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States Could Better Leverage Coverage and Access Requirements To Promote Maternal Health Care Access in Medicaid Managed Care

HHS Office of Inspector General

REPORT HIGHLIGHTS

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States Could Better Leverage Coverage and Access Requirements To Promote Maternal Health Care Access in Medicaid Managed Care

Why OIG Did This Review

- The United States is experiencing a maternal health crisis, with worse outcomes here than in any other high-income country. Significant racial and geographic disparities exist in maternal deaths and complications. Access to maternal health care influences these outcomes.
- Medicaid is the Nation's largest maternal health care payor, and most pregnant enrollees are covered by managed care organizations (MCOs). States use provider coverage rules and network adequacy standards (i.e., requirements that MCOs include enough providers in their networks) to help ensure that Medicaid managed care enrollees have adequate access to care.

What OIG Found

States are not leveraging managed care provider coverage requirements and network adequacy standards to promote access to maternal health care services that can support better maternal and infant health outcomes.

All States require their MCOs to cover obstetrician/gynecologist (OB/GYN) physicians and hospitals, but many States reported they **do not require their MCOs to cover other important types of maternal health providers and professionals,** some of whose services are federally required.

Some States are **not using network adequacy standards to address** important dimensions of **maternal health care access.** For example, some States do not measure access to specific provider types such as OB/GYN physicians. Additionally, some States do not tailor their standards to maternal health care (e.g., by varying appointment wait time requirements by stage of pregnancy).

All States reported monitoring MCOs' compliance with network adequacy standards, but they may **lack data on the standards' impact on enrollees' access to maternal health care.**

What OIG Recommends

OIG recommends that CMS:

1. Take steps to confirm that all States cover required services from maternal health care providers for Medicaid managed care enrollees.
2. Clarify the requirement that States have a provider-specific OB/GYN network adequacy standard.
3. Support States in tailoring their network adequacy standards to better address maternal health care needs.

CMS concurred with all three recommendations.

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BACKGROUND

OBJECTIVES

1. To determine what provider coverage rules and network adequacy standards State Medicaid agencies (States) have set for maternal health care in Medicaid managed care.
2. To assess State oversight of quantitative network adequacy standards.

Poor Maternal Health Outcomes and Health Disparities

Pregnant and postpartum women in the United States experience worse outcomes than in any other high-income country.[1, 2, 3] Furthermore, significant racial and geographic disparities exist. Specifically, women who are Black or American Indian or Alaska Native and women who live in rural areas face much higher rates of maternal mortality and morbidity than women who are White and women in urban areas.[a, 4, 5, 6] The COVID-19 pandemic worsened maternal health outcomes. COVID-19 during pregnancy was associated with more severe illness and a greater risk of pregnancy complications.[7]

Concerns About Access to Maternal Health Care

Access to timely and high-quality maternal care is particularly important to promote healthy outcomes. For example, a lack of adequate prenatal care is associated with riskier deliveries and a three to four times greater likelihood of death from pregnancy-related causes.[8, 9] Infants born to women who did not receive prenatal care are five times more likely to die than infants born to women who did receive care.[10] In addition, without adequate postpartum care, women may be more vulnerable to complications that arise after childbirth, such as postpartum depression.[11]

Several factors influence access, including the ability to make appointments with providers in a timely manner, the distances patients must travel for care, and providers' ability to provide services without bias or discrimination and in patients' native languages.[12] Maternal health provider shortages and a lack of diversity among providers contribute to limited provider access in the United States.[13, 14] The White

[a] In 2022, the maternal mortality rate for non-Hispanic Black pregnant women was more than twice as high as the rate for non-Hispanic White women. The rate for American Indian or Alaska Native women was two times higher. From 2016 to 2019, the maternal mortality rate in rural areas was 1.8 times higher than the rate in urban areas. See endnotes 4 through 6.

House has identified increasing access to maternal health care as a priority area for improving maternal health outcomes.[15]

Improving access to maternal health care in Medicaid managed care specifically could help improve maternal health outcomes and reduce disparities in maternal health outcomes overall. Medicaid is the Nation's largest maternal health care payor, financing more than 40 percent of all U.S. births and more than half of births among women who are Black or American Indian or Alaska Native and women who live in rural areas.[16, 17, 18] Furthermore, most States require managed care enrollment during pregnancy.[19]

Maternal Health Providers and Professionals

Maternal health care is provided by a range of health care workers, including providers and other professionals who specialize or receive training in maternal health care. Maternal health providers include obstetrician/gynecologist (OB/GYN) physicians, OB/GYN physicians who specialize in maternal-fetal medicine (maternal-fetal medicine specialists), family medicine physicians, and certified nurse-midwives. Maternal health professionals include doulas, lactation consultants, and community health workers.[b] Access to a variety of maternal health providers and professionals is important for ensuring that diverse pregnancy and postpartum care needs are met. Maternal health providers, who receive training in pregnancy and postpartum care, provide the majority of maternal health care.[20] OB/GYN physicians, in particular, have specialized training in obstetrics and are important in managing high-risk pregnancies.[21] Certified nurse-midwives and family medicine physicians play an essential role in providing maternal health care in rural areas, including areas with OB/GYN physician shortages.[22] Finally, care from maternal health professionals can help improve maternal health outcomes and reduce racial disparities in outcomes.[23, 24, 25, 26] For example, doula care has been associated with lower rates of preterm births and cesarean deliveries, which disproportionately impact women of color.[27]

Maternal health providers also include birth settings, such as hospitals and freestanding birth centers. Both hospitals and birth centers provide safe maternal health care for low- and moderate-risk pregnancies.[28] Patients with high-risk pregnancies benefit from receiving care at hospitals with more specialized obstetric services.[29] Birth centers, meanwhile, may improve care quality while reducing the cost of care. One evaluation showed that Medicaid enrollees who received prenatal care at birth centers participating in the Strong Start for Mothers and Newborns Initiative experienced better birth outcomes at a lower cost to Medicaid compared to Medicaid enrollees who received care in other settings.[30]

[b] CMS informed OIG that the term "health care providers" has a specific meaning in Medicaid and does not include doulas, lactation consultants, or community health workers. Therefore, we refer to these workers as "professionals" throughout this report.

Maternal Health Care Coverage in Medicaid

Federal statute and regulations require States to provide certain services for all Medicaid enrollees during pregnancy. Required pregnancy-related services include services that are necessary for the health of the pregnant patient and fetus.[31] Federal rules specifically require States to cover services from physicians (including OB/GYNs), certified nurse-midwives, and freestanding birth centers when licensed or otherwise recognized by the State.[32] Beyond these requirements, the Federal rules generally allow States to determine which types of maternal health providers and professionals they cover, leading to variation across States.[33] For example, States may choose to cover services from other types of midwives besides certified nurse-midwives—such as certified professional midwives or certified midwives—or support from other maternal health professionals. States may only cover services from providers or professionals that are licensed or otherwise recognized by the State.

The Centers for Medicare & Medicaid Services (CMS) allows States to provide Medicaid services using several delivery systems, including managed care and fee-for-service.[34] States must ensure that they cover all federally required services (known as mandatory benefits) from providers that are licensed or otherwise recognized in their State using the delivery system(s) of their choice. In States with managed care, States contract with one or more managed care plans to provide specified services to enrollees. If their managed care contracts do not include all mandatory benefits, States must provide those services via another delivery system instead.[35]

During pregnancy, most Medicaid enrollees are in a comprehensive, risk-based managed care plan with a managed care organization (MCO).[36, 37] In these arrangements, MCOs contract with providers to build networks to provide services.[38] Generally, MCOs limit enrollees' access to the providers within these networks.[39] However, Federal regulations require States to ensure that if plans cannot provide necessary services covered under the contract using in-network providers, plans cover those services out-of-network instead.[c, 40] Some MCOs require that enrollees receive prior authorization before receiving care from an out-of-network provider with limited exceptions, such as emergency care and family planning.[41, 42]

Ensuring Access in Medicaid Managed Care

Federal regulations require States to ensure, through their contracts, that MCOs maintain sufficient provider networks to provide all enrollees with adequate access to

[c] The regulations we discuss in this section also apply to other types of managed care plans not covered in this report (i.e., prepaid inpatient health plans and prepaid ambulatory health plans).

services covered under the contracts.[43] States use a variety of tools to do this, including coverage requirements and quantitative network adequacy standards.

Coverage Requirements

As permitted by Federal rules and State-specific policies, States determine which provider types they will reimburse in Medicaid. They then determine which services they will include in their comprehensive, risk-based managed care programs and specify this in their contracts with MCOs. For provider types that States do not require in their contracts, coverage is generally at the MCOs' discretion. MCOs may also choose to cover additional services, often called "value-added services," that are not Medicaid services covered under the State plan. However, States cannot include the cost of value-added services when setting capitation rates for MCOs.[44, 45]

Network Adequacy Standards

Network adequacy standards are requirements meant to ensure that there are enough providers in managed care networks to meet enrollees' needs. They have changed over time, but Federal regulations currently in effect require that States have at least one quantitative network adequacy standard related to OB/GYN care. Specifically, States must develop and enforce a provider-specific quantitative network adequacy standard for the provider type "OB/GYN" if covered under the managed care contract.[46] CMS reported to the Office of Inspector General (OIG) that when assessing this standard, States can include any providers who are approved in their States to provide OB/GYN services (OB/GYN providers), such as OB/GYN physicians, family medicine physicians, certified nurse-midwives, and other types of midwives. CMS does not require States to set quantitative network adequacy standards for specific maternal health provider types, such as OB/GYN physicians or certified nurse-midwives. In addition to the OB/GYN provider type, CMS names six other provider types for which States must develop a quantitative network adequacy standard: primary care providers (adult and pediatric), behavioral health providers (mental health and substance use disorder; adult and pediatric), hospitals, pharmacies, pediatric dental providers, and specialists as designated by the State (adult and pediatric).[47]

Quantitative network adequacy standards commonly fall into three categories: time and/or distance standards, appointment wait time standards, and provider-enrollee ratio standards. See Exhibit 1 on the next page for more information on each type of standard.

Exhibit 1: Different types of quantitative network adequacy standards work in tandem to help ensure that enrollees have access to care

Time and/or distance standards

Limit the time and/or distance enrollees should have to travel to visit providers

Intended to ensure that enrollees can visit providers within a reasonable distance from where they live

Appointment wait time standards

Limit the amount of time enrollees must wait for provider appointments

Intended to ensure that enrollees can visit a provider within a reasonable timeframe

Provider-enrollee ratio standards

Specify the number of providers that networks must include relative to the number of enrollees

Intended to ensure that plans' provider networks are large enough to serve enrollees and that enrollees have a choice of providers

In May 2024, CMS finalized a new rule that will require States to have two types of quantitative standards related to OB/GYN care. In addition to the provider-specific quantitative network adequacy standard for OB/GYN providers, States will also need to develop an appointment wait time standard for routine appointments for OB/GYN services if covered under plan contracts. States will have at least 3 years from the July 9, 2024, effective date of the final rule to comply with the new requirement.[48]

Monitoring

Federal regulations require CMS and States to monitor access to care in Medicaid managed care programs. CMS reviews all State plans, plan amendments, and contracts with MCOs to ensure that they comply with Federal requirements.[49] Additionally, States must conduct readiness reviews of each MCO's ability and capacity to perform satisfactorily in certain areas, including service delivery, and must have monitoring systems to track MCOs' performance that address the availability and accessibility of services, including network adequacy standards.[50] States are required to submit several reports to CMS detailing their managed care access requirements and compliance activities, including the Managed Care Program Annual Report and the Network Adequacy and Access Assurances Report.[51] Finally, as of February 2024, States' contracted External Quality Review Organizations (EQROs) must annually validate that plans' provider networks meet their States' network adequacy standards.[52] Some States' EQROs began performing these validation activities prior to February 2024.[53]

CMS's recent final rule also includes additional monitoring requirements for access to care in Medicaid managed care. CMS will now require States to use a "secret shopper" method to validate compliance with appointment wait time standards.[54] CMS will also require States to use data from annual enrollee experience surveys to improve the performance of their managed care programs, which will help States understand enrollees' perceptions of access to care.[55] Finally, CMS will require States to submit remedy plans for areas in which an MCO's access to care under the access standards in 42 CFR part 438 could be improved.[56]

Related OIG Work

OIG last evaluated States' access requirements for Medicaid MCOs in 2014.[57] We found that States' requirements varied widely and were often not specific to provider types or areas of the State. We also found that CMS's oversight of States' requirements was limited. In a companion report published the same year, we assessed the availability of Medicaid managed care providers.[58] We found that more than half of the providers could not offer appointments to enrollees and that some enrollees faced long wait times for appointments. We recommended that CMS strengthen its oversight of States' access requirements and provide States with technical assistance, among other things. CMS concurred with our recommendations.

OIG recently evaluated rates of prior authorization denials in Medicaid managed care.[59] We found that some plans had high rates of prior authorization denials and that State oversight of denials was limited. We issued five recommendations to CMS, including that CMS require States to conduct more oversight of plans' prior authorization decisions and work with States to identify and address MCOs issuing inappropriate prior authorization denials. CMS concurred with the recommendation to work with States on actions to identify and address instances of MCOs issuing inappropriate prior authorization denials. It neither concurred nor non-concurred with the remaining four recommendations.

Lastly, OIG is currently evaluating access to both behavioral health care and maternal health care in some Federal programs. Enrollees often face challenges accessing both of these service types. Specifically, OIG recently evaluated access to behavioral health care providers in Medicare fee-for-service, Medicare Advantage, and Medicaid managed care, including determining provider-enrollee ratios and travel time/distance between providers and enrollees.[60] In addition, OIG is currently evaluating behavioral health provider availability, appointment wait times, and the accuracy of provider directories.[61] OIG is also evaluating access to maternal health care providers in Medicaid managed care.[62] OIG's work in these areas will provide insight into the number of behavioral health providers operating in Medicare and Medicaid and the number of maternal health providers operating in Medicaid managed care. It will also address the extent to which these providers provide services to enrollees.

Methodology

This report examines provider coverage rules and network adequacy standards established by States for maternal health care in comprehensive, risk-based MCOs and their implications for pregnant and postpartum enrollees' access to care.[d] While a variety of health care workers provide maternal health care services and support, this report focuses primarily on OB/GYN physicians (including maternal-fetal medicine specialists), certified nurse-midwives, other midwives that are not certified nurse-midwives, doulas, lactation consultants, community health workers, hospitals with obstetric services, and birth centers.

We based this study on data from a survey of State Medicaid agency (State) staff, with email followup as needed, and supporting documentation. In some cases the States provided the documentation, and in other cases it was publicly available. We identified 41 States that have comprehensive, risk-based managed care programs covering pregnant and/or postpartum enrollees. Between January and April 2023, we surveyed the 41 States and collected MCO contracts[e] and links to their network adequacy standards.

In our survey, we asked States about:

- their coverage of maternal health providers,
- their requirements for network adequacy, and
- their assessment and enforcement of compliance with network adequacy standards.

All 41 States responded to our survey. We analyzed survey responses to understand States' requirements regarding maternal health care access in Medicaid managed care and considered potential access implications for enrollees in those States. We also reviewed MCO contracts and States' annual external quality review (EQR) technical reports for additional details and followed up with States individually to clarify responses as needed.

Limitations

Our analysis relied primarily on self-reported data from State Medicaid agencies. As discussed above, we used additional documents, including MCO contracts and annual EQR technical reports, to clarify or contextualize self-reported information when necessary.

[d] This study does not address other types of Medicaid managed care plans, such as limited benefit plans (i.e., prepaid inpatient health plans and prepaid ambulatory health plans).

[e] We asked States to submit their contract(s) that were in effect for 2023 (or the most recent contract(s) in effect) that covered pregnant and/or postpartum enrollees.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

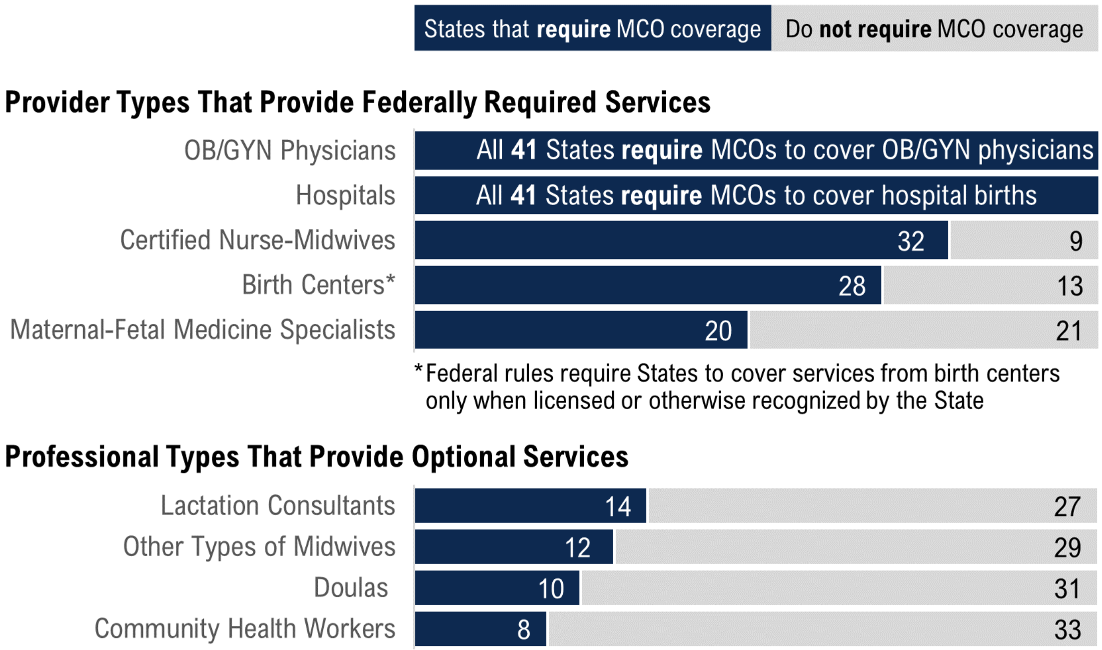
Many States are not fully leveraging Medicaid managed care coverage and access requirements to promote access to maternal health care. We found that many States do not require MCOs to cover important types of maternal health providers and professionals. Furthermore, some States are not using network adequacy standards to address important dimensions of maternal health care access in managed care. Finally, while States monitor MCO compliance with network adequacy standards, they may lack data on the standards' impact on their enrollees' access to maternal health care.

All States require their MCOs to cover OB/GYN physicians and hospital births, but many States do not require their MCOs to cover other important types of maternal health providers and professionals

We asked States if they require their MCOs to cover a variety of types of maternal health providers and professionals. All 41 States reported that they require MCOs to cover care from OB/GYN physicians and hospital births. However, many States reported that they do not require MCOs to cover some other important types of providers and professionals, including provider types whose services are federally required (i.e., certified nurse-midwives, birth centers, and maternal-fetal medicine specialists) and professionals whose services are optional Medicaid benefits (e.g., doulas, community health workers).[f, 63] Exhibit 2 on the next page shows the MCO coverage rules States reported for each provider and professional type.

[f] Some States reported that they require MCOs to cover OB/GYN physicians but not maternal-fetal medicine specialists, even though maternal-fetal medicine specialists are OB/GYN physicians.

Exhibit 2: Many States reported that they do not require their MCOs to cover certain types of maternal health providers and professionals



Source: OIG analysis of survey data and followup information from States, 2023.

Some States reported that they do not require MCOs to cover certified nurse-midwives, freestanding birth centers, and/or maternal-fetal medicine specialists. States must cover services from these providers in Medicaid, whether through managed care or another delivery system, if they are licensed or otherwise recognized by the State. Nine States reported that they do not require MCOs to cover certified nurse-midwives, and 21 States reported that they do not require MCOs to cover maternal-fetal medicine specialists, although all States license or recognize both of these provider types. Thirteen States reported that they do not require MCOs to cover birth centers, including at least eight that license them. Furthermore, all but one of the States that reported not requiring MCOs to cover services from certified nurse-midwives, birth centers, and/or maternal-fetal medicine specialists also reported not covering these services via another delivery system, like fee-for-service. Consequently, it is unclear how these States cover services from these providers for MCO enrollees.

CMS reported that it reviews MCO contracts for compliance with the Federal regulatory requirements found at 42 CFR part 438 and that it reviews State Medicaid plan amendments for compliance with statutory requirements, but it did not report that it tracks which delivery system(s) each State uses to cover federally required services from certified nurse-midwives, maternal-fetal medicine specialists, and birth centers. CMS also reported that it does not dictate how these providers participate in each State's Medicaid program and that it expects that States are operating their Medicaid programs in compliance with all applicable laws and regulations.

Federal rules do not require States to cover all types of maternal health professionals in Medicaid, including in managed care. For example, States have the option, but are not required, to cover services from professionals such as doulas and community health workers. Twenty-four States reported that they require their MCOs to cover at least one maternal health professional type that is not required by Federal laws or rules. Only one State reported that it requires its MCOs to cover all four optional types of maternal health professionals we asked about in our survey. While factors like provider licensure and availability can influence State coverage decisions, covering a wider variety of maternal health professional types, where feasible, could improve access to certain services, particularly for areas experiencing OB/GYN shortages.[64, 65] Covering more types of providers and professionals could also improve quality of care and reduce costs and disparities in outcomes.[66, 67]

Three States reported that they were planning to make changes to require MCOs to cover additional optional maternal health professional types. These States reported plans to require MCO coverage of professional types such as doulas, community health workers, and lactation consultants.

Several States that do not require MCOs to cover certain maternal health provider or professional types reported that some MCOs voluntarily cover services from these providers and professionals as value-added services. For example, MCOs in at least 10 States voluntarily cover doula services as a value-added service. MCOs that cover additional maternal health provider or professional types as value-added services provide these services to pregnant and postpartum enrollees in their plans. However, because value-added services are not included when States set Medicaid capitation payment rates, there may not be a strong incentive for MCOs to voluntarily cover these additional services.

If enrollees cannot access care from certain providers or professionals because those providers or professionals are not covered, enrollees may face worse outcomes as a result. Three-quarters of States reported that they do not require their MCOs to cover doula services. HHS has identified coverage of doula services as a promising strategy for improving the maternal health care experience for patients and providing supports that can contribute to improved maternal health outcomes.[68] Additionally, more than three-quarters of States reported that they do not require their MCOs to cover community health workers. Community health workers can play an important role in increasing access to care for marginalized communities by helping them navigate the health care system.[69] This professional type may be particularly valuable for improving maternal health given the well-documented disparities in maternal health outcomes among women who are Black or American Indian or Alaska Native.

CMS is taking steps to increase enrollee access to a wider variety of maternal health services, including in Medicaid managed care. In December 2023, CMS announced the new Transforming Maternal Health Model, which is aimed at improving maternal health and birth outcomes and reducing health disparities.[70] This model will support up to 15 selected States in increasing access to important maternal health provider types, such as midwives and birth centers, and to services provided by maternal health professionals, such as community health workers and doulas.

Some States are not using network adequacy standards to address important dimensions of maternal health care access

While Federal rules require States to have a quantitative network adequacy standard for OB/GYN providers, States have significant flexibility in the standards they set. Many States have used network adequacy standards in ways that may better promote maternal health care access in Medicaid managed care. States that have not taken these steps may be missing important opportunities to ensure access for their pregnant and postpartum enrollees. In particular, some States have not:

- implemented network adequacy standards that measure availability of specific types of maternal health providers,
- implemented multiple types of quantitative network adequacy standards for maternal health care, or
- tailored their network adequacy standards to better address maternal health care needs.

Some States' network adequacy standards for OB/GYN providers do not measure availability of specific maternal health provider types, including OB/GYN physicians

Although all States reported to OIG that they have at least one quantitative network adequacy standard for OB/GYN providers, as CMS currently requires, some of these standards do not measure availability of specific provider types within the OB/GYN category.[g] Specifically, 22 States reported that they allow multiple provider types—including OB/GYN physicians, other types of physicians, and physician assistants—to count toward their standards for OB/GYN providers. Furthermore, one other State's only OB/GYN standard measures availability of prenatal care without specifying provider type. By contrast, 18 States reported standards that measure access specifically to OB/GYN physicians. CMS reported to OIG that the requirement at 42 CFR § 438.68(b)(1)(ii) permits States to have standards for providers of OB/GYN services generally rather than for OB/GYN physicians specifically, but it has not published guidance on this.

[g] If a State's contracts with MCOs include coverage of OB/GYN services—as all of the 41 States in our study reported—CMS requires that the State set a quantitative network adequacy standard for providers of OB/GYN services (OB/GYN providers). See 42 CFR § 438.68(b).

In States with standards that include a broad range of maternal health provider types, MCOs could meet these standards with any combination of the allowed provider types. While standards that include multiple provider types are allowable under CMS rules, they leave decisions about the composition of provider networks—which and how many of different provider types to include—largely to MCOs. As a result, MCOs could potentially meet the standards even when their enrollees have limited access to certain maternal health provider types, including those whose services States are required to cover in Medicaid. MCOs must ensure access to medically necessary covered services out-of-network if they are not available in-network, but accessing out-of-network services may be more difficult for enrollees. By contrast, in States with standards that measure access to specific maternal health provider types, such as OB/GYN physicians, MCOs must ensure that their networks include sufficient numbers and/or locations of such provider types. As such, enrollees in these States may find it easier to access care from those types of providers.

Furthermore, nine States reported general network adequacy standards that classify OB/GYN physicians as specialist physicians and measure access to "specialists" as one group (in addition to their network adequacy standards for OB/GYN providers).[71] MCOs could meet these standards for network adequacy using any combination of specialist providers. As a result, these standards likely have little influence on provider adequacy for any individual specialty, including maternal health care. At the time of our survey, one State's only reported network adequacy standard for OB/GYN providers in fact measured access to all specialist physicians collectively. As such, this State's survey response indicated that it did not have a provider-specific network adequacy standard for OB/GYN providers as required by Federal rules.[72] This State also reported that it was updating its standards because it deemed them insufficient for assessing access to OB/GYN providers. As of January 2024, this State now has an OB/GYN network adequacy standard that is specific to providers of OB/GYN services, including OB/GYN physicians, multiple kinds of midwives, and OB/GYN nurse practitioners.[73]

Some States have only one type of network adequacy standard for maternal health care

Fourteen States have only one type of quantitative network adequacy standard specific to maternal health care.[h, i] The rest of the States have more than one type specific to maternal health care. Among the 14 States with only one type of quantitative network adequacy standard for maternal health care, nearly all (12) have

[h] This includes 13 States we identified in our analysis, as well as 1 State that reported it was revising its network adequacy standards and has since implemented a new network adequacy standard for OB/GYN providers (as previously discussed).

[i] Our analysis in this section includes standards that are for OB/GYN providers or explicitly reference maternity care, pregnancy care, or prenatal care. It does not include standards States reported that measure network adequacy for a larger pool of physicians such as "specialists" collectively.

time and/or distance standards, while 1 has appointment wait time standards and another has provider-enrollee ratio standards.

Examples of each type of quantitative network adequacy standard

Most quantitative network adequacy standards for maternal health care fall into one of three categories:

Time and/or Distance Standards

Example: MCOs must have one OB/GYN available within 30 miles or 30 minutes for urban counties and 60 miles or 60 minutes for rural counties.

Appointment Wait Time Standards

Example: MCOs must ensure initial pregnancy appointments are available within 10 calendar days of request.

Provider-Enrollee Ratio Standards

Example: MCOs must have 1 in-network OB/GYN provider per 3,000 Medicaid enrollees.

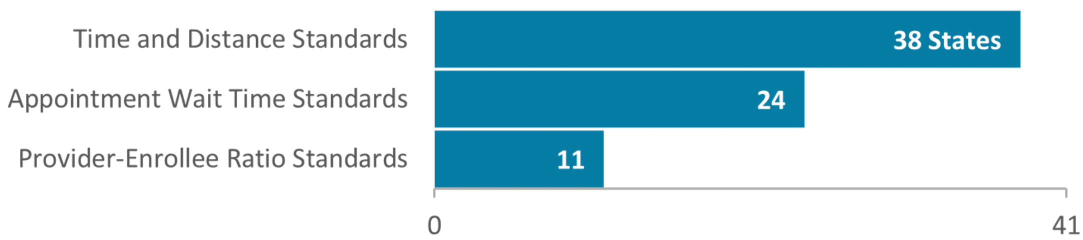
Source: OIG survey of States, 2023.

Having multiple types of quantitative network adequacy standards for maternal health care could help States ensure better access for pregnant and postpartum enrollees. This is because each type of network adequacy standard—time and/or distance, appointment wait time, and provider-enrollee ratio—enables States to assess access from a different angle. For example, appointment wait time standards require MCOs to limit the time enrollees must wait for an appointment, but they do not address whether providers in MCO networks are located within a reasonable travel time or distance from enrollees. This is important for pregnant and postpartum enrollees because travel time is a known barrier to accessing care.[74, 75] By developing multiple types of network adequacy standards, States can require MCOs to account for different factors impacting enrollee access to maternal health care.

For OB/GYN providers, CMS currently requires States to set only one type of quantitative network adequacy standard, chosen by the State. However, CMS recently finalized requiring States to have two types of quantitative standards related to OB/GYN care: one for appointment wait time for routine appointments for OB/GYN services, and one of a different quantitative type chosen by the State for OB/GYN providers.[76] States have at least 3 years from the July 9, 2024, effective date of the final rule to implement these network adequacy standards.[77]

As shown in Exhibit 3 on the next page, among network adequacy standards for maternal health care, States most commonly have time and/or distance standards (38 States). Twenty-four States have appointment wait time standards for maternal health care. Only 11 States have provider-enrollee ratio standards.

Exhibit 3: Nearly all States (38/41) have time and/or distance standards for maternal health care, but standards for appointment wait time and provider-enrollee ratio are less common



Source: Analysis of OIG survey data and followup information from States, MCO contracts, and EQRO reports, 2023.

Many States have tailored their network adequacy standards to better address maternal health care needs, but not all States have done so

Many States' network adequacy standards for maternal health care have one or more features that address the access needs for pregnant and postpartum Medicaid enrollees. OIG identified two strategies States use to tailor their standards: making their appointment wait time standards more specific to pregnancy and developing additional network adequacy standards for maternal health provider and professional types beyond OB/GYN physicians. Twenty-five of 41 States use one or both of these strategies.

> As an example of a **standard adapted to maternal health care,** one State's appointment wait time standard contains provisions for each trimester of pregnancy, as well as for high-risk appointments and emergent care:
>
> "**Maternity care** must be available no later than fourteen (14) calendar days after request during the first trimester, no later than seven (7) calendar days after request during the second trimester, and no later three (3) calendar days after request during the third trimester. For **high-risk pregnancies**, the member must be seen no later than three (3) calendar days after identification of high risk by the MCO or maternity care provider, or immediately if an **emergency exists.**"

Twenty-two States have appointment wait time standards that specify wait times for pregnancy-related appointments. Fifteen of these States further specify wait times by trimester, which enables them to require shorter wait times as pregnancy progresses and more frequent care is needed. Additionally, 13 States specify separate, shorter wait time standards for high-risk pregnancies. By contrast, two States use only a general appointment wait time standard for OB/GYN providers that does not differ by the type of service, stage of pregnancy, or level of risk.

Adapting appointment wait time standards to maternal health needs may be particularly important because pregnancy-related care is often time-sensitive. For example, prenatal visits typically occur weekly in the last month of pregnancy.[78] Additionally, high-risk pregnancies or complications may necessitate more frequent visits, and initial prenatal care appointments may be required to identify the pregnancy risk level.

Additionally, seven States have opted to set separate quantitative network adequacy standards for maternal health providers and professionals other than OB/GYN physicians. These other providers and professionals include midwives, doulas, birth centers, and hospitals with obstetric services. As discussed above, non-OB/GYN provider types such as midwives and doulas have been shown to improve access and may particularly benefit communities experiencing maternal health disparities. Furthermore, having better access to hospitals with obstetric services may improve outcomes: A lack of hospital-based obstetric services may be associated with an increased risk of preterm births in rural areas.[79] Federal rules require States to have a quantitative network adequacy standard for hospitals, but they do not require States to have a standard for hospitals with obstetric services specifically.

All States reported monitoring MCOs' compliance with network adequacy standards, but they may lack data on the standards' impact

Federal regulations require that States have a monitoring system for their Medicaid managed care programs that addresses the availability and accessibility of services, including network adequacy standards.[80] As of February 2024, States are specifically required to have their EQROs validate that each MCO's provider network meets the State-defined network adequacy standards. States are also required to submit information about their MCOs' compliance with State network adequacy standards to CMS in the Managed Care Program Annual Report and the Network Adequacy and Access Assurances Report.[81, 82]

All 41 States reported that they, their EQROs, or another entity used a variety of strategies to assess MCOs' compliance with the State's network adequacy standards for maternal health care. The strategies States most often reported were network adequacy reviews, such as geo-mapping of travel time and distance between providers and enrollees, reviewing enrollee and/or provider complaints or appeals, and validating provider directories. About one-third of States (14) reported identifying MCO noncompliance with their standards in the last few years. Among these States, half reported that noncompliance was rare or minor. Some States also noted that noncompliance was related to provider shortages, commonly in rural areas.

Although States monitor MCOs' compliance with network adequacy standards, they may have limited data regarding the standards' impact on access. Specifically, 36 States reported that they had not observed or measured any changes in access to maternal health care after implementing quantitative network adequacy standards in Medicaid managed care. Furthermore, nine of these States said their standards had been in place for so long that they lacked baseline data on their effectiveness. While Federal rules for the EQR network adequacy validation activity require validating that MCOs meet State network adequacy standards, they do not require evaluating the standards' effectiveness in ensuring access.[83, 84] Additionally, neither the Managed Care Program Annual Report nor the Network Adequacy and Access Assurances Report require evaluating the impact of network adequacy standards on access. For example, they do not require States or EQROs to assess Medicaid enrollees' realized access to maternal health care.

CONCLUSION AND RECOMMENDATIONS

The maternal health crisis in the United States is a serious public health issue, and policymakers continue to seek effective, timely ways to address it. Medicaid is particularly important in efforts to improve maternal health outcomes and reduce disparities because it is a primary source of coverage for groups that experience worse outcomes, including women who are Black or American Indian or Alaska Native and women who live in rural areas. Additionally, most Medicaid enrollees are in managed care during pregnancy. As a result, improving access to maternal health care for enrollees in Medicaid managed care could help improve maternal health outcomes more broadly.

Federal rules require States to provide pregnancy-related services; to ensure that their Medicaid programs cover physicians, certified nurse-midwives, and birth centers when licensed or otherwise recognized by the State; and to develop network adequacy standards for OB/GYN providers and services in Medicaid managed care. However, States have considerable latitude in implementation, in part to account for State-specific circumstances that impact services, such as provider licensure and availability. We found that many States are not fully leveraging provider coverage requirements and network adequacy standards to promote access to maternal health care in their managed care programs. Furthermore, we found that States may not have sufficient data to assess the impact of their standards.

While CMS has recently finalized new regulatory requirements for States' network adequacy standards to help improve enrollees' access to timely maternal health care, our findings demonstrate that there are additional steps States can take to help ensure access to pregnancy and postpartum care in Medicaid managed care. CMS has opportunities to help ensure that States' requirements function most effectively to promote maternal health care access, which could particularly benefit Medicaid enrollees experiencing the worst maternal and infant health outcomes.

We recommend that CMS:

Take steps to confirm that all States cover required services from maternal health providers for Medicaid managed care enrollees

CMS should ensure that all States cover federally required services from maternal health providers—including certified nurse-midwives, maternal-fetal medicine specialists, and birth centers that are licensed or otherwise recognized by the State—for Medicaid managed care enrollees. Some States reported that they neither require their MCOs to cover services from these providers nor provide them via another delivery system. Furthermore, CMS did not report that it tracks which delivery system(s) each State uses to provide coverage of these services for Medicaid managed care enrollees.

To implement this recommendation, CMS could conduct outreach to States that reported they do not require their MCOs to cover certified nurse-midwives, maternal-fetal medicine specialists, and/or birth centers to confirm that managed care enrollees have coverage for these services elsewhere. CMS could also verify coverage by reviewing data sources in these States, such as claims and encounter data and provider directories. If CMS identifies any States that are not currently covering federally required services from maternal health providers for Medicaid managed care enrollees, it should take prompt action to address the issue. Additionally, to facilitate oversight for all States going forward, CMS could consider collecting information in the Managed Care Program Annual Report or the Network Adequacy and Access Assurances Report about which delivery systems States use to cover required maternal health services.

Clarify the requirement that States have a provider-specific OB/GYN network adequacy standard

CMS reported to OIG that the requirement at 42 CFR § 438.68(b)(1)(ii)—that States must have a "provider-specific network adequacy standard" for the "provider type . . . OB/GYN" means that States must have a network adequacy standard for *providers of OB/GYN services*, as identified by the State, not specifically for OB/GYN physicians. CMS also reported that States can select which specific provider types they allow to count toward this network adequacy standard. OIG found that many States had OB/GYN standards specific to physicians while others had standards that included a range of providers, which may indicate that the requirement is not clearly or consistently understood across States and stakeholders. CMS should provide guidance clarifying the meaning of this requirement, given the implications for the types of network adequacy standards that are compliant.

Support States in tailoring their network adequacy standards to better address maternal health care needs

CMS should take steps to support States in developing network adequacy standards for Medicaid managed care that are tailored to serve pregnant and postpartum enrollees' needs. As a first step, CMS should collect data on which provider types States are including in their OB/GYN standards, as well as how specifically those standards are assessed (e.g., for each provider type individually or across all included provider types as a group). To do so, CMS could consider revising its Managed Care Program Annual Report and/or Network Adequacy and Access Assurances Report templates to reflect this information, as appropriate. Additionally, CMS should provide States with guidance or technical assistance to help improve their network adequacy standards for maternal health care. For example, CMS could provide guidance on which provider types are most appropriate for States to include in their OB/GYN standards. CMS could also provide States with guidance on developing network adequacy standards that focus on maternal health needs, such as those that specifically assess access by pregnancy stage or risk level.

CMS could take these steps as part of efforts to oversee its new network adequacy requirements. CMS's recent final rule requires many States to develop appointment wait time standards for OB/GYN services for the first time. CMS guidance could encourage States to tailor their new appointment wait time standards to better promote access to maternal health care. CMS could also encourage States to monitor access to OB/GYN providers before and after implementation of their appointment wait time standards and use that information to adjust their standards as needed.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with all three of our recommendations.

In response to our first recommendation—that CMS take steps to confirm that all States cover required services from maternal health care providers for managed care enrollees—CMS stated that it will conduct outreach to States that reported they do not require their MCOs to cover certified nurse-midwives, maternal-fetal medicine specialists, and/or birth centers to confirm managed care enrollees have access to these services elsewhere. If CMS identifies any States that are not currently covering federally required services from maternal health providers for managed care enrollees, it should take appropriate action to address the issue.

In response to our second recommendation—that CMS clarify the requirement that States have a provider-specific OB/GYN network adequacy standard—CMS stated that it provided guidance to States on defining eligible providers for each provider type outlined in 42 CFR § 438.68(b)(1) in its Toolkit for Ensuring Provider Network Adequacy and Service Availability. Additionally, CMS stated that it would provide additional clarification to States on the types of professionals that could be included in network adequacy standards for OB/GYN providers. While the Toolkit does include guidance for defining primary care providers, it does not include such guidance for OB/GYN providers as specified at 42 CFR § 438.68(b)(1)(ii). We look forward to CMS further clarifying States' requirements and options for their OB/GYN network adequacy standards.

In response to our final recommendation—that CMS support States in tailoring their network adequacy standards to better address maternal health care needs—CMS stated that it will continue to provide guidance and technical assistance to States in improving their network adequacy standards, including those for maternal health. CMS stated it will also share examples of how States could tailor their network adequacy standards to better meet the needs of pregnant and postpartum enrollees. Additionally, CMS stated that it will update the Network Adequacy and Access Assurances Report to collect data on which provider types States include in their OB/GYN network adequacy standards. CMS will also have States specify whether those standards are assessed for each provider type individually or across all included provider types.

For the full text of CMS's comments, see Appendix B.

APPENDICES

Appendix A: Detailed State Data

The information in this appendix is based on multiple data sources, including States' survey and followup responses from January through April 2023 and OIG review of MCO contracts and EQRO reports, as described in the Methodology section.

Exhibit 4: Maternal health provider and professional types that States require MCOs to cover

All States require MCOs to cover OB/GYN physicians and hospital births.

✓ = State requires MCOs to cover the provider or professional type

State	Certified Nurse-Midwives	Birth Centers	Maternal-Fetal Medicine Specialists	Lactation Consultants	Other Types of Midwives	Doulas	Community Health Workers
Arizona	✓						
Arkansas	✓		✓	✓			
California	✓	✓			✓	✓	✓
Colorado							
Delaware	✓	✓		✓	✓		
Florida	✓				✓		
Georgia	✓	✓	✓	✓			

State	Certified Nurse-Midwives	Birth Centers	Maternal-Fetal Medicine Specialists	Lactation Consultants	Other Types of Midwives	Doulas	Community Health Workers
Hawaii	✓						
Illinois	✓	✓	✓				
Indiana							
Iowa	✓	✓	✓	✓	✓		
Kansas	✓	✓	✓	✓			
Kentucky	✓		✓				
Louisiana	✓	✓	✓	✓			✓
Maryland		✓	✓			✓	
Massachusetts	✓	✓	✓				
Michigan	✓			✓		✓	✓
Minnesota	✓	✓	✓	✓	✓	✓	✓
Mississippi	✓		✓				
Missouri		✓					
Nebraska	✓	✓	✓	✓			
Nevada	✓	✓	✓		✓	✓	✓

State	Certified Nurse-Midwives	Birth Centers	Maternal-Fetal Medicine Specialists	Lactation Consultants	Other Types of Midwives	Doulas	Community Health Workers
New Hampshire	✓	✓			✓		
New Jersey	✓	✓			✓	✓	✓
New Mexico	✓	✓			✓		
New York	✓	✓	✓	✓	✓		
North Carolina							
North Dakota	✓	✓					
Ohio	✓	✓					✓
Oregon			✓	✓		✓	
Pennsylvania	✓	✓					
Rhode Island	✓	✓		✓		✓	
South Carolina			✓				
Tennessee		✓	✓				
Texas	✓	✓	✓		✓		✓
Utah		✓					
Virginia	✓			✓		✓	

State	Certified Nurse-Midwives	Birth Centers	Maternal-Fetal Medicine Specialists	Lactation Consultants	Other Types of Midwives	Doulas	Community Health Workers
Washington	✓	✓					
Washington, DC	✓	✓		✓		✓	
West Virginia	✓	✓	✓				
Wisconsin	✓	✓	✓		✓		

Exhibit 5: Some States allow only OB/GYN physicians to count toward their quantitative network adequacy standards for OB/GYN providers, while other States allow multiple provider types

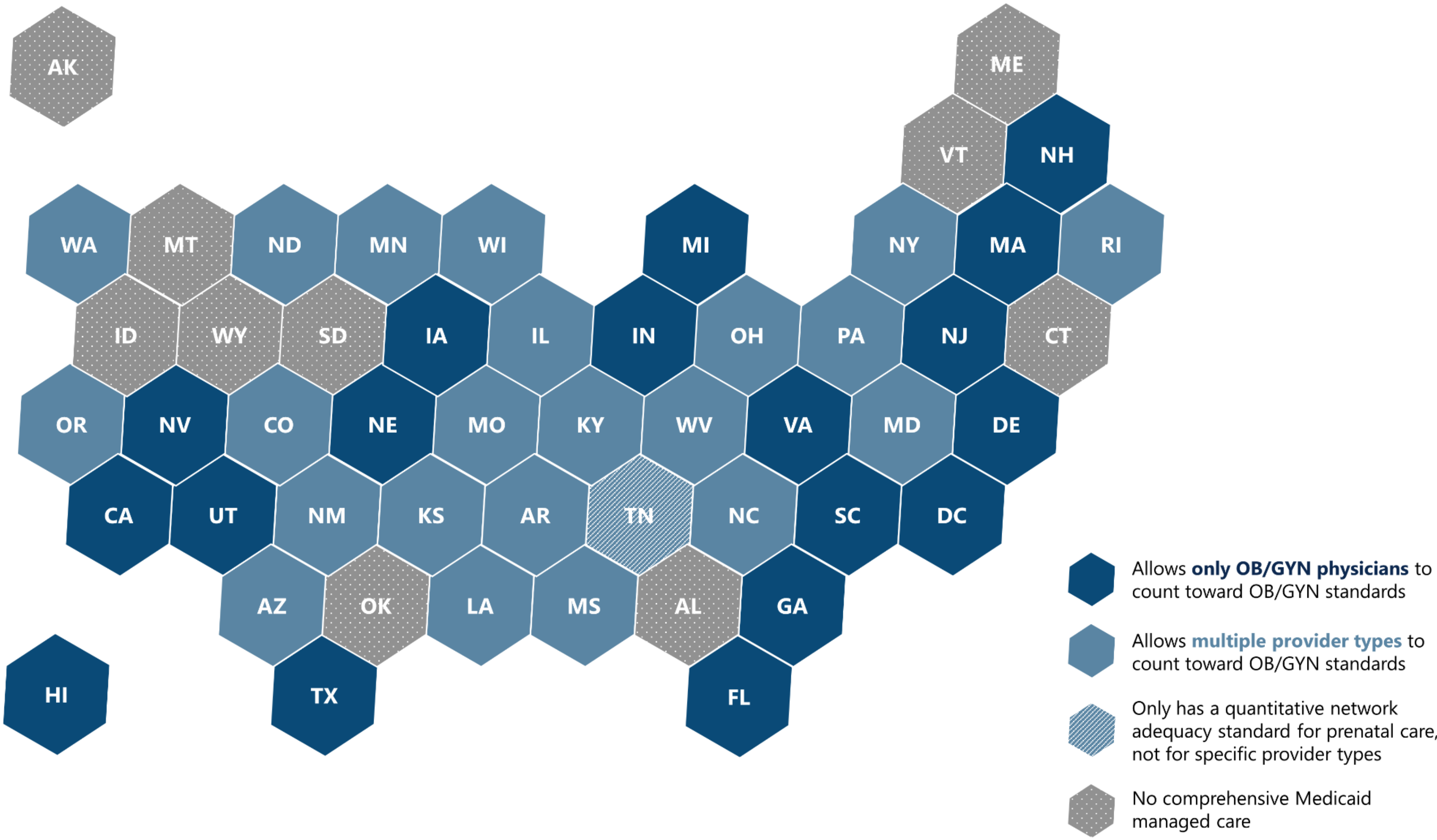
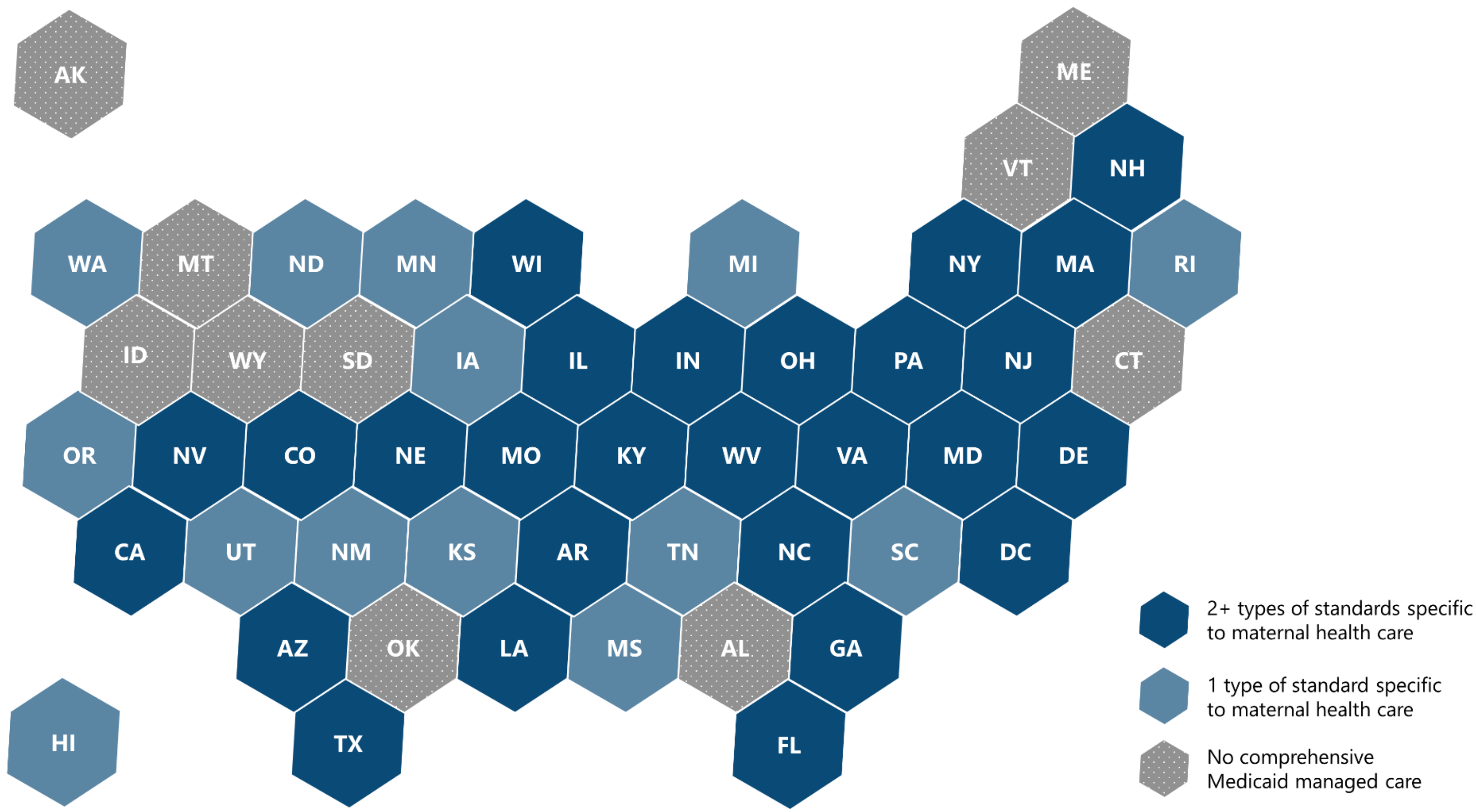


Exhibit 6: Number of types of quantitative network adequacy standards for maternal health care, by State



Note: Types of network adequacy standards include time and/or distance standards, appointment wait time standards, and ratio standards, among others.

Exhibit 7: Types of quantitative network adequacy standards for maternal health care, by State

✓ = Has a standard of the given type that is specific to maternal health care

State	Time and/or Distance	Appointment Wait Time	Provider-Enrollee Ratio
Arizona	✓	✓	
Arkansas	✓	✓	✓
California	✓	✓	
Colorado	✓		✓
Delaware	✓	✓	
Florida	✓		✓
Georgia	✓	✓	
Hawaii	✓		
Illinois	✓	✓	
Indiana	✓		✓
Iowa	✓		
Kansas	✓		
Kentucky	✓	✓	

State	Time and/or Distance	Appointment Wait Time	Provider-Enrollee Ratio
Louisiana	✓	✓	✓
Maryland	✓	✓	
Massachusetts	✓		✓
Michigan	✓		
Minnesota	✓		
Mississippi	✓		
Missouri	✓	✓	
Nebraska	✓	✓	
Nevada	✓	✓	
New Hampshire	✓	✓	
New Jersey	✓	✓	✓
New Mexico	✓		
New York		✓	✓
North Carolina	✓	✓	
North Dakota			✓

State	Time and/or Distance	Appointment Wait Time	Provider-Enrollee Ratio
Ohio	✓	✓	
Oregon	✓		
Pennsylvania	✓	✓	
Rhode Island	✓		
South Carolina	✓		
Tennessee		✓	
Texas	✓	✓	
Utah	✓		
Virginia	✓	✓	
Washington	✓		
Washington, DC	✓	✓	
West Virginia	✓	✓	✓
Wisconsin	✓	✓	✓

Note: We considered standards specific to maternal health care if they measured access specifically to OB/GYN physicians or other maternal health providers or explicitly referenced maternity care, pregnancy care, or prenatal care.

Exhibit 8: States with pregnancy-related appointment wait time standards

✓ = Has an appointment wait time standard with the given feature

State	Explicitly References Pregnancy Appointments	Specifies Wait Time by Trimester	Specifies Wait Time for High-Risk Pregnancies
Arizona	✓	✓	✓
Arkansas	✓		
California	✓		
Delaware	✓	✓	✓
Georgia	✓	✓	
Illinois	✓	✓	
Louisiana	✓	✓	✓
Maryland	✓		
Missouri	✓	✓	✓
Nebraska	✓	✓	✓
Nevada	✓	✓	✓
New Jersey	✓	✓	✓
New York	✓	✓	

State	Explicitly References Pregnancy Appointments	Specifies Wait Time by Trimester	Specifies Wait Time for High-Risk Pregnancies
North Carolina	✓	✓	✓
Ohio	✓	✓	✓
Pennsylvania	✓	✓	✓
Tennessee	✓		
Texas	✓	✓	✓
Virginia	✓	✓	✓
Washington, DC	✓		
West Virginia	✓		
Wisconsin	✓		✓

Note: We included standards that limit the time a pregnant enrollee should have to wait for an appointment or that specifically limit appointment wait times for maternity care, pregnancy care, or prenatal care. States not listed have no appointment wait time standards that meet these criteria.

Exhibit 9: States with quantitative network adequacy standards for specific types of maternal health providers and professionals other than OB/GYN physicians

✓ = Has a quantitative network adequacy standard for the given provider or professional type

State	Hospitals With Obstetric Services	Birth Centers	Certified Nurse-Midwives	Other Types of Midwives	Doulas
California		✓	✓	✓	
Florida[j]	✓		✓		
Maryland					✓
New Hampshire	✓				
New Jersey	✓		✓		
New York					✓
Washington	✓				

Note: States not listed either: (1) have only general standards for providers of OB/GYN services rather than for specific types of maternal health providers or professionals or (2) have standards only for OB/GYN physicians.

[j] Florida's network adequacy standard is for midwives. It does not specify which types of midwives count.

Appendix B: Agency Comments

See the following page for formal comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 2, 2024

TO: Ann Maxwell
Deputy Inspector General
for Evaluation and Inspections

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: States Could Better Leverage Coverage and Access Requirements to Promote Maternal Health Care Access in Medicaid Managed Care (OEI-05-22-00330)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. Addressing the United States' maternity care crisis is a key priority for CMS. In June 2022, the White House released a Blueprint for Addressing the Maternal Health Crisis, which describes the Biden-Harris Administration's whole-of-government approach to improving maternal health and addressing persistent inequities in maternal health outcomes.[1] CMS's Maternity Care Action Plan, published in July 2022, takes a holistic look at the policies and programs across CMS to identify opportunities to enhance maternity care - specifically, through a focus on driving improvements in access to and quality of care during pregnancy, childbirth, and the postpartum period.[2] CMS's coordinated action plan is built on promising approaches, like extending postpartum coverage in Medicaid, and aims to advance equitable, high-quality maternity care and reduce unnecessary maternal illnesses and deaths.

To ensure meaningful access to care before, during, and after pregnancy, CMS is working with states to improve access to comprehensive health coverage for individuals with Medicaid. Many pregnant individuals qualify for Medicaid on the basis of their pregnancy, through the eligibility group for pregnant individuals described at 42 CFR § 435.116. Pregnant individuals may also be eligible for Medicaid on another basis, for example, as a parent or caretaker relative or on the basis of disability status. Typically, pregnant individuals are eligible 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. 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. The American Rescue Plan Act of 2021 (ARP) gave states a new option to provide 12 months of extended postpartum coverage to pregnant individuals. The ARP initially made this option available to states for a 5-year period beginning on April 1, 2022, however the Consolidated

[1] The White House, White House Blueprint for Addressing the Maternal Health Crisis. 2022. Accessed at https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf
[2] CMS, CMS Cross Cutting Initiative: Maternity Care Action Plan. 2022. Accessed at https://www.cms.gov/files/document/cms-maternity-care-action-plan.pdf

Appropriations Act, 2023 (CAA, 2023) subsequently removed the 5-year time limit making this option permanently available to states. As of July 2024, 46 states, plus the District of Columbia and the United States Virgin Islands, have adopted this 12-month extended postpartum coverage option.

CMS is also working to improve health outcomes and reduce disparities for people during pregnancy, childbirth, and the postpartum period. For example, CMS's Maternal and Infant Health Initiative (MIHI) combines webinars for all states featuring best practices and effective models of care, with affinity groups that provide intensive quality improvement technical assistance to states committed to action. Past areas of focus for the MIHI include: increasing the use and quality of postpartum care visits, increasing the use and quality of well-child visits, and decreasing the rates of cesarean section births in low-risk pregnancies.[3] More recently, in May 2024, the MIHI began focusing on hypertension and mental health/substance use – two of the main drivers of poor maternal health outcomes. State Medicaid agencies, along with maternal health providers, managed care plans, public health agencies, and other quality improvement partners are invited to participate. Lastly, as part of the MIHI, CMS has published a suite of quality improvement tools and resources born out of the improving postpartum learning collaboratives,[4] as well as a Toolkit to assist states in maximizing the use of existing authorities to increase postpartum care access, quality, and equity for individuals with Medicaid.[5]

As part of the commitment to ensuring that pregnant and postpartum individuals receive high-quality maternity care, CMS created the "Birthing-Friendly" designation. To earn the designation, hospitals and health systems report their progress on CMS's Maternal Morbidity Structural Measure as part of the Hospital Inpatient Quality Reporting (IQR) Program; a pay-for-reporting program for acute care hospitals that participate in the Medicare and Medicaid programs.[6] The Maternal Morbidity Structural Measure assesses whether or not a hospital participates in a state or national Perinatal Quality Collaborative, as well as if the hospital implements patient safety practices or bundles related to maternal morbidity to address complications. Perinatal Quality Collaboratives are statewide, or multi-state networks, that work to improve maternal health outcomes by employing clinical practices and processes to address gaps in care, as well as collecting and reviewing performance data. Patient safety practices and bundles are collections of evidence-based best practices and have been shown to improve health outcomes across several clinical areas, including hypertension during pregnancy, cardiac conditions, and care for pregnant and postpartum people living with substance use disorders. Beginning in October 2023, CMS began displaying the 'Birthing-Friendly' designation icon, along with an interactive map, on the CMS Care Compare website, which allows individuals to find a hospital or health system with the 'Birthing-Friendly' designation in their area.[7]

Recently, in the Calendar Year 2025 Hospital Outpatient Prospective Payment System and ASC Payment System Proposed Rule, CMS proposed new Conditions of Participation (CoPs) for hospitals and Critical Access Hospitals (CAHs) that participate in the Medicare and Medicaid programs.[8] The

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[3] CMS, Maternal & Infant Health Care Quality. Accessed at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/index.html

[4] CMS, Postpartum Care. Accessed at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/postpartum-care/index.html

[5] CMS, Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP. 2023. Accessed at: https://www.medicaid.gov/sites/default/files/2023-08/ppc-for-state-and-medicaid-toolkit.pdf

[6] CMS, Maternal Morbidity Structural Measure. Accessed at: https://www.cms.gov/files/document/maternal-morbidity-structural-measure-specifications.pdf

[7] CMS, Birthing-Friendly Hospitals and Health Systems. Accessed at: https://data.cms.gov/provider-data/birthing-friendly-hospitals-and-health-systems

[8] *Federal Register*: "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health

proposed rule, if finalized, would add new requirements for maternal quality assessment and performance improvement (QAPI), and baseline standards for the organization, staffing, and delivery of care within obstetrical units, as well as emergency services readiness, transfer protocols, and annual staff training on evidence-based maternal health practices. For example, CMS proposed that hospitals and CAHs must use their QAPI program to assess and improve outcomes and disparities among obstetrical patients, which would include analyzing data on diverse subpopulations and conducting at least one maternal health improvement activity each year. CMS also proposed that if a Maternal Mortality Review Committee (MMRC) is available at the state or local jurisdiction in which the facility is located, the facility must have a process for incorporating MMRC data and recommendations into the QAPI program. In addition, CMS proposed requiring that labor and delivery rooms have certain basic resuscitation equipment readily available, including a call-in system, cardiac monitor, and fetal doppler or monitor. CMS also proposed a new standard that, if finalized, would require hospitals and CAHs that offer obstetrical services outside of the emergency department to develop policies and procedures to ensure that relevant staff are trained on certain topics aimed at improving the delivery of maternal care. These training topics should reflect the scope and complexity of services offered, including, but not limited to, facility-identified evidence-based best practices and protocols to improve the delivery of maternal care within the facility. If finalized, the new CoPs would ensure that all Medicare and Medicaid participating hospitals and CAHs offering obstetric services are held to a consistent standard of high-quality maternity care that protects the health and safety of patients.

CMS, along with states and other federal partners, will also continue to identify opportunities to expand and improve access to a diverse maternity care workforce, including midwives and community-based practitioners, such as doulas and community health workers. As noted in the OIG's report, states must cover certified nurse midwife and birth center services when licensed or otherwise recognized by the state. However, CMS acknowledges that there are barriers to the practice of midwifery across the country, with variation across states related to training, scope of practice laws, and education pathways. For example, while all states allow certified nurse midwives to practice legally, many states require supervision or a collaborative agreement from a partnering physician rather than allowing them to practice independently.[9] States also have the flexibility to cover community-based maternity services, such as those furnished by doulas and community health workers, and in December 2021 CMS released guidance encouraging states to expand access to these services.[10] Doula support is associated with improved health outcomes, a decreased likelihood of postpartum depression, and near-universal breastfeeding among low-income individuals. Medicaid coverage of doula services may be effectuated through multiple benefit categories, including, but not limited to, preventive services, services of licensed practitioners, clinic services, and freestanding birth center services. States can also utilize value-based payment arrangements to incentivize the use of innovative maternal health care delivery models and improve health outcomes.

In December 2023, CMS announced the new Transforming Maternal Health (TMaH) Model which will support participating state Medicaid agencies in the development of a whole-person approach to

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and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities"; Proposed Rule (89 FR 59186) (July 22, 2024).

[9] CMS, Improving Access to Maternal Health Care in Rural Communities. Accessed at: https://www.cms.gov/about-cms/agency-information/omh/downloads/improving-access-to-maternal-health-care-in-rural-communities-an-issue-brief.pdf

[10] CMS, Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). 2021. Accessed at: https://www.medicaid.gov/sites/default/files/2021-12/sho21007_1.pdf

pregnancy, childbirth, and postpartum care.[11] The TMaH Model will provide states with targeted support in the form of funding and technical assistance, and will also enable states to develop a value-based alternative payment model for maternity care services which will improve quality and health outcomes and promote long term sustainability of services. In addition, participating states will implement patient safety bundles, and will work with their hospitals and health systems toward achieving the CMS "Birthing-Friendly" designation. The TMaH Model also seeks to support or increase access to additional maternal care providers, such as midwives, birth centers, and doula services. CMS will work with participating states to examine workforce capacity and reimbursement, expand coverage and training availability, and incentivize team-based care. CMS recently released a Notice of Funding Opportunity for the TMaH Model and will announce up to 15 model awardees after thorough review of all applications.[12] Each participating state Medicaid agency will be eligible for up to $17 million during the model's 10-year period.

CMS also recognizes the need for strong federal and state oversight of Medicaid managed care programs and has taken a number of steps to support states in this area. For example, CMS has created a Managed Long-Term Services and Supports Access Monitoring Toolkit,[13] Behavioral Health Provider Network Adequacy Toolkit,[14] Managed Care Quality Strategy Toolkit,[15] and a Toolkit for Ensuring Provider Network Adequacy and Service Availability.[16] As finalized in several regulations adopted or amended by the 2016 Managed Care Final Rule, states are required to submit to CMS several reports on their managed care programs and operations.[17] CMS has developed reporting templates that states must use when submitting the Managed Care Program Annual Report (MCPAR) required in 42 CFR § 438.66(e),[18] the Medical Loss Ratio (MLR) Summary Report required in 42 CFR § 438.74(a),[19] and the Network Adequacy and Access Assurance Report (NAAAR) required in 42 CFR § 438.207(d) and (e).[20] CMS launched a web-based submission portal, known as the Medicaid Data Collection Tool for Managed Care Reporting (MDCT-MCR), which can now collect both MCPAR and MLR reports from states. For both reports, the MDCT-MCR collects the same information included in the templates, creating a single submission process and repository for these state reporting requirements.

In addition, it is essential for states to monitor their managed care plans' compliance with Federal requirements, and states are required to have a monitoring system for their managed care programs in accordance with 42 CFR § 438.66. While states have flexibility in how they design their monitoring

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[11] CMS, Transforming Maternal Health (TMaH) Model. Accessed at: https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model
[12] https://grants.gov/search-results-detail/354874
[13] CMS, Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit. 2022. Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf
[14] CMS, Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit. 2021. Accessed at: https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf
[15] CMS, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit. 2021. Accessed at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf
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system, it must demonstrably address all aspects of their managed care program(s) and managed care plan performance for at least the 13 specific program areas enumerated at 42 CFR § 438.66(b), which includes provider network management and availability and accessibility of services (including network adequacy standards), and additional provisions of the managed care contract as appropriate. The regulations at 42 CFR § 438.66(c) further require that each state uses the data collected from its monitoring activities to improve the performance of its managed care program(s). The regulations do not include an exhaustive list of performance areas in which data may be used for oversight; however, 42 CFR § 438.66(c) describes several types of data for various performance areas that are fundamental to managed care programs. States have flexibility in determining how to operationalize their monitoring system, and to assist states with these efforts, CMS has issued multiple technical assistance Toolkits and resources.[21] CMS is committed to strengthening the monitoring and oversight of Medicaid managed care programs and will continue to engage and collaborate with states on this important topic.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation 1

Take steps to confirm that all States cover required services from maternal health providers for managed care enrollees.

CMS Response 1

CMS concurs with this recommendation. As the largest single payer of pregnancy-related services in the United States, ensuring that individuals can access covered services is a crucial element of the Medicaid program. As noted above, certified nurse midwife and birth center services, when licensed or otherwise recognized by the state, are both mandatory benefits in Medicaid. Maternal-fetal medicine specialists are physicians that have additional education and training on how to manage and treat high-risk pregnancies and, as such, are included as part of the mandatory Medicaid benefit for physician services. All states must operate their Medicaid programs in accordance with federal requirements, including providing all mandatory Medicaid benefits that are required by law.

As noted in the OIG's report, depending on the state and its Medicaid program structure, eligible individuals access their health care services through managed care, fee-for-service (FFS), or a combination of both. States have flexibility in determining how providers participate in their Medicaid program, and which services to cover through a managed care delivery system. Further, federal regulations require states to ensure that managed care plans cover services from out-of-network providers if the provider network is unable to provide necessary services covered under the contract.[22] CMS will conduct outreach to the states that reported that they do not require their managed care plans to cover certified nurse midwife, maternal-fetal medicine specialists, and birth center services to confirm that managed care enrollees have access to these mandatory services.

OIG Recommendation 2

Clarify the requirement that States have a provider-specific OB/GYN network adequacy standard.

[21] CMS, Medicaid and CHIP Managed Care Monitoring and Oversight Initiative. Accessed at: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html

[22] 42 CFR § 438.206(b)(4)

CMS Response 2

CMS concurs with this recommendation. CMS regulations require states to ensure that managed care plans maintain sufficient provider networks to provide adequate access to covered services for all enrollees. For example, 42 CFR § 438.68(b)(1) requires that states set a quantitative network adequacy standard for specified provider types, including Obstetrics/Gynecology (OB/GYN) providers. Examples of quantitative network adequacy standards include minimum provider-to-enrollee ratios, maximum travel time or distance to providers, a minimum percentage of contracted providers that are accepting new patients, or hours of operation requirements. The recently finalized Managed Care Access, Finance, and Quality Final Rule established additional requirements for states to set maximum appointment wait time standards of 15 business days for routine primary care and OB/GYN services, and 10 business days for outpatient mental health and substance use disorder services. [23] These new appointment wait time standards cannot be used to meet the quantitative network adequacy standard required in 42 CFR § 438.68(b)(1), and become applicable with the first rating period beginning on or after July 9, 2027.

When establishing network adequacy standards, states must first define the professionals and service settings that qualify under each provider type or category. For example, a state may include physicians, physician assistants, nurse practitioners, and certified nurse midwives in their definition of OB/GYN providers. This flexibility is important, as a multidisciplinary workforce is critical for ensuring access to maternal health services in areas impacted by workforce shortages. For example, while midwives currently attend less than 10% of all births in the United States, they attend over 30% of deliveries in rural hospitals. CMS has provided guidance to support states in developing their network adequacy standards, and in the Toolkit for Ensuring Provider Network Adequacy and Service Availability included information and examples on how states can define eligible providers for each provider type outlined in 42 CFR § 438.68(b)(1). CMS will provide further clarification to states on the types of professionals that could be included in network adequacy standards for OB/GYN providers.

OIG Recommendation 3

Support States in tailoring their network adequacy standards to better address maternal health care needs.

CMS Response 3

CMS concurs with this recommendation. As noted above, CMS regulations at 42 CFR § 438.68(b)(1) require that states set a quantitative network adequacy standard for specified provider types, including OB/GYN providers. In addition, for rating periods beginning on or after July 9, 2027, states must establish maximum appointment wait time standards of 15 business days for routine primary care and OB/GYN services, and 10 business days for outpatient mental health and substance use disorder services. CMS will continue to provide guidance and technical assistance to support states in improving their network adequacy standards, including those for maternal health care. While states have flexibility in developing their network adequacy standards, so long as they meet all applicable regulatory requirements, CMS can share examples of how states might tailor their network adequacy standards to the needs of pregnant and postpartum enrollees.

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[23] *Federal Register*: "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality"; Final Rule (89 FR 41002) (May 10, 2024).

In addition to the network adequacy standards described above, under 42 CFR § 438.206(d), states must also submit an assurance of compliance to CMS that each managed care plan meets the state's requirement for availability of services, along with documentation of an analysis that supports the assurance of the adequacy of the network for each contracted managed care plan. CMS has developed a standard format, with instructions, for states to use when submitting the Network Adequacy and Access Assurance Report (NAAAR), and plans to incorporate this into the Medicaid Data Collection Tool for Managed Care Reporting (MDCT-MCR) in the future.[24] CMS will update the NAAAR to collect data on which provider types states are including in their OB/GYN network adequacy standards, as well as information on whether those standards are assessed individually or in the aggregate.

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ACKNOWLEDGMENTS AND CONTACT

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Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does it Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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