 2103(a) of the Act, such as benchmark or Secretary-approved coverage; however, states may elect to provide a more generous coverage option during the extended postpartum period.

State Plan Amendment Submission

States that elect the extended postpartum coverage option in Medicaid must also elect the option for a separate CHIP, unless the state only provides coverage to unborn children in its separate CHIP. In order to elect the option, states must submit a Medicaid SPA through MACPro to extend postpartum coverage under Medicaid and, as appropriate, submit a CHIP SPA in the Medicaid Model Data Lab (MMDL) to extend postpartum coverage for pregnant individuals covered in a separate CHIP. Subject to the requirements at 42 C.F.R. § 430.12, *et seq.* and 42 C.F.R. § 457.60, states may submit SPAs with proposed effective dates no earlier than April 1, 2022. States are strongly encouraged, but not required, to maintain their SPA through March 31, 2027, when the current statutory authority for the extended postpartum coverage option expires. CMS will work with states to identify other options to maintain extended postpartum coverage if the statutory authority to extend coverage is not reauthorized. States may contact their Medicaid state lead for technical assistance to complete the Medicaid SPA and their CHIP project officer for technical assistance to complete the CHIP SPA.

Federal Financial Participation for “Newly Eligible” Individuals Receiving Extended Postpartum Coverage

Currently, many Medicaid beneficiaries (such as, but not limited to, those covered under the eligibility group for pregnant individuals described at 42 C.F.R. § 435.116) become eligible for, and transition to, the adult group described at 42 C.F.R. § 435.119, at the end of the 60-day postpartum period. Some of the individuals who transition to the adult group after their 60-day postpartum period are “newly eligible,” as defined in 42 C.F.R. § 433.204(a)(1), for purposes of the increased FMAP described in section 1905(y) of the Act (“newly eligible FMAP”).

¹³ Clause VII in the matter following section 1902(a)(10)(G) of the Act. Services related to pregnancy include prenatal, delivery, postpartum, and family planning services. Because the health of a pregnant individual is so intertwined with the health of the expected child, most states consider all services required for categorically needy Medicaid beneficiaries to be pregnancy-related services.

States have shared concerns that electing the extended postpartum coverage option could result in the application of a lower FMAP than the state could claim for individuals who would otherwise be determined newly eligible in the adult group, if not for the state's adoption of the extended postpartum coverage option. States have expressed concern that, to make the extension of postpartum coverage financially possible for the state, the state would need to conduct a redetermination before the end of the 60-day postpartum period only to obtain information sufficient to determine whether the individual beneficiary qualifies as newly eligible so that the state may continue claiming the increased FMAP under section 1905(y) of the Act with respect to the individual. However, this redetermination would be unnecessary for purposes of establishing the individual's eligibility for benefits and would be administratively burdensome for the individual and the state; its only purpose would be to support the state's claiming of service expenditures at the applicable FMAP.

To support states interested in adopting the extended postpartum coverage option under the ARP without requiring that they conduct a redetermination that would be unnecessarily burdensome for beneficiaries and the state, states may use a proxy methodology to account for the proportion of individuals covered under the extended postpartum coverage option who would otherwise be eligible for coverage in the adult group and for the newly eligible FMAP under section 1905(y) of the Act. Under current law, states can claim the newly eligible FMAP for individuals if (1) the individual is eligible for the adult group under 42 C.F.R. § 435.119; (2) the individual is newly eligible, as defined in 42 C.F.R. § 433.204(a)(1); and (3) the individual is receiving benefits that meet the Alternative Benefit Plan requirements in section 1937 of the Act. States may claim the newly eligible FMAP for individuals receiving extended postpartum coverage if the state implements a CMS-approved proxy methodology to ascertain the proportion of medical assistance expenditures for beneficiaries receiving extended postpartum coverage that are for individuals who would be eligible for the adult group and qualify as newly eligible, if the state completed a redetermination. This option is available provided beneficiaries receiving extended postpartum coverage receive benefits satisfying the Alternative Benefit Plan requirements under section 1937 of the Act.

Similar to the resource proxy methodology set forth in 42 C.F.R. § 433.206(d), the extended postpartum coverage proxy methodology must identify the basis that would make an individual eligible for the adult group as newly eligible and must comprehensively describe the criteria used to determine the adjustment to the total medical assistance expenditures for individuals receiving extended postpartum coverage to identify the portion that may be claimed at the newly eligible FMAP under section 1905(y) of the Act. For example, if parents between 100 percent of the federal poverty level (FPL) and 133 percent of the FPL are newly eligible in a state, the state would need a reasonable, statistically valid method to identify the percentage of individuals receiving 12-month postpartum coverage who are between 100 and 133 percent FPL whom the state would otherwise transition to the adult group and claim newly eligible FMAP; and then apply that percentage to the total expenditures for individuals receiving 12-month postpartum coverage to claim at the newly eligible FMAP. The methodology must be auditable and based on statistically valid data. The proxy methodology would not apply to individuals who are enrolled in the adult group when they become pregnant and remain in that group through pregnancy and the postpartum period.

States that adopt the extended postpartum coverage option and intend to claim the newly eligible FMAP using a proxy methodology must submit an FMAP SPA amendment that meets the requirements of 42 C.F.R. § 433.206(h), as relevant to the proxy methodology. CMS is available to provide technical assistance to states interested in developing a proxy methodology to claim the newly eligible FMAP for certain individuals during the extended postpartum coverage period.

Opportunities to Improve Maternal Health

In order to realize the potential of extended postpartum coverage to improve postpartum care and advance equity in health outcomes for beneficiaries, CMS encourages states to make a concerted effort to increase awareness of the extended postpartum coverage to both providers and beneficiaries. To maximize the impact of adopting the extended postpartum coverage option, it also will be critical for states to measure and monitor utilization and quality of care in the postpartum period, and to work with health plans, providers and other stakeholders to improve maternal health care. Drawing on the experiences of states in several learning collaboratives (discussed below), CMS has developed a number of tools and strategies that states can employ and can provide technical assistance to states to support these quality measurement and improvement activities.

Care during the postpartum period involves not just a single visit but a series of encounters and a range of services tailored to the needs of the beneficiary. The American College of Obstetricians and Gynecologists (ACOG) recommends that all postpartum individuals have contact with their health care providers within the first three weeks after delivery followed by individualized ongoing care as needed.¹⁴ Coverage during an extended postpartum period gives providers opportunities to assess beneficiaries' physical recovery from pregnancy and childbirth, and, critically, to screen for and provide care to address conditions that can lead to morbidity and mortality in the later postpartum period. High quality, comprehensive postpartum care should address chronic health conditions (e.g., diabetes or hypertension), mental health and psychological well-being (e.g., postpartum depression, interpersonal violence), and family planning (e.g., contraceptive counseling). Postpartum visits are also a time for providers to counsel individuals on nutrition, breastfeeding, tobacco and other drug use, and other preventive health issues that affect both the postpartum individual's longer-term health and that of their infant, and to help individuals retain coverage under Medicaid or CHIP or successfully transition to other coverage at the end of the postpartum period, including enrollment in a qualified health plan available through the Health Insurance Marketplace.

States may also consider building on person-centered models of perinatal care to support individuals in the prenatal, delivery, and postpartum periods, such as doula services and home visiting. Doula support, which can be delivered in a home setting, is associated with improved health outcomes including decreased likelihood of postpartum depression and near-universal breastfeeding among low-income individuals.¹⁵ Coverage of doula services may be effectuated

¹⁴ Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018; 131:e 140-50. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>

¹⁵ <https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf>

through multiple benefit categories, including, but not limited to, preventive services, services of licensed practitioners, clinic services, and freestanding birth center services. Similarly, while there is no distinct Medicaid state plan benefit called home visiting, states may cover many of the individual component services of home visiting programs through existing Medicaid coverage authorities.¹⁶ States can utilize value-based payment arrangements to incentivize the use of innovative maternal health care delivery models and improve health outcomes. CMS is available for technical assistance to states interested in adding these coverage options to their programs.

Maternity Core Set

To support states in their maternal, perinatal, and infant health-focused quality improvement efforts, CMS identified a core set of 11 measures for voluntary reporting¹⁷ by state Medicaid and CHIP agencies. This Maternity Core Set, which consists of seven measures from CMS's Child Core Set and four measures from the Adult Core Set, is used by CMS to measure and evaluate progress toward improvement of maternal and infant health in Medicaid and CHIP. The areas of maternal health addressed in this set include: timeliness of prenatal care, postpartum care visits, contraceptive care, elective delivery, and low-risk cesarean section births. Two of these measures, Live Births Weighing Less than 2,500 Grams and Postpartum Care, are included in the State Health System Performance pillar of the Medicaid and CHIP Scorecard.¹⁸ Additionally, several measures on the Adult Core Set measure follow-up care for conditions that are associated with maternal morbidity and mortality (e.g., controlling high blood pressure and screening for depression and follow-up plan) and to assess ongoing well-woman care (e.g. cervical and breast cancer screening).¹⁹

CMS strongly encourages states to stratify these quality measures and other metrics of interest to states by race, ethnicity, geography, language and other indicators in order to identify disparities in access to care and health outcomes and to develop targeted initiatives to improve maternal health equity.

Maternal and Infant Health Initiative

To improve access to and quality of care for pregnant and postpartum beneficiaries and their infants, CMS launched the Maternal and Infant Health Initiative (MIHI) in July 2014.²⁰ Today, the MIHI is focused on driving improvement in three areas, each of which is associated with one or more Maternity Core Set measures:

- 1) Increase the use and quality of postpartum care visits;
- 2) Increase the use and quality of well-child visits; and

¹⁶ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf>

¹⁷ Pursuant to Section 50102(b) of the Bipartisan Budget Act, reporting on the seven measures that are part of the Child Core Set will become mandatory for states beginning in 2024. Additionally, the behavioral health measures on the Adult Core Set will also become mandatory in 2024, pursuant to Section 5001 of the SUPPORT Act.

¹⁸ <https://www.medicaid.gov/state-overviews/scorecard/state-health-system-performance/index.html>

¹⁹ <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-maternity-core-set.pdf>

²⁰ <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html>

- 3) Decrease the rates of cesarean section births in low-risk pregnancies, defined as nulliparous (first-time pregnancies), term (37 or more weeks gestation), singleton (one fetus), vertex (head facing down in the birth canal) or “NTSV births.”

These three areas of focus were selected based on input from a stakeholder workgroup, which was charged with identifying areas where Medicaid and CHIP programs had the greatest capacity to influence improvement and where CMS and states could, collectively, have the greatest impact on maternal and infant health care and outcomes.

To support state Medicaid agencies and their partners in driving improvement in these areas, CMS designs and runs learning collaboratives, which combine webinars for all states featuring best practices and effective models of care with affinity groups that provide intensive quality improvement technical assistance to state teams committed to action in these areas. Two learning collaboratives began in 2021: [Postpartum Care](#) and [Infant Well-Child Visits](#). The third learning collaborative, focused on low-risk cesarean section births, is scheduled to begin in 2022. CMS will continue to assess the quality measurement and improvement technical assistance needs of states and will develop future opportunities and resources to address the identified needs and to facilitate shared learning across states.

CMS publishes quality measures and other data and resource materials on [Medicaid.gov](https://www.Medicaid.gov) for states to use in their quality improvement efforts. Currently available data and resources related to improving the quality of postpartum care are included in the Appendix of this letter. CMS anticipates adding additional resources as we learn more about states’ technical assistance needs and their successes and lessons learned from postpartum care quality improvement activities.

Section 1115 Demonstrations

CMS has approved several state section 1115(a) demonstrations to implement initiatives in Medicaid and CHIP aimed at immediate extension of postpartum coverage. States that extended postpartum coverage through an approved section 1115 demonstration may choose to transition the authority for their extended postpartum coverage to the new SPA option. These states, as well as states with a pending 1115 demonstration application to extend postpartum coverage, should contact their demonstration project officer to discuss their options.

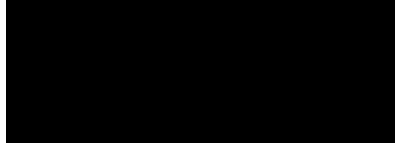
In addition, CMS has previously approved section 1115 demonstration projects providing coverage of family planning and related preventive health services, authorizing evidence-based home visiting services, and incentivizing providers to demonstrate specific quality improvements and beneficiary health outcomes for maternal health. CMS supports states in submitting section 1115 proposals to test approaches that address challenges associated with maternal mortality and morbidity and stands ready to work with states on such proposals.

Closing

CMS appreciates the partnership with states to ensure Medicaid and CHIP drive improvements in health outcomes and promote health equity, and CMS remains committed to collaborating with states to improve access to coverage and maternal health outcomes. CMS is available to provide technical assistance to states as they extend postpartum coverage, implement innovative

payment and delivery system efforts, and engage in initiatives to measure and improve quality aimed at addressing the needs of pregnant and postpartum beneficiaries. Please submit requests for technical assistance to your CMS Medicaid state lead or CHIP Project Officer.

Sincerely,



Daniel Tsai
Deputy Administrator and Director

Cc:

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Appendix

Resources for Improving the Quality of Postpartum Care

The following resources to support states in improving the quality and effectiveness of postpartum coverage are available on Medicaid.gov.

- The [Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health](#) provides an overview of the demographics, health status, health outcomes, risk factors, and health care utilization among reproductive age individuals, individuals with a recent live birth, and infants covered by Medicaid and CHIP.
- [Quality of Maternal and Perinatal Health Care in Medicaid and CHIP: Findings from the 2019 Maternity Core Set](#). CMS annually releases information on state progress in reporting the Maternity Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and that met CMS standards for data quality. This resource provides information about performance on frequently-reported health care quality measures in the Maternity Core Set.
- [Postpartum Care Learning Collaborative webinar recordings and slides](#). CMS launched the Improving Postpartum Care Learning Collaborative in January 2021. The webinar series includes presentations from experts in the field and by state Medicaid and CHIP programs on strategies for states to improve the use of postpartum care for individuals at high risk of postpartum complications, improve the continuity of coverage for postpartum individuals, and implement payment reform to incentivize changes in maternal health care practice.
- [Issue Brief: Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP](#). This issue brief summarizes some of the lessons learned by states that participated in CMS' Postpartum Care Action Learning Series. The resource includes lessons for fee-for-service delivery systems as well as alternative payment models and population-based payment.
- [Issue Brief: Improving Postpartum Care: State Projects Conducted through the Postpartum Care Action Learning Series and Adult Medicaid Quality Grant Program](#). This issue brief presents profiles of state quality improvement projects focused on improving postpartum care and includes driver diagrams summarizing system components and activities that are associated with increasing the rate and quality of postpartum care visits.
- [Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations](#). This document compiles strategies that have been shown to be effective to improve the postpartum care visit rate and the content of care.

Frequently Asked Questions (FAQs)
Sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP): 12 Months Postpartum Coverage in Medicaid and the Children’s Health Insurance Program (CHIP)
DECEMBER 14, 2021

The following questions and answers apply to implementation of the 12-month extended postpartum coverage option under sections 1902(e)(16) and 2107(e)(1)(J) of the Act as outlined in State Health Official (SHO) letter #21-007, “Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children’s Health Insurance Program (CHIP).”

General Requirements

Q1. Are states required to provide 12 months postpartum coverage for Medicaid and CHIP beneficiaries?

A1. No. States are not required to extend postpartum coverage in Medicaid and CHIP, but extending postpartum coverage offers opportunities to provide care that can reduce pregnancy-related death and severe maternal morbidity and improve continuity of care for chronic conditions including behavioral health conditions. States that have already expanded Medicaid eligibility to the adult group under 42 C.F.R. § 435.119, which has allowed more individuals to remain enrolled beyond the end of the month in which their 60th day postpartum occurs, report an increase in postpartum care visits, continuity in coverage, and enhanced engagement of individuals in health care.¹

Q2. Are states able to extend postpartum coverage only under Medicaid or a separate CHIP?

A2. No. States that elect to extend postpartum coverage in Medicaid must also take up the option to extend postpartum coverage in their separate CHIP if they provide coverage to targeted low-income children (defined in section 2110(b) of the Act) who are pregnant and targeted low-income pregnant individuals (defined in section 2112 of the Act) in a separate CHIP. States may not adopt the option in a separate CHIP if the state does not elect to extend postpartum coverage in Medicaid.

Q3. Who is eligible for extended postpartum coverage on the effective date selected by the state?

A3. States that adopt the extended postpartum coverage option must provide 12 months of extended postpartum coverage to individuals who apply for coverage or become pregnant while enrolled in Medicaid or CHIP on or after the effective date of the state plan amendment (SPA). This includes individuals who apply for Medicaid after their pregnancy ends, but who were pregnant and received Medicaid-covered services in the state while pregnant on or after the effective date of the SPA if such services were received during a period of retroactive eligibility granted under section 1902(a)(34) of the Act and 42 C.F.R. § 435.915(a). In addition, states adopting this option must provide extended postpartum coverage to beneficiaries who are

¹ Gordon, S.H., B.D. Sommers, I. Wilson, O. Galarraga, and A.N. Trivedi. “The Impact of Medicaid Expansion on Continuous Enrollment: A Two-State Analysis.” *Journal of General Internal Medicine*, vol. 34, no. 9, 2019, pp. 1919–1924.

enrolled in Medicaid or CHIP on the effective date of the SPA and who are pregnant or who are within an extended 12-month postpartum period on such date.

For example, a state elects to extend postpartum coverage beginning April 1, 2022. Julie is enrolled in Medicaid on April 1, 2022, and had given birth while enrolled on November 15, 2021. The state must provide Julie with continuous extended postpartum coverage through the end of the month in which her 12-month postpartum period ends (November 30, 2022).

Q4. Do states have the option to provide extended postpartum coverage under the state plan for a period of less than 12 months?

A4. No. The state plan option provides 12 months of postpartum coverage. States extending postpartum coverage under the state plan option do not have the flexibility to establish a different postpartum period.

Q5. Can a state implement the 12-month extended postpartum coverage SPA option before April 1, 2022?

A5. No. States may only elect the 12-month extended postpartum coverage SPA option with an effective date on or after April 1, 2022.

However, states that wish to implement extended postpartum coverage before April 2022 may work with CMS to propose a section 1115 demonstration project for Medicaid and/or CHIP.

Eligibility for Extended Postpartum Coverage

Q6. Does the American Rescue Plan (ARP) establish a new optional eligibility group in order for states to provide 12 months postpartum coverage in Medicaid?

A6. No, the ARP does not establish a new eligibility group. Individuals who receive the 12-month postpartum extension remain in the eligibility group in which they were enrolled when pregnant for the duration of the postpartum period. For additional information on Federal Medical Assistance Percentage (FMAP) and coverage in the adult group, see questions Q21-22, below.

Q7. Is an individual entitled to extended postpartum coverage if they enroll in Medicaid or CHIP during the postpartum period?

A7. No. To be eligible for extended postpartum coverage, the individual must have been eligible for and enrolled in Medicaid or CHIP while pregnant (including during a period of retroactive eligibility in Medicaid). Individuals who apply for and are enrolled in Medicaid or CHIP after a pregnancy ends are not entitled to continuous eligibility for the remainder of their 12-month postpartum period because they were not enrolled under the Medicaid or CHIP state plan while pregnant. For additional information on eligibility for extended postpartum coverage granted during a period of retroactive eligibility, see question Q10, below.

For example, an individual submits an application for Medicaid four months after giving birth. The agency determines the individual is eligible for Medicaid and enrolls the individual. The individual is not entitled to extended and continuous postpartum coverage through the end of a 12-month postpartum period, however, because the individual was not enrolled in Medicaid while pregnant.

Q8. Is an individual entitled to an additional 12-month postpartum period in Medicaid or CHIP if they become pregnant during the extended postpartum period?

A8. Yes. An individual who becomes pregnant during an initial extended postpartum period and therefore is enrolled in Medicaid or CHIP during such pregnancy would be entitled to an extended 12-month postpartum period following the end of the subsequent pregnancy. The individual in this case would receive continuous coverage through the end of 12th month after the subsequent pregnancy ends consistent with section 1902(e)(16) or 2107(e)(1)(J) of the Act.

For example, Emily is enrolled in Medicaid while pregnant. Her pregnancy ends in May 2022, and an extended 12-month postpartum coverage period begins. Seven months later, Emily becomes pregnant again in December 2022, while she is still eligible for and enrolled in coverage. Emily’s subsequent pregnancy ends in September 2023. At that point, a new 12-month extended postpartum period will begin, and Emily will remain continuously eligible through the end of the subsequent extended postpartum period (through September 2024). In September 2024, the state will need to conduct a redetermination of eligibility and determine whether Emily remains eligible for Medicaid under the same or another eligibility group.

Q9: Do individuals who qualify as medically needy with a spenddown while pregnant have to continue to meet their spenddown each budget period to be eligible for the coverage available under the 12-month postpartum option?

A9: No. An individual who attained Medicaid eligibility through a spenddown while pregnant is eligible for the extended postpartum coverage even if the individual does not have sufficient incurred medical or remedial care expenses to meet their spenddown in any subsequent budget period during the pregnancy or extended postpartum period. For example, if a pregnant individual applies for Medicaid in January in a state that has adopted the 12-month postpartum option and covers medically needy individuals, and the individual establishes eligibility by meeting their spenddown in February, the state must maintain the individual’s Medicaid coverage through the remainder of the individual’s pregnancy and the end of the month in which the 12-month postpartum period ends. The individual will not have to meet a spenddown again until the end of continuous 12-month postpartum period.

Q10. Are individuals eligible for extended postpartum coverage if they enroll in Medicaid during their postpartum period but were pregnant during a period of retroactive eligibility?

A10. Yes, individuals who received Medicaid services and met Medicaid eligibility requirements while pregnant during a period of retroactive eligibility must be provided extended postpartum coverage.

For example, Ava submits an application on June 15, 2022 and is determined eligible for Medicaid. Ava was pregnant and gave birth on May 15, 2022, which is within the 3-month period prior to the month in which Ava applied for coverage. The agency determines that Ava would have been eligible for Medicaid had she applied in May, and thus is covered retroactively to May, when she was pregnant. Ava is entitled to extended postpartum coverage from the time of enrollment through the end of the month in which Ava’s 12-month postpartum period ends (May 31, 2023).

Q11. Do pregnant individuals who receive Medicaid or CHIP coverage under the “CHIPRA 214 option” qualify for extended postpartum coverage?

A11. Yes. A state that has elected to cover lawfully residing pregnant individuals in Medicaid and CHIP under the option provided for at sections 1903(v)(4)(A)(i) and 2107(e)(1)(O), and has also elected the extended postpartum coverage option, must provide 12 months of extended postpartum coverage to such individuals under the option described at 1902(e)(16) and/or 2107(e)(1)(J) of the Act. Sections 1903(v)(4)(A) and 2107(e)(1)(O) of the Social Security Act provide states the option to provide full Medicaid and/or CHIP coverage to lawfully residing children and pregnant individuals, if they otherwise meet eligibility requirements under the state’s program (e.g., income and state residency requirements). This option is commonly referred to as “the CHIPRA 214 option.”

Section 1902(e)(16) of the Act, added by section 9812 of the ARP, and section 2107(e)(1)(J) of the Act, added by section 9822 of the ARP, provide states with an option to provide coverage during an extended 12-month postpartum period for individuals who, while pregnant, were eligible for and received Medicaid or CHIP under the state plan, or a waiver of such plan. If this option is elected, states cannot offer extended postpartum coverage to only some individuals enrolled in Medicaid or CHIP while pregnant, but must provide extended postpartum coverage to all such individuals. Thus, in a state which has elected both the CHIPRA 214 option for pregnant individuals in Medicaid and CHIP and also elects the option to provide 12 months of extended postpartum coverage under sections 1902(e)(16) and 2107(e)(1)(J) of the Act, lawfully residing adolescents who become pregnant while enrolled in Medicaid or CHIP and pregnant individuals covered under the Medicaid or CHIP state plan (or waiver of the state plan) during pregnancy would be eligible for the extended 12-month postpartum coverage.²

Continuous Eligibility for Individuals During Pregnancy and the Postpartum Period

Q12. Does the ARP require states that elect the option to provide 12 months postpartum coverage to provide continuous eligibility to individuals in Medicaid and CHIP during the pregnancy and extended postpartum period?

A12. Yes. Individuals who are eligible for extended postpartum coverage in Medicaid and CHIP are entitled to continuous eligibility throughout the pregnancy and postpartum period until the last day of the month in which the 12-month postpartum period ends. Pregnant and postpartum individuals in states that elect the ARP option remain eligible regardless of changes

² A list of which states have elected to cover lawfully residing children and pregnant women in Medicaid and CHIP, is available at <https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women>

in circumstances that may affect eligibility such as a change in household composition, a change in categorical eligibility (e.g., reaching an age milestone, eligibility conferred through receipt of other program benefits). States must ensure that individuals eligible for extended postpartum coverage, who would otherwise lose eligibility due to a change in circumstances, remain enrolled in Medicaid or CHIP until the end of the 12-month postpartum period, unless: (1) the individual requests voluntary termination, (2) the individual ceases to be a state resident, (3) the agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual, or (4) the individual dies.

Q13. Does the ARP require states to provide continuous eligibility to pregnant individuals in Medicaid regardless of changes in circumstances, even if the state does not extend postpartum coverage?

A13. In states that do not extend postpartum coverage, pregnant individuals enrolled in Medicaid are entitled to continuous eligibility through the last day of the month in which a 60-day period, beginning on the last day of pregnancy, ends, regardless of changes in income that would otherwise result in a loss of eligibility, as required at 42 C.F.R. § 435.170. States that provide postpartum coverage consistent with 42 C.F.R. § 435.170 must act on changes in circumstances that may affect eligibility, other than changes in income, while the individual is pregnant or in their 60-day postpartum period. In states that do not provide extended postpartum coverage, we believe changes in circumstances that may affect eligibility for pregnant and postpartum individuals are rare, and may include, for example, a change affecting categorical eligibility or a change in immigration status.

Q14. Does the ARP require states to provide continuous eligibility to pregnant individuals enrolled in a separate CHIP if the state does not adopt the option to provide 12 months of extended postpartum coverage?

A14. No. Section 2107(e)(1)(J) of the Act provides that section 1902(e)(5), which requires continuous eligibility for pregnant individuals in Medicaid, applies to separate CHIPs only if the state has adopted the extended postpartum option in section 1902(e)(16). There is not a continuous eligibility requirement for pregnant individuals enrolled in CHIP unless the state adopts the option in sections 1902(e)(16) and 2107(e)(1)(J) of the Act.

Q15. Are states required to transition individuals enrolled in CHIP who become eligible for Medicaid during the continuous extended postpartum period?

A15. No. Section 2107(e)(1)(J) applies paragraphs 5 and 16 of section 1902(e) of the Act equally to CHIP, which requires that if an individual was eligible for CHIP and receiving services while pregnant, they are entitled to continuous eligibility throughout their pregnancy and postpartum period. Therefore, states must keep individuals enrolled in CHIP for the duration of their pregnancy and extended postpartum period, even if they become eligible for Medicaid, unless one of the allowable exceptions to the continuous eligibility period (as discussed in Q12) is applicable. However, we note that if an individual voluntarily elects to end their CHIP enrollment during their extended postpartum period, the individual would not be entitled to continuous eligibility for the remainder of their 12-month postpartum period in Medicaid. In

order to enroll in Medicaid, the individual would need to establish eligibility on a basis other than their postpartum status.

Q16. In a separate CHIP, may states disenroll individuals for non-payment of premiums during their pregnancy or extended postpartum period?

A16. No. Section 2107(e)(1)(J) of the Act applies the requirements of section 1902(e)(16) of the Act to CHIP, which requires that an individual who was eligible under the state plan while pregnant remain eligible until the last day of the 12th month after the pregnancy ends, regardless of changes that may affect eligibility. Because the individual met all CHIP requirements during the pregnancy, they are entitled to continuous eligibility in CHIP for the entire duration of their pregnancy and extended postpartum period even if they do not pay premiums.

Renewals for Individuals Receiving Extended Postpartum Coverage

Q17. When should states conduct renewals for pregnant and postpartum individuals?

A17. Pregnant individuals enrolled in Medicaid and CHIP in a state that elects to provide 12-months postpartum coverage are entitled to continued coverage through the end of the 12-month extended postpartum period regardless of changes in circumstances, except in the case of a change in state residency, voluntary termination, an erroneous determination of eligibility, or death. For almost all pregnant individuals, the end of the postpartum period will occur after the individual's regular renewal date. States that adopt the 12-month extended postpartum option will not need to conduct a redetermination or renewal prior to the end of the extended postpartum period. The state will need to complete a full renewal, consistent with 42 C.F.R. § 435.916 and § 457.343, at the end of the extended postpartum period.

For example, Sydney applies for Medicaid in June 2022 and is enrolled in the eligibility group for pregnant individuals under 42 C.F.R. § 435.116 in a state that elects to provide 12-months postpartum coverage under section 1902(e)(16) of the Social Security Act. Sydney's 12-month eligibility period for purposes of regular renewals, described at 42 C.F.R. § 435.916(a)(1), extends from June 1, 2022, to May 31, 2023. But because Sydney is eligible and enrolled in Medicaid while pregnant, she is entitled to continuous eligibility through the end of the month in which her 12-month postpartum period ends. Sydney's pregnancy ends December 15, 2022. Her 12-month postpartum period ends December 31, 2023, which is after the end of her regular 12-month eligibility period (May 31, 2023). Because Sydney is eligible for continuous eligibility through the end of the extended 12-month postpartum period, the agency does not need to complete a renewal by May 31, 2023, and may not act on changes in circumstances until she reaches the end of her postpartum period (December 31, 2023).

Q18. Are states required to move pregnant and postpartum individuals between Medicaid eligibility groups during a period of continuous eligibility? What if the individual is enrolled in the adult group under 42 C.F.R. § 435.119 and becomes pregnant?

A18. No. A redetermination of eligibility is required to move individuals between eligibility groups, but because pregnant individuals are entitled to continuous eligibility, states electing to provide 12 months of extended postpartum coverage do not need to complete a renewal or act on

changes in circumstances, with limited exceptions (see Q17), until the end of the individual's 12-month postpartum period. Therefore, Medicaid beneficiaries may remain in the eligibility group in which they are enrolled during pregnancy through the 12-month postpartum period, including individuals enrolled in the adult group under 42 C.F.R. § 435.119 who become pregnant after enrollment in the adult group and were not transitioned to another group during the course of their pregnancy.

Q19. May states complete periodic renewals of eligibility based on available information during a period of continuous eligibility?

A19. Yes. A state may, but is not required to, conduct redeterminations and periodic renewals of eligibility based on available information without requesting information from the individual during a period of continuous eligibility, and if appropriate, move the individual to a new eligibility group as long as the transition to the new group would not result in a loss of or reduction in coverage (e.g., reduction in benefits, increase in premiums or cost sharing). However, states may not send a renewal form or request additional information from the individual in order to complete a renewal or redetermination based on a change in circumstances, unless the state has information indicating the individual is no longer a state resident or is deceased. A state may also not request additional information or terminate coverage for an individual whose eligibility is renewed based on available information during a period of continuous eligibility if the individual responds to the renewal notice to inform the state that the information used to determine eligibility is not correct.

Q20. May a state redetermine eligibility at the end of the 60-day postpartum period described at 1902(e)(5) of the Social Security Act for individuals eligible for extended postpartum coverage who are enrolled in a group for which pregnancy status is a factor of eligibility?

A20. A state may, but is not required to, redetermine eligibility based on available information for individuals enrolled in an eligibility group where pregnancy status is a factor of eligibility who are eligible for extended postpartum coverage at the end of the month in which the 60th postpartum day occurs. Individuals determined eligible at application for the group for pregnant individuals described at 42 C.F.R. § 435.116 must be provided a 12-month eligibility period in accordance with requirements for renewals for MAGI-based individuals at 42 C.F.R. § 435.916(a)(1). For individuals enrolled in the group for pregnant individuals or a group where pregnancy status is a factor of eligibility, the end of the 60-day postpartum period represents a change in circumstances that impacts their eligibility for the group. At the end of the 60-day postpartum period, states typically must act on the end of the 60-day postpartum period as a change in circumstances, consistent with 42 C.F.R. § 435.916(d)(1), and transition the individual to another group for which the state is able to determine the individual is eligible. In states that have adopted the extended postpartum coverage under section 1902(e)(16) of the Act, the state must provide continuous coverage for 12 months postpartum under the group for pregnant individuals if the state is unable, at the end of the 60-day postpartum period, to determine that the beneficiary is eligible for another group conferring full Medicaid benefits without requesting any information from the beneficiary.

For example, Jane submitted an application on January 10, 2022, and was determined eligible for and enrolled in the group for pregnant individuals with verified income equal to 50 percent of the federal poverty level (FPL) in a state that has adopted the extended postpartum coverage option. Her effective date of coverage is January 1, 2022, and her 12-month eligibility period extends through December 31, 2020. Jane’s pregnancy ends on August 16, 2022, her 60-day postpartum period ends October 31, 2022, and her 12-month postpartum period ends August 31, 2023. The state’s income standard for parents and caretaker relatives is 65 percent FPL.

Because Jane is eligible for extended postpartum coverage, the state does not need to redetermine eligibility at the end of Jane’s 60-day postpartum period or complete a renewal of eligibility until the end of her 12-month postpartum period (August 31, 2023), and she may remain enrolled in the group for pregnant individuals through the remainder of her extended postpartum period. However, if the state does not have any information indicating Jane’s income has changed since application when she reaches the end of the 60-day postpartum period (October 31, 2022), it is permissible for the state to shift Jane’s coverage to the eligibility group for parents and caretaker relatives effective November 1, 2022. The state will need to complete Jane’s next regular renewal at the end of her extended postpartum period.

Federal Financial Participation

Q21. What FMAP applies to individuals enrolled in the adult group who become pregnant?

A21. States are not required to track the pregnancy status of beneficiaries enrolled in the adult group and are not required to move them to the eligibility group for pregnant individuals if the state becomes aware of their pregnancy. Beneficiaries who become pregnant must be given the option of moving to the pregnancy-related coverage category. States must inform beneficiaries of the differences in coverage between the adult group and pregnancy-related coverage (including any differences in benefits, premiums, and cost sharing), and if the state covers any additional benefits for pregnant individuals under 42 C.F.R. § 440.250(p) not provided to other individuals eligible under the state plan, such benefits also must be provided to pregnant individuals enrolled in the adult group in an alternative benefit package. If an individual enrolled in the adult group who becomes pregnant does not elect to switch groups and remains enrolled in the adult group, the individual’s status for FMAP purposes (as newly eligible or not) is unchanged until such time the individual is determined eligible for another group, which would in no case be sooner than the end of the 12-month postpartum period.

Q22. Is increased FMAP related to the adult group available to states for individuals covered in the extended postpartum coverage option who might otherwise qualify for the adult group?

A22. Yes. Increased FMAP is available for beneficiaries receiving coverage during an extended 12-month postpartum period who would meet the requirements for coverage in the adult group described in 42 C.F.R. § 435.119 and the definition of “newly eligible” in 42 C.F.R. §433.204(a)(1).

For individuals who would otherwise transition to the adult group after the 60-day postpartum period, the state would typically determine whether they meet the requirements for coverage under the adult group and the newly eligible criteria under 42 C.F.R. § 433.204(a)(1) for the purpose of the increased FMAP. However, because a state adopting the option to provide 12 months of postpartum coverage does not need to conduct a redetermination of eligibility until the end of the extended postpartum period, the state might not conduct the determination under Subpart E of Part 433 for adult group FMAP. Instead, states seeking to claim the increased FMAP for newly eligible individuals enrolled in the adult group may adopt a proxy methodology to determine the percentage of beneficiaries who would have transitioned to alternative benefit package coverage as newly eligible beneficiaries in the adult group for whom newly eligible FMAP is available. Once the methodology is approved by CMS, the state would apply the relevant percentage to medical assistance expenditures for the entire extended postpartum population to claim the increased FMAP for the proportion of newly eligible individuals determined under the proxy methodology.

If a state chooses to conduct renewals based on available information as discussed in Q19 and Q20, this will have implications on whether and how a state develops a proxy methodology to claim newly eligible FMAP. CMS will provide additional technical assistance on the possibility of using a proxy methodology to states in this circumstance.

SPAs and Capitation Rate Amendments

Q23. Are states required to submit separate state plan amendments (SPA) to provide extended postpartum coverage in Medicaid and its separate CHIP?

A23. Yes. States must submit a Medicaid SPA as well as a CHIP SPA in order to make the election in both programs. CMS will make a Medicaid SPA template available in MACPro and a CHIP SPA template available in MMDL.

Q24. Are states required to create new managed care capitation rates for a 12-month postpartum period?

A24. Capitation rates paid by states to Medicaid managed care plans must be actuarially sound in accordance with 42 C.F.R. § 438.4, including that the capitation rates are appropriate for the populations to be covered and the services to be furnished under the contract between the state and plan. Therefore, the state's actuary must evaluate if programmatic changes to the managed care program, such as a change in eligibility and coverage, impact the development of actuarially sound capitation rates or require a rate amendment if the programmatic change occurs after the development of the capitation rates for the applicable rating period. The state and its actuary should ensure that the rate development standards and documentation expectations outlined in the [Medicaid Managed Care Rate Development Guide](#) are met within the rate certification.