Frequently Asked Questions (FAQs)
Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP) (SHO #21-007)

January 29, 2024

On December 7, 2021, the Center for Medicaid and CHIP Services (CMCS) issued a State Health Official letter[1] (SHO) to inform state Medicaid and Children's Health Insurance Program (CHIP) agencies about the new option for states to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP. Sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) initiated this option beginning April 1, 2022, with a sunset date of March 31, 2027. Section 5113 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328) made the option permanent for both Medicaid and CHIP.

This FAQ document addresses common questions related to Medicaid benefits and state plan amendment (SPA) submissions.[2] Questions related to other provisions of the SHO may be addressed in subsequent FAQs.

Q1. What benefits are considered full benefits during the extended postpartum period (i.e., during the period that starts after the end of the mandatory 60-day postpartum period through the end of the month that occurs 12 months postpartum)?

A1. Full benefits during the extended postpartum period include all items and services covered under the state plan (or waiver of the state plan) that are not less in amount, duration, or scope, or are determined to be substantially equivalent by CMCS, to the benefits for a Medicaid eligible individual described in section 1902(a)(10)(A)(i) of the Social Security Act (the Act).[3] Depending on the individual, this may include all state plan benefits a state covers under section 1905(a) of the Act for categorically needy Medicaid eligible adults or the Alternative Benefit Plan (ABP) under section 1937 of the Act. For Medicaid eligible individuals under the age of 21, a state must also cover any services coverable under section 1905(a) of the Act needed to correct and ameliorate health conditions based on a state determination of medical necessity, as required by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirements at section 1905(r)(5) of the Act. As indicated in the SHO letter, coverage of services only related to pregnancy or a condition that may complicate pregnancy are not considered full benefits.

Q2. What are enhanced pregnancy-related services?

A2. Generally, under the comparability requirements at section 1902(a)(10)(B) of the Act and 42 CFR § 440.240, a state may not provide services to a categorically needy individual at a lesser amount, duration, or scope than a medically needy individual and services must be equal in amount, duration, or scope for categorically needy beneficiaries and within the respective medically needy groups. Per 42 CFR § 440.250(p), a state may cover enhanced pregnancy-

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[1] https://www.medicaid.gov/sites/default/files/2021-12/sho21007_1.pdf

[2] Pages 6-7 of SHO #21-007 describe benefit requirements for states that elect the postpartum eligibility extension.

[3] See section 1902(e)(16)(B)(i) of the Act.

related services as an exception to the comparability requirements. With enhanced pregnancy-related services, a state may choose to cover services related to a pregnancy or a condition that may complicate a pregnancy, as defined in section 42 CFR § 440.210(a)(2), at a higher amount, duration, or scope for pregnant individuals than for other Medicaid eligible adults. For example, a state may choose to cover the dental services benefit for pregnant Medicaid beneficiaries and not for other Medicaid eligible adults.

Q3. What is the mandatory tobacco cessation benefit for pregnant individuals?

A3. The tobacco cessation for pregnant individuals benefit described at sections 1905(a)(4)(D) and defined in section 1905(bb) of the Act is a required state plan benefit. This benefit includes coverage of diagnostic, therapy, and counseling services, as well as pharmacotherapy for cessation of tobacco use by pregnant individuals who use tobacco products or who are being treated for tobacco use. Tobacco cessation services to non-pregnant adults are not coverable under this benefit, but may be covered under other state plan benefits, such as the preventive services benefit and as a Medicaid outpatient drug benefit. For additional information, please see our 2011 State Medicaid Director letter (SMD).[4]

Q4. Must a state cover enhanced pregnancy-related services and the mandatory tobacco cessation for pregnant individuals benefit during the extended postpartum period?

A4. No. A state may choose not to cover enhanced pregnancy-related services and the tobacco cessation for pregnant individuals benefit during the extended postpartum period (after the mandatory 60-day postpartum period). A state must cover the tobacco cessation for pregnant individuals benefit and enhanced pregnancy-related services (if covered by the state) through the end of the month in which a Medicaid eligible individual reaches 60-days postpartum. CMCS strongly encourages states to cover the tobacco cessation for pregnant individuals benefit and enhanced pregnancy-related services during the extended postpartum period to ensure continuity of care for these individuals.

Q5. What benefits must a state cover during the extended postpartum period if the state implements a Centers for Medicare & Medicaid Services (CMS)-approved proxy methodology to claim the increased Federal Medical Assistance Percentage (FMAP) for the proportion of claims which, but for the postpartum extension, would be claimed at the newly eligible FMAP for the adult group (described at 42 C.F.R. § 435.119)?

A5. A state may choose to claim FMAP through a CMS-approved proxy methodology for the proportion of individuals who would become eligible for, and transition to, the adult group at the end of the mandatory 60-day postpartum period if the state conducted a redetermination. If electing this choice, a state must assure to CMS, by including an attestation in the FMAP SPA described in SHO #21-007, that the benefit package provided for ***all*** individuals through the postpartum extension complies with section 1937 of the Act, including the provision of essential health benefits (EHBs), compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), and the absence of cost sharing for preventive services meeting the definition of an

[4] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD11-007.pdf

EHB. CMS is available for technical assistance to states in determining compliance with section 1937 requirements.

Q6. Must a state submit a SPA to identify if enhanced pregnancy-related services and the tobacco cessation benefit are covered during the extended postpartum period?

A6. States must submit a SPA only if their current coverage pages limit service provision to a 60-day postpartum period and the state intends to continue coverage of enhanced pregnancy-related services and the tobacco cessation benefit during the 12-month extended postpartum period. These states should submit SPAs to update references to a 60-day postpartum period to a 12-month postpartum period in Attachment 3.1-A, Attachment 3.1-B (if the state covers the medically needy group), and any corresponding supplemental limitation pages. Typically, references to the postpartum period are included in item 20 of these attachments, but this may differ from state to state.

While a SPA is not necessary for a state that does not cover enhanced pregnancy-related services and the tobacco cessation benefit during the 12-month extended postpartum period, a state that previously covered those services during the extended postpartum period and reduces coverage must comply with advanced notice requirements in accordance with 42 C.F.R. § 435.917.

Q7. What effective date may a state choose when making a technical change to clarify that enhanced pregnancy-related services and the tobacco cessation benefit are covered during the extended postpartum period?

A7. If a state is simply making a technical change to update references to a 60-day postpartum period to a 12-month postpartum period to reflect the coverage individuals are currently and have been receiving, then the state may request a retroactive SPA effective date to align with their corresponding postpartum extension eligibility SPA. In accordance with 42 C.F.R. § 430.20(b)(3), CMCS may approve these SPAs with an effective date that is prior to the beginning of the quarter in which the SPA is submitted to align with the effective date of a state's corresponding postpartum extension eligibility SPA. If a state submits a SPA that includes ***any*** other changes, including expanding or reducing coverage, then this special retroactive effective date provision would not apply and standard SPA effective date and notice requirements apply.