Maternal Health Inequities during the COVID-19 Pandemic

Challenges, Promising Advances, and Opportunities to Promote Equitable Care

Emily Burroughs, Ian Hill, Kimá Joy Taylor, Sarah Benatar, Jennifer M. Haley, Eva H. Allen, and Sarah Coquillat

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The COVID-19 pandemic has prompted dramatic changes to the delivery of maternal health care; consumers' fears of contracting the virus and the imperative of social distancing exacerbated discontinuities in care, limited in-person visits with providers, and increased reliance on telehealth (Gonzalez et al. 2021; Hill and Burroughs 2020). The public health crisis has also highlighted preexisting deficiencies in our health care system. Most notably, long-standing racial inequities in health care access and health outcomes have been amplified by the disproportionate toll the pandemic has taken on communities of color (Artiga, Corallo, and Pham 2020). The pandemic has also raised new challenges, increasing both medical and social needs while isolating people from community and family supports. On the other hand, the crisis has generated creative thinking and innovative strategies for safely reaching and serving patients. These developments are occurring during an ongoing maternal mortality and morbidity crisis in the United States, which has been further compounded by the public health emergency.[1]

In this brief, we identify challenges and promising strategies for addressing maternal health inequities during the COVID-19 crisis and opportunities for sustained improvements to maternal health after the pandemic. Part of a larger series on the pandemic and maternal health equity,[2] this paper primarily reflects insights into how the public health emergency affected maternity care and what provider and system responses emerged from March through October 2020. We also place

these findings in the context of early 2021 and the recent passage of the American Rescue Plan Act. With support from the Robert Wood Johnson Foundation, our team conducted literature reviews and in-depth interviews with maternal health stakeholders and facilitated a discussion with panelists representing varied community provider perspectives at a virtual convening in October 2020 (box 1).[3] Key findings from this work include the following:

- Though the pandemic has disrupted care delivery, stakeholders are optimistic that access to care could be strengthened by federal and state policies that ease restrictions on telehealth and expand health insurance coverage. However, some worry that these changes may not be sustained after the pandemic and that not all populations are equitably benefiting from them.

- The public health emergency necessitated some shifts away from traditional interventionist maternity care, such as Caesarean sections and labor inductions, and simultaneously increased patients' and policymakers' interests in alternative care models, like birth centers and doula services. The pandemic-induced economic downturn also highlighted that addressing families' basic needs is critical to overall maternal health.

- Expanding and diversifying the maternal health workforce is critical for promoting more culturally and linguistically effective care and addressing inequities. Pandemic-related staffing shortages have underscored this need and prompted legislators and payers to reimburse a broader range of providers.

- Payers, providers, health systems, and communities lack data on maternal outcomes disaggregated by race and ethnicity, creating uncertainty as to how pandemic-related changes to maternity care may be affecting preexisting inequities. Addressing these gaps will require transparent, community-driven data collection, data analysis, and data sharing that protects people's privacy.

BOX 1
Research Methods

From March to September 2020, we conducted individual and small-group interviews with 40 maternal health experts, maternity care providers, consumer advocates, philanthropic funders, and frontline health workers serving pregnant women to identify and examine key concerns about maternal health equity and challenges raised by the pandemic. We also conducted and periodically updated a comprehensive scan of publicly available information on maternal health equity during the pandemic from national policy and research organizations, professional and provider trade organizations, and leading maternal and infant health advocacy groups. Finally, we facilitated a panel discussion in October 2020 that represented various community-based provider perspectives, including midwifery, care coordination, maternal support services, and public health. The panelists were Diana Jolles, a midwife at El Rio Community Health Center and research chair of the American Association of Birth Centers; Kimberly Lyles, senior director of population health at HealthCare Access Maryland; Aza Nedhari, executive director of Mamatoto Village; and Oxiris Barbot, senior fellow for public health and social justice at the JPB Foundation and former New York City health commissioner.

Because of social distancing during the pandemic, this analysis has some limitations. We could not interview mothers directly, and though we interviewed provider and advocate stakeholders, we recognize their perspectives do not directly represent lived experiences. In addition, our interviewees were predominantly located on the East Coast, but we acknowledge community needs and realities differ by region and understand the importance of authentic community voice, partnership, and engagement as solutions are developed, implemented, and evaluated.

We center this work, part of the Urban Institute's larger Transforming Health and Health Care Systems project, around the Center for Social Inclusion's definition of racial equity: when "people, including people of color, are owners, planners, and decisionmakers in the systems that govern their lives" and society "[acknowledges and accounts for] past and current inequities and provides all people, particularly those most impacted by racial inequities, the infrastructure needed to thrive."[a]

[a] "What Is Racial Equity?," Center for Social Inclusion, accessed May 3, 2021, https://www.centerforsocialinclusion.org/our-work/what-is-racial-equity.

Background: Maternal Health Inequities before the Pandemic

Before the pandemic, the United States was already experiencing a maternal morbidity and mortality crisis. Maternal health outcomes are considerably worse in the US than in other high-income countries, and the maternal death rate has nearly doubled in recent decades (Tikkanen et al. 2020). Further, stark racial and ethnic inequities persist in these outcomes. Black and Indigenous women[*] are approximately two to three times more likely to die of pregnancy-related causes than white women (MacDorman et al. 2016; Petersen et al. 2019).[4] Further, racial disparities in maternal morbidity and mortality remain even when controlling for socioeconomic factors (Vilda et al. 2019). Various approaches to improving overall maternal and child health have been implemented, but they have seldom been targeted and thus have not eliminated inequities (Taylor and Benatar 2020).

Systemic racism has been identified as a key driver of disparate maternal health outcomes. Women of color with low incomes are more likely to face food insecurity, unstable housing, and mental health challenges such as depression and anxiety, all of which may negatively affect maternal and child health outcomes (Benatar et al. 2020; Davenport et al. 2020). Further, women of color have reported racism and discrimination, stressful interactions with providers, unmet needs for information, and inconsistent social support during pregnancy-related care (McLemore et al. 2018). Discrimination and racism in health care encounters can occur regardless of socioeconomic status and may cause chronic stress, a risk factor for poor maternal health outcomes (Latendresse 2009).

In addition, maternity services and supports tend to be sustained through a patchwork of funding streams, often leaving critical gaps that perpetuate maternal health disparities (Allen and Benatar

[*] We recognize some people who become pregnant and give birth do not identify as women. In this report, we use "women" and "mothers" as shorthand for all people who might need pregnancy, birth, and postpartum care. "Maternal care" includes these services and anyone requiring them.

2020). Financing structures and funding streams historically have not aligned with patients' desires and needs, thus limiting access to care women want and will use. The payment structures in Medicaid—which pays for nearly half of all births in the US and is the largest payer for births among women of color—incentivize hospital-based births and costly interventions that do not necessarily lead to better outcomes (HCPLAN 2016).[5] Historically, communities, payers, and providers have also lacked access to data on maternal outcomes and patient preferences that are disaggregated by race and ethnicity, which has hampered effective policy and programmatic responses.

Challenges and Promising Advances during the Pandemic

Prepandemic health inequities have been exacerbated by the public health emergency and resulting economic downturn. This is evidenced by the higher rates of COVID-19 exposure and deaths among people of color, which has raised concerns that inequities in maternal health outcomes have also worsened. Early evidence showed that Hispanic and non-Hispanic Black pregnant women were disproportionately affected by COVID-19; this is particularly alarming because pregnancy may pose an elevated risk for severe COVID-19 illness, and pregnant women with COVID-19 have experienced higher rates of maternal morbidity and mortality (Ellington et al. 2020; Jering et al. 2021). Further, Hispanic and Black adults are more likely than white adults to report the pandemic has negatively affected their families' finances, layering additional burdens onto mothers already at higher risk of poor maternal outcomes (Karpman et al. 2020).[6]

Key informants identified myriad challenges and barriers to equitable maternal health care posed by the pandemic, but they also noted that rapid health care delivery changes have led to considerable ingenuity and resourcefulness. As federal, state, and local governments have responded to the crisis, adaptations in policy and practice have highlighted both challenges to and promising advances toward ensuring more equitable maternal health outcomes during and after the pandemic. In the following sections, we identify such challenges and advances related to health care access, the content of care, the maternal health care workforce, and data and accountability.

Access to Care

During the pandemic, many patients have delayed or gone without health care because of cost concerns or fear of exposure to COVID-19 (Gonzalez et al. 2021). Patients seeking perinatal care faced particularly acute concerns about health care access, because early changes to labor and delivery protocols separated birthing people from their partners, support people, and infants (Haley and Benatar 2020).[7] As the pandemic intensified, health systems, policymakers, and payers made changes to better facilitate access to needed care.

Key informants identified skyrocketing virtual care use as a promising approach to increasing access to care during and potentially beyond the pandemic. As of October 2020, telehealth accounted

for 6 percent of all outpatient visits, compared with 1 percent of visits before the crisis, and one in three adults reported having used telehealth between March and September 2020 (Smith and Blavin 2021; Mehrotra et al. 2020). For many patients, telehealth removed barriers to care, such as a lack of transportation or child care. Specifically, interviewees mentioned increased attendance for postpartum visits, which previously had high no-show rates (CDC 2007), and higher participation in group prenatal care sessions.

New federal and state policies prompted by the crisis have eased telehealth restrictions, such as which services can be provided, who can provide them, and how they can be delivered and reimbursed. Before the pandemic, only 19 state Medicaid programs paid for telehealth services delivered to patients in their homes and often reimbursed such care at lower rates than for in-person care (Weigel et al. 2020). But in 2020, all states and the District of Columbia expanded telehealth for Medicaid populations (Augenstein et al. 2021). For example, North Carolina updated state policies to cover virtual prenatal care, postpartum care, and maternal support services (e.g., childbirth education),[8] and in New Jersey, the Department of Health can now provide doula support, home visiting, and early intervention services virtually.[9] Many major private insurers (e.g., Aetna, Blue Cross Blue Shield, and UnitedHealthcare), whether voluntarily or by state law, have also made policy changes to facilitate access to virtual care, including waiving cost-sharing for select services, expanding virtual mental health and/or substance use services, and instituting payment parity requirements for providers.

In addition, federal and state actions have bolstered access to health insurance coverage. States are currently bound by a maintenance-of-effort provision under Medicaid that prohibits them from disenrolling Medicaid beneficiaries during the public health emergency,[10] thus effectively extending postpartum coverage for all pregnant women enrolled in the program nationally (Dolan et al. 2020). At the state level, Medicaid programs were considering measures to extend postpartum coverage even before the pandemic; several states, such as Illinois, submitted waiver applications to extend postpartum coverage from 60 days to 12 months.[11] Other states, such as Tennessee, Virginia, and Washington, initially postponed similar proposals because of anticipated pandemic-related budget constraints, though Tennessee and Virginia reinitiated such efforts as state fiscal outlooks improved.[12] State Medicaid programs have also removed cost-sharing requirements, suspended prior authorization requirements, increased Medicaid billing flexibilities for out-of-state providers, and eased restrictions on nonhospital birth settings to make services more accessible (Allen and Benatar 2020; Dolan and Artiga 2020).[13] In fact, 15 states enacted temporary changes to eliminate all deductibles, copayments, coinsurance, and/or other cost-sharing charges in Medicaid under disaster relief State Plan Amendment authority.[14] Further, President Biden signed the American Rescue Plan into law in March 2021, and it includes a provision that allows states to extend Medicaid coverage from 60 days to one year postpartum via a State Plan Amendment rather than a Section 1115 waiver (Ranji, Salganicoff, and Gomez 2021).

The American Rescue Plan includes key provisions that could extend access to comprehensive affordable health care more broadly. Specifically, it temporarily implements more affordable Marketplace subsidies and further incentivizes expanding Medicaid coverage to people with incomes

up to 138 percent of the poverty level in states that have chosen not to do so thus far (Rudowitz, Corallo, and Garfield 2021). Studies show adoption of Medicaid expansion is associated with lower maternal mortality (Eliason 2020). Improving access to care across the lifespan in this manner, not just during pregnancy, could also improve maternal outcomes by ensuring women are healthy before they become pregnant (Searing and Cohen Ross 2019). As of this writing, Missouri and Oklahoma are poised to implement Medicaid expansion following successful ballot initiatives, though the former's legislature is moving to counter the measure. Policymakers in Alabama and Wyoming are also actively debating this topic.[15]

Though key informants were optimistic about these advances to prenatal and postpartum care access, they also worried about whether all populations were benefiting from them equitably. Systemic disparities affect access to care for women of color, as manifested in relatively low insurance coverage rates, geographic availability of care, and access to transportation (Haley and Benatar 2020; Johnston et al. 2019). Increased reliance on virtual care may exacerbate preexisting inequities among patients who lack reliable internet access or necessary devices, have limited English proficiency, are homeless, or are experiencing postpartum depression or other mental health challenges (Haley and Benatar 2020). For instance, stakeholders were concerned that patients in rural communities theoretically might benefit from increased telehealth use, but, in practice, may disproportionately lack broadband internet access.

Though further analysis of data disaggregated by race, ethnicity, and other demographic intersections is needed to evaluate the use of and outcomes from telehealth for all populations, early studies have shown inequities. One found that providers in a practice serving predominantly uninsured and Medicaid-insured patients expressed doubt that patients would have the necessary technology for telehealth and, as such, assumed it was not a viable care option; in reality, a patient survey showed the majority of patients were interested in video visits and had access to needed devices and internet (Ukoha et al. 2021). This research suggests provider attitudes and perceptions may result in differential implementation of virtual care. Another study found safety net providers lagged in offering telemedicine early in the public health emergency, likely because the supportive technology infrastructure that may have already existed in higher-resource settings, like video-enabled clinic computers and training for providers, was not in place before the pandemic (Park et al. 2018; Ukoha et al. 2021).

Content and Value of Care

Key informants discussed how payment and policy mechanisms have historically incentivized expensive, interventionist prenatal care in the United States, such as high-cost ultrasounds, genetic risk testing, inappropriate Caesarean sections, and other overused antenatal testing for low-risk patients. Interviewees emphasized such care is not only unnecessary but may be harmful, as time and resources could instead be used to implement evidence-based, culturally and linguistically effective health care practices and to address social determinants of health. The pandemic necessitated a shift away from some of these practices, which may have highlighted the value of alternative approaches to

care. Notably, interviewees reported fewer Caesarean sections, inductions, and in-person prenatal visits during the pandemic.

Additionally, Medicaid has historically emphasized and reimbursed traditional medical models of care, offering very limited coverage of alternative models, like birth center care, home births for low-risk pregnancies, midwife and doula services, and group prenatal care (Gifford et al. 2017),[16] despite evidence that supports the value of these models (Dubay et al. 2020; Gruber, Cupito, and Dobson 2013; Mazzoni and Carter 2017).[17] During the pandemic, however, patient and provider concerns over hospital strain and risk of exposure to COVID-19 spurred increased interest in nonhospital birth settings.[18] Policymakers in some states expanded reimbursement of these alternative care models as a part of their COVID-19 responses; whereas only 6 state Medicaid programs covered doulas in 2019, 16 states have proposed legislation related to covering doula services during the pandemic.[19] A handful of states have also enacted emergency orders to expand reimbursement for midwifery care (ACNM 2020). These alternative approaches and models are known to improve outcomes and reduce maternal health disparities by providing support and advocacy for women who face numerous risk factors for poor birth outcomes (Benatar et al. 2013).[20]

Moreover, the pandemic and resulting economic downturn have underscored that addressing patients' basic needs is critical to their overall health. Meeting basic needs is particularly important for addressing inequities in maternal health care, because pregnant women of color with low incomes experience higher risks for factors that adversely affect maternal health, including food insecurity, unstable housing, and depression and anxiety (Davenport et al. 2020). Interviewees emphasized the importance of localities working in partnership with communities and listening to the needs of consumers, as well as investing in improving linkages to culturally and linguistically effective, community-based social services. For example, all but three states are participating in a pilot program that allows Supplemental Nutrition Assistance Program beneficiaries to purchase their groceries online,[21] thus facilitating access to food assistance while reducing risks of COVID-19 transmission.

Maternal Health Workforce

As maternal health inequities have garnered more attention in recent years, people increasingly recognize how providers' cultural and linguistic effectiveness, communication abilities, and implicit biases and racial concordance between patients and providers can affect health outcomes.[22] Even before the pandemic, several cities and states began exploring implementing implicit bias trainings in various settings. In 2019, New York City started a three-year initiative that funds implicit bias training for hospital medical staff.[23] In 2019, the California state legislature began requiring that maternity care staff receive implicit bias training to help reduce the maternal death rate among Black women.[24] These efforts alone, however, are insufficient because disparities have persisted.

In addition, key informants emphasized that access to supports and patient advocates during the prenatal and postpartum periods and labor and delivery is critical to improving maternal health outcomes (NPWF 2018). [25] This is especially true for Black mothers, who are more likely to experience discrimination or mistreatment when receiving care. Informants noted access to such supports could

be augmented by bolstering the maternal health workforce. For example, reimbursing a wider range of providers, including midwives, doulas, community health workers, social workers, mental health providers, home visitors, substance use disorder providers, and outreach workers, could be essential to providing culturally and linguistically effective care and promoting equity. Increased demand for out-of-hospital maternal health services, as described above, also requires expanding the traditional maternity care workforce. Further, diversifying the provider workforce may reduce inequities, as racial concordance between patients and providers has been shown to facilitate higher-quality communication and patient-centered decisionmaking (Shen Johnson et al. 2017).

Interviewees also emphasized the importance of ensuring providers have adequate resources to provide high-quality care. They reported that the pandemic necessitated personnel shifts to crisis response efforts, shedding new light on preexisting staffing shortages. Stakeholders also raised concerns about providers' abilities to maintain their own health and well-being and avoid burnout. They also worried that staffing shortages could exacerbate inequities in maternal health outcomes. Several states, such as Maine, New Jersey, New York, Pennsylvania, Tennessee, and Texas, have adopted midwifery expansions during the pandemic to address such provider shortages.[26] These changes, along with relaxed licensing requirements and regulations for nonphysician providers delivering services, have reportedly helped bolster the maternal health workforce. However, they have largely been tied to the public health emergency and thus may only be temporary.

Additionally, key informants noted that inadequate supplies, training, and attention to staff safety may hamper providers' effectiveness. For example, increased access to care afforded by telehealth is only meaningful if providers have the equipment and training to deliver high-quality virtual services. Recognizing this need and illustrating a possible path forward for policymakers to address this problem, the California Health Care Foundation provided funds to 40 safety net providers to increase telehealth capabilities and provide hands-on technical assistance.[27] Interviewees also highlighted the importance of ensuring providers have what they need to work safely and efficiently, such as sufficient personal protective equipment and stress management support (Hermann, Fitelson, and Bergink 2021).

Accountability

To date, definitive data are lacking on whether pandemic-related service delivery changes have improved or exacerbated maternal health inequities, though stakeholders believe they are worsening. As such, the pandemic has underscored the need for improving collection and analysis of disaggregated data and for tying accountability to the findings (Taylor and Benatar 2020). For example, many interviewees identified telehealth as one of the most prominent changes to care delivery during the pandemic and noted it will likely be sustained. Yet little is known about which populations are using virtual services, how such services are associated with quality of care, how virtual care affects health outcomes, or whether virtual care access and outcomes are equitable across population groups, particularly whether such care reduces or exacerbates race- and income-related inequities.

Many communities have developed effective, culturally and linguistically relevant services that have not yet been evaluated (Taylor and Benatar 2020). In addition, some solutions that are purportedly evidence based have not been evaluated to see if they are effective within communities of color. Key informants emphasized the need for researchers to conduct community-engaged evaluations, which involve consumers in all aspect of research design, data collection, and analysis, and argued community voice should be the basis for evaluating interventions and approaches. Along these lines, many states have begun trying to improve data collection during the pandemic. For example, California's Department of Public Health assembled a health equity technical assistance team that will partner with community organizations and advocacy groups to develop resources and best practices. Additionally, Tennessee's Department of Health and Office of Minority Health implemented three COVID-19 data dashboards, including one that tracks pregnancies.[28] These models could serve as a template for other states and be maintained and further developed.

As stakeholders improve data collection and build data-sharing platforms, key informants emphasized that privacy and transparency are needed to ensure these efforts' effectiveness. Stakeholders emphasized only deidentified data should be included in such platforms to maintain provider-patient confidentiality and avoid punitive actions in systems that have historically had racially inequitable outcomes, such as the criminal justice and child welfare systems (Taylor and Benatar 2020). Key informants also argued that making patient, provider, and outcomes data easily accessible to patients and communities could improve care quality and reduce disparities in outcomes. For example, consumers could view data demonstrating which providers, alternative birthing locations, hospitals, and payers have produced high-quality, equitable outcomes and make choices about their care accordingly. Such platforms and privacy protections should also be designed in partnership with community stakeholders. Leadership and facilitation by federal and state policymakers are also needed.

Opportunities to Improve Maternal Health Equity after the Pandemic

Drawing on lessons learned throughout this research, we identified numerous opportunities to improve maternal health equity during and after the pandemic. Policymakers, health systems, providers, and payers could consider the following strategies both to capitalize on promising advances in maternal health care made during the crisis and promote improved and more equitable outcomes beyond the pandemic:

- **State and federal policymakers could expand Medicaid eligibility.** At the state and federal levels, policymakers could expand financial access to care by permanently expanding subsidized health care coverage, such as adoption of Medicaid expansion under Affordable Care Act authority and extension of postpartum Medicaid eligibility to 12 months, as the American Rescue Plan currently allows. Because many maternal deaths occur after delivery, several state maternal mortality review committees recommend extending postpartum

eligibility (Allen and Benatar 2020). Evidence shows women living in states that have expanded Medicaid have better access to preventive care, experience fewer adverse health outcomes during and after pregnancy, and have lower maternal mortality rates than women living in states that have not expanded Medicaid (Searing and Cohen Ross 2019).

- **Legislators, payers, and health systems could expand access to services and alternative care models that promote equitable outcomes.** Legislators could increase funding for services that may be more culturally and linguistically effective, such as telehealth, midwifery, doula support, prenatal risk assessments, screening for postpartum depression and social determinants of health, substance use treatment services, home visiting, and alternative care models like birth centers and group prenatal care. Interviewees also suggested legislators could remove barriers that prevent providers from working across state lines. All payers could incentivize delivery of high-value care by broadening the range of services they reimburse. Stakeholders stressed that this reimbursement must be adequate to *fully* cover service provision, including the costs associated with these models, like patient education materials and baby supplies. Tying reimbursement to outcomes and measures that promote health equity and emphasizing programming developed by and for communities could promote higher-quality patient-centered care. Additionally, health systems could establish midwifery units in hospitals, grant hospital privileges to midwives practicing in freestanding birth centers, and continually assess and act upon disaggregated data on access to and outcomes of these services.

- **Governments and payers could capitalize on the momentum and potential of telehealth while centering patient preferences and equity in care delivery.** Careful consideration should be given to making permanent the payment parity policies adopted during the pandemic and to expanding the scope of permitted and reimbursable maternal telehealth providers and benefits, including services critical to populations that disproportionately face poor maternal health outcomes. Payers could increase access to and use of at-home monitoring tools by covering the technology necessary for telehealth as durable medical equipment. Barriers to access, such as the "digital divide" and safety net providers' capacity limitations, could also be addressed through infrastructure investments in low-income and rural communities so all populations, including those who do not speak English, those with low incomes, and rural communities, can access virtual care. Health systems could train patients and providers on how to effectively use telehealth and track access and outcome measures by subgroup to assess equity implications. However, virtual care cannot always substitute for in-person care when high medical or psychosocial needs demand more hands-on care. The advantages of virtual care will need to be balanced against prioritizing patients' needs and preferences.

- **Payers could bolster payment mechanisms for addressing patients' social needs**. Because social needs significantly influence overall health, government programs and private payers could provide coverage for and/or linkage to wraparound supports (e.g., case management, home visiting, nutritional counseling), patient education, and social services. As interviewees noted, these services have often fallen short of addressing patient needs because of limited

funding (Allen and Benatar 2020). Thus, all payers have the opportunity to establish adequate reimbursement mechanisms to support these services and to use data to assess if access and outcomes are equitable across populations. This is particularly important given that the pandemic and economic downturn have increased needs for many Americans.

Throughout and after the pandemic, the United States has been and will continue being challenged to change maternal health care delivery and financing to ensure equitable outcomes. To take advantage of the opportunities discussed in this paper and develop systems of care patients and providers want and will use, policymakers and researchers would be wise to ask communities for input on research questions, data needs, and solutions. Further, data disaggregated across race, ethnicity, sexual orientation, gender identity, and other intersections must be collected as strategies are implemented, and the resulting findings must be shared with communities to enact changes where care and outcomes are falling short. Finally, as one stakeholders emphasized, "one size does not fit all," and the need for patient-centered alternatives remains.

Though this brief identifies opportunities for change within the health care system, the strategies proposed do not address the large, underlying inequities in income, wealth, education, and other factors that contribute to significant racial inequities in maternal health (Vilda et al. 2019). The American Rescue Plan includes several policies projected to dramatically cut poverty rates and racial disparities in poverty rates (Wheaton et al. 2021). Though these provisions are temporary, they could help build more permanent supports for families into the US safety net. These federal provisions, in conjunction with improved fiscal projections for the coming year (Hill, Courtot, and Burroughs 2021), should facilitate states' and localities' implementation of the infrastructure and support investments we have identified. Such health care system changes, coupled with policies targeting underlying structural inequities, could improve maternal health outcomes. Though the insights and responses to the pandemic explored here require additional exploration given the rapidly changing nature of the pandemic, the urgency of addressing the US maternal health crisis remains clear.

Notes

[1] "Pregnancy Mortality Surveillance System," Centers for Disease Control and Prevention, last reviewed November 25, 2020, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm; and "Severe Maternal Morbidity in the United States," Centers for Disease Control and Prevention, last reviewed February 2, 2021, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

[2] "Addressing Maternal Health Equity: Lessons Learned during the COVID 19 Pandemic," Urban Institute, accessed May 10, 2021, https://www.urban.org/policy-centers/health-policy-center/projects/addressing-maternal-health-equity-lessons-learned-during-covid-19-pandemic.

[3] For more information about the event, see https://www.urban.org/events/addressing-maternal-health-inequity-during-covid-19-pandemic.

[4] "Pregnancy Mortality Surveillance System," Centers for Disease Control and Prevention; and Monica R. McLemore, "COVID-19 Is No Reason to Abandon Pregnant People," *Scientific American*, March 26, 2020, https://blogs.scientificamerican.com/observations/covid-19-is-no-reason-to-abandon-pregnant-people/.

[5] "Births Financed by Medicaid," Kaiser Family Foundation, accessed May 3, 2021, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid.

[6] Steven Brown, "The COVID-19 Crisis Continues to Have Uneven Economic Impact by Race and Ethnicity," *Urban Wire* (blog), Urban Institute, July 1, 2020, https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity.

[7] Meshawn Tarver and Linda Richardson, "Increased Awareness of Midwifery and Home Birth Options in Response to the COVID-19 Pandemic," Association of Maternal and Child Health Programs, accessed May 3, 2021, http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Pages/Increased-Awareness-of-Midwifery-and-Home-Birth-Options-in-Response-to-the-COVID-19-Pandemic.aspx.

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[9] "How Do Pregnant People or New Mothers Stay Safe? What Rules Are in Place for Labor and Delivery during COVID-19?" New Jersey COVID-19 Information Hub, last updated April 14, 2021, https://covid19.nj.gov/faqs/nj-information/health-care-professionals/what-resources-or-guidance-is-there-for-expecting-mothers-new-mothers-and-health-care-providers.

[10] To receive the 6.2 percentage-point increase in the federal share of state Medicaid spending, states must meet the maintenance-of-effort requirements, including providing continuous coverage for current beneficiaries.

[11] On April 12, 2021, the Centers for Medicare & Medicaid Services approved Illinois's request to amend its Section 1115 demonstration waiver to extend postpartum Medicaid eligibility; see Anne Marie Costello (acting deputy administrator and director, Centers for Medicare & Medicaid Services), letter to Theresa Eagelson (director, Illinois Department of Healthcare and Family Services), regarding approval of Illinois's request to amend its Section 1115 demonstration waiver, April 12, 2021, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-continuity-care-admin-simplification-ca.pdf.

[12] Shannon Smith, "TennCare Postpartum Care Expansion Cut from Revised State Budget," WBIR, June 8, 2020, https://www.wbir.com/article/life/tenncare-postpartumcare-expansion-cut-from-revised-state-budget/51-8587612b-7c73-4566-b5e2-be7f524ace0d; Abigail Painchaud, "States Respond to COVID-19: Postpartum Medicaid Coverage, Contact Tracing," America's Essential Hospitals, April 28, 2020, https://essentialhospitals.org/policy/states-respond-covid-19-postpartum-medicaid-coverage-contact-tracing/; and Emily Eckert, "Despite Many States Doing What They Can, the Federal Government Must Act Now to Extend Postpartum Medicaid Coverage," *Health Affairs Blog,* December 8, 2020, https://www.healthaffairs.org/do/10.1377/hblog20201207.582148/full/.

[13] "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," Kaiser Family Foundation, April 28, 2021, https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/.

[14] "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," Kaiser Family Foundation.

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About the Authors

Emily Burroughs is a research analyst in the Health Policy Center at the Urban Institute. She primarily conducts research and analysis focused on maternal and child health, as well as access to health care coverage. Her qualitative data collection experience includes conducting key informant interviews, structured observations, and focus groups with a wide range of participants, such as health care consumers, providers, and administrators.

Ian Hill is a senior fellow in the Health Policy Center. He has over 30 years of experience directing evaluation and technical assistance projects on health insurance programs for mothers, children, and families. He is a nationally recognized qualitative researcher with extensive experience developing case studies of health program implementation and conducting focus groups with health care consumers, providers, and administrators.

Kimá Joy Taylor is the founder of Anka Consulting, a health care consulting firm, and a nonresident fellow at the Urban Institute. Taylor collaborates with Urban Institute researchers on a number of topics, including analyses of racial disparities in screening and treatment practices for parents with substance use disorder, management of neonatal abstinence syndrome at hospitals in California, and prevention and early detection of mental and behavioral health problems among adolescents and young adults. She most recently served as the director of the Open Society Foundations' National Drug Addiction Treatment and Harm Reduction Program. She oversaw grantmaking that supported the expansion of access to a nonpunitive continuum of integrated, evidence-informed, and culturally effective substance use disorder services. Before joining the Open Society Foundations, Taylor served as deputy commissioner for the Baltimore City Health Department, a health and social policy legislative assistant for Senator Sarbanes, and a pediatrician at a federally qualified health center in Washington, DC. Taylor is a graduate of Brown University, Brown University School of Medicine, and the Georgetown University residency program in pediatrics. In 2002, Taylor was awarded a Commonwealth Foundation fellowship in minority health policy at Harvard University.

Sarah Benatar is a principal research associate in the Health Policy Center. Her research investigates how public policies affect vulnerable populations' health outcomes, access to care, use of services, and enrollment in coverage programs, with a particular focus on maternal and child health. Benatar has led and participated in several projects focused on maternal and child health, the Children's Health

Insurance Program, and Medicaid, combining qualitative and quantitative methods to achieve the richest findings. She is working on a national evaluation of the Centers for Medicare & Medicaid Services' Strong Start for Mothers and Newborns enhanced prenatal care program; she leads the evaluation's process measurement and monitoring task and is a senior member of the case study team. Benatar is also deputy project director for a multiyear evaluation of a home visitation and community-based program intervention in Los Angeles, aimed at improving health and developmental outcomes for low-income mothers and children. She is also coleading a study to examine the impact of the Affordable Care Act on women's preventive health care service use. Additional recent work includes an evaluation of ongoing efforts to redesign the county clinic system in San Mateo County, California, an evaluation of a physician incentive program in Los Angeles, a review of recent family planning research, and a feasibility assessment of a universal vaccine-purchasing program for children in New York State. Benatar holds a PhD in public policy from the George Washington University.

Jennifer M. Haley is a research associate in the Health Policy Center, focusing on Medicaid, the Children's Health Insurance Program, and uninsurance among children and adults. She also studies health care and insurance coverage among groups including military veterans and children in immigrant families. She has an MA in sociology from Temple University

Eva H. Allen is a research associate in the Health Policy Center, where her work focuses on the effects of Medicaid policies and initiatives on disadvantaged populations, including people with chronic physical and mental health conditions, pregnant and postpartum women, and people with substance use disorders. Allen has played a key role in several federal demonstration evaluations and research projects on a range of topics, including opioid use disorder and treatment, maternal and child health, long-term care services and supports, and cross-sector collaborations to address social determinants of health. Her current work also includes a focus on integrating health and racial equity in research and policy analysis. Allen is experienced in qualitative research methods and adept at communicating complex policy issues and research findings to diverse audiences. Allen holds an MPP from George Mason University, with emphasis in social policy.

Sarah Coquillat is a research analyst in the Health Policy Center, where she conducts qualitative research and analysis focused on substance use disorder, health information technology, and child and maternal health. She has been involved in qualitative data collection and analysis for a number of projects. Her qualitative data collection experience includes conducting key informant interviews and focus groups with a wide range of participants, such as health care consumers, providers, and administrators.

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