Reducing cardiovascular maternal mortality by extending Medicaid for postpartum women

Janki P Luther  
*Washington University School of Medicine in St. Louis*

Daniel Y Johnson  
*Washington University School of Medicine in St. Louis*

Karen E Joynt Maddox  
*Washington University School of Medicine in St. Louis*

Kathryn J Lindley  
*Washington University School of Medicine in St. Louis*

Follow this and additional works at: [https://digitalcommons.wustl.edu/open_access_pubs](https://digitalcommons.wustl.edu/open_access_pubs)

**Recommended Citation**
[https://digitalcommons.wustl.edu/open_access_pubs/10640](https://digitalcommons.wustl.edu/open_access_pubs/10640)

This Open Access Publication is brought to you for free and open access by Digital Commons@Becker. It has been accepted for inclusion in Open Access Publications by an authorized administrator of Digital Commons@Becker. For more information, please contact vanam@wustl.edu.
MINI-REVIEW

Reducing Cardiovascular Maternal Mortality by Extending Medicaid for Postpartum Women

Janki P. Luther, MD, MPH; Daniel Y. Johnson, BA; Karen E. Joynt Maddox, MD, MPH; Kathryn J. Lindley, MD

ABSTRACT: Maternal mortality has been increasing in the United States over the past 3 decades, while decreasing in all other high-income countries during the same period. Cardiovascular conditions account for over one fourth of maternal deaths, with two thirds of deaths occurring in the postpartum period. There are also significant healthcare disparities that have been identified in women experiencing maternal morbidity and mortality, with Black women at 3 to 4 times the risk of death as their White counterparts and women in rural areas at heightened risk for cardiovascular morbidity and maternal morbidity. However, many maternal deaths have been shown to be preventable, and improving access to care may be a key solution to addressing maternal cardiovascular mortality. Medicaid currently finances almost half of all births in the United States and is mandated to provide coverage for women with incomes up to 138% of the federal poverty level, for up to 60 days postpartum. In states that have not expanded coverage, new mothers become uninsured after 60 days. Medicaid expansion has been shown to reduce maternal mortality, particularly benefiting racial and ethnic minorities, likely through reduced insurance churn, improved postpartum access to care, and improved interpregnancy care. However, even among states with Medicaid expansion, significant care gaps exist. An additional proposed intervention to improve access to care in these high-risk populations is extension of Medicaid coverage for 1 year after delivery, which would provide the most benefit to women in Medicaid nonexpanded states, but also improve care to women in Medicaid expanded states.

Key Words: health policy ■ Medicaid ■ postpartum

Maternal mortality in the United States has been increasing compared with most other developed countries. Although there are likely many contributing factors, one major element distinguishing the United States from its counterparts is the lack of universal health insurance, and thus access to basic health care; this is an issue that disproportionately impacts low-income women, minorities, and those living in rural areas. With policy changes at the state or federal level, maternal mortality, specifically attributable to cardiovascular conditions, could perhaps be mitigated. Currently, almost half of all births in the United States are to women covered by Medicaid, the US public insurance program aimed at people living in poverty. In many states, Medicaid coverage is terminated 60 days postpartum, leading to both inadequate postpartum follow-up and gaps in coverage between pregnancies where chronic conditions remain unaddressed. One potential avenue toward improving coverage among women of childbearing age is extension of Medicaid coverage to 1 year postpartum, a solution that is being considered in many states across the country.

MATERNAL MORTALITY IN THE UNITED STATES

Maternal mortality, defined by the Centers for Disease Control and Prevention as deaths during pregnancy and within 1 year of delivery, has been increasing in...
the United States over the past 3 decades, doubling from 7.2 deaths per 100,000 live births in 1987 to 17.3 deaths per 100,000 live births in 2017. This is in stark contrast to all other high-income countries, where maternal mortality has been decreasing over the same time period.

More important, during this time, although deaths from direct obstetric causes have declined, the United States has had an increase in deaths from indirect obstetric causes, including cardiovascular disease. In fact, cardiovascular conditions are now the leading cause of maternal mortality, accounting for one fourth of maternal deaths. When including stroke and hypertension, cardiovascular conditions account for over half of maternal deaths. Although about a third of pregnancy-related deaths occur during pregnancy, most occur in the postpartum period, with 40% occurring during the first 42 days after delivery and 25% occurring between 42 days and 1 year after delivery. Among deaths that occur between 42 days and 1 year after delivery, cardiomyopathy is the leading cause of death, followed by mental health conditions.

Marked healthcare disparities have been identified among women experiencing maternal morbidity and mortality, with Black women at 3 to 4 times the risk of death as their White counterparts. The American College of Obstetricians and Gynecologists recently identified Black race, age >40 years, hypertensive disorders, and obesity as the 4 key factors related to maternal cardiovascular mortality. Furthermore, as more mothers choose to delay childbearing and the prevalence of obesity, hypertension, and diabetes mellitus continues to climb, maternal mortality can only be expected to continue to increase.

**MATERNAL MORTALITY IS PREVENTABLE**

Most states now have Maternal Mortality Review Committees that review all maternal deaths to assess for cause and preventability and make recommendations for improvement in patient care. Between 2008 and 2017, 14 states shared their data with the Centers for Disease Control and Prevention; and among 1347 reviewed deaths to women during or within a year of pregnancy, about 1 in 3 deaths were determined to be pregnancy related. Of those, almost one quarter were attributable to cardiovascular conditions or cardiomyopathy, with about 70% of cardiovascular pregnancy-related deaths noted to be preventable.

The most common factors underlying preventable maternal deaths were patient factors, followed by provider and systems of care factors. For example, major patient factors included chronic conditions, such as obesity, and lack of knowledge, including failure to recognize and obtain treatment for symptoms. Major provider-related factors included failure to recognize disease or provision of ineffective treatment, and major systems of care factors included barriers to coordination of care. However, although patient factors were most common, they often reflected factors dependent on providers and systems of care; for example, patients may wait too long to seek care because of concerns about costs or accessibility, or clinicians may be unable to provide follow-up because of lack of insurance coverage. Thus, efforts to improve education of both patients and healthcare teams, and improved access to care, may be key solutions to addressing maternal cardiovascular mortality.

**CURRENT ROLE OF MEDICAID**

Currently, Medicaid finances almost half of all births in the United States. Federal law mandates Medicaid coverage for pregnant women with incomes up to 138% of the federal poverty level, and is required to provide coverage through 60 days postpartum, although many states have gone above this threshold in the context of Medicaid expansion. The Affordable Care Act (ACA) began Medicaid expansion as early as 2010, with the proposed law requiring states to provide Medicaid to those with incomes at or below 138% of the federal poverty level, regardless of if they had dependent children or not. A small number of "early expanders" (6 states, including the District of Columbia) did so under waiver authority, with an additional 20 states adopting expansion in 2014, and 13 more opting for expansion in later years.

Although expansion was initially intended to be national, a ruling from the Supreme Court found that states could not be mandated to expand Medicaid, and thus the remaining 12 states have not yet expanded this coverage.

In the 37 states (including the District of Columbia) that have expanded and implemented Medicaid under the ACA, many, but not all, women remain covered after the 60 days because they qualify based on income eligibility requirements for parents. However, in the 12 states that have not expanded coverage and in 2 states that have passed expansion but not yet implemented it (Missouri and Oklahoma), new mothers become uninsured after 60 days, and postpartum women need to requalify as parents to continue their coverage (Figure 1 and Table S1). However, the income eligibility for parents is dramatically more strict.
than the income eligibility for pregnant women in these
states, with some states, such as Texas, limiting coverage
to those who fall below just 17% of the federal poverty
level (Figure 2).8,17,18 Thus, many women become uninsured 60 days postpartum.

The postpartum period has recently been rec-
ognized as a critically important time to address the
physical and mental health of women.19,20 It is not only
a time to provide postpartum care, but also interpreg-
nancy care; closing these healthcare gaps is essential
to improve maternal health and reduce the risk of com-
lications in subsequent pregnancies. As many women
who are Medicaid beneficiaries lose their healthcare
coverage at 60 days postpartum, they do not even
have the opportunity to undergo the routine postpar-
tum cardiometabolic screening recommended by the
American College of Obstetricians and Gynecologists
to identify and treat cardiovascular risk factors; this is
critically important as long-term cardiovascular condi-
tions, including coronary artery disease, heart fail-
ure, and stroke, are known to be markedly elevated
in women with adverse pregnancy outcomes, such as
preeclampsia and gestational diabetes mellitus.6
Furthermore, those women with identified cardiovas-
cular risk factors or new-onset cardiovascular condi-
tions, such as cardiomyopathy, coronary dissection,
hypertension, or pulmonary embolism, are unable to
receive ongoing therapeutic treatment for their cardio-
vascular disease beyond 60 days if they lose access
to healthcare coverage, potentially contributing to late
maternal deaths.

THE BURDEN OF HEALTH CARE FOR
UNINSURED MOTHERS

It is known that continuous insurance coverage is
necessary for women to receive appropriate care be-
fore, during, and after pregnancy, and that without it,
there are significant gaps in access to physician care,
increased emergency department use, and overall
worse health status.21 Before the enactment of the
ACA, a significant proportion of pregnant women ex-
perienced “insurance churn,” with almost 60% moving
between insurance plans during their pregnancy and
about half becoming uninsured in the 6-month period
after giving birth. The ACA expanded coverage for
reproductive age women, but nearly half of women in
Medicaid nonexpansion states and about one third of
women in Medicaid expansion states continued to ex-
perience an insurance disruption from preconception
to postpartum.21,22

In a study by the Urban Institute, about 1 in 5 unin-
sured new mothers reported cost of care being the rea-
son for at least one unmet need for medical care. More
than half were worried about paying their medical bills
and reported that losing Medicaid or other insurance
coverage after pregnancy was the reason they were
uninsured. Among those women who lost Medicaid
coverage after delivery, one third were obese before
their pregnancy and 18% reported gestational diabe-
tes mellitus or pregnancy-related hypertension, both of
which would require ongoing care after giving birth.23

MEDICAID EXPANSION HAS
DECREASED MATERNAL AND
CARDIOVASCULAR MORTALITY

In this context, there is great potential for Medicaid
coverage to improve outcomes. A recent study ex-
amined the effects of Medicaid expansion on mater-
nal mortality, using separate definitions of maternal
mortality, including the following: (1) maternal deaths
up to 42 days after delivery and late maternal deaths
>42 days after delivery and (2) maternal deaths up to
42 days after delivery, excluding late maternal deaths.
The study showed that Medicaid expansion had a
statistically significant favorable effect on total mater-
nal deaths, resulting in 7.01 fewer deaths per 100 000
live births in expansion states relative to nonexpansion
states (P=0.002). Even when excluding late maternal
deaths using their second definition of maternal mor-
tality, there were 6.65 fewer deaths per 100 000 live
births in expansion states versus nonexpansion states
(P=0.004). There was also evidence that racial and
ethnic minority women may have particularly benefited
from expansion; non-Hispanic Black mothers had
16.27 fewer maternal deaths per 100 000 in expan-
sion versus nonexpansion states (P=0.022).24 These
findings suggest that increased access to health insur-
ance coverage may contribute to improved maternal
outcomes through improved interpregnancy care, op-
timizing maternal health before subsequent pregnan-
cies, providing more timely prenatal care, and giving
extended postpartum care, reducing late deaths.24
Several studies have also shown Medicaid expansion
specifically reduces mortality from cardiovascular con-
ditions, with 4.3 fewer deaths per 100 000 in expansion
states versus nonexpansion states, and improves
access to and frequency of preventive care visits.25,26

POTENTIAL POLICY CHANGES

Despite Medicaid coverage options for low-income
pregnant women, gaps in coverage in the critical
postpartum period remain. There is opportunity for
Medicaid to improve medical and behavioral health
conditions for new mothers who would otherwise
lose insurance coverage after 60 days postpartum.
Two forms of Medicaid expansion could reduce in-
surance churn and improve the health of postpartum
Figure 1. Current Medicaid expansion status and legislation extending Medicaid coverage for postpartum women.

A. Current status of Medicaid expansion in each state. B. Current status of legislation extending Medicaid coverage for postpartum women beyond 60 days postpartum. Minnesota has pending legislation that would require the commissioner of human services to examine extending postpartum Medicaid coverage for an unspecified length of time. Postpartum Medicaid coverage extension is limited to individuals who have been diagnosed with a maternal mental health condition in California and individuals with substance use disorders in South Carolina. Indiana is pending legislation to extend coverage to only those with opioid use disorder.9,11–16
Figure 2. Pregnant woman vs parent Medicaid eligibility in 50 states and the District of Columbia.
For states with Medicaid expansion, women are eligible for Medicaid if their income falls below 138% of the federal poverty level (FPL). For states without Medicaid expansion, such as Alabama, Missouri (recently passed), Tennessee, and Texas, eligibility is significantly more restrictive, falling as low as 17% to 21% of the FPL. During pregnancy, Medicaid eligibility is expanded such that even those states with Medicaid expansion have much broader income eligibility criteria, as high as 380% of the FPL. Although nonexpansion states will see the greatest number of women benefit, even women in expansion states will see benefit from extension of postpartum Medicaid.
women: (1) expansions as included in the ACA for low-income parents to reduce the gap in income eligibility for pregnant and nonpregnant women and (2) extension of pregnancy-related Medicaid beyond 60 days postpartum.

Currently, 5 states have already passed legislation extending Medicaid for postpartum women up to 6 to 12 months, whereas 14 states still have pending legislation (Figure 2). Of those 14 states, those without Medicaid expansion would see the greatest number of women benefit from extension of postpartum Medicaid (ie, Alabama, Missouri, Tennessee, and Texas).

In March 2021, the American Rescue Plan Act of 2021 was passed by Congress and included a provision allowing states the option to extend Medicaid for up to 1 year postpartum. This provision would allow states that opt in to receive their regular federal matching rate for the additional 10 months of coverage they provided. In states that have not yet expanded Medicaid, this would provide coverage to several mothers who would otherwise lose coverage after 60 days postpartum. However, even in the states where Medicaid has already been expanded, new mothers who fall in the gap between the typical coverage level for custodial parents and the generally more-generous coverage level for pregnant women would still benefit from extension. Although this bill does include a sunset clause that would limit this law to 5 years, Congress could elect to make it permanent in the future.

The anticipated fiscal impact of Medicaid extension to 1 year postpartum is expected to be modest because of the limited number of impacted patients and relatively short duration of coverage, although actual state outlays would depend on the degree to which states had already expanded Medicaid as well as their federal match rate. However, financial outlays could be offset to some degree by potential benefits of increased employment, delayed enrollment in other insurance plans, increased use of outpatient services rather than emergency department visits and hospitalizations, and increased uptake of preventative care, including contraception and cardiovascular screening, ultimately reducing long-term disease burden and unintended pregnancies, and improving interpregnancy care.28

CONCLUSIONS

Maternal mortality has been steadily increasing in the United States, predominantly because of cardiovascular disease. In addition to the numerous cardiovascular contributors to this increase, racial disparities and income inequality are other major drivers of adverse outcomes in the postpartum period. These factors have been shown to be modifiable, and with policy change, maternal cardiovascular mortality could potentially be reduced. Improving access to care could reduce disparities, improve maternal outcomes, and improve long-term cardiovascular health for women across the United States.

ARTICLE INFORMATION

Affiliations

Cardiovascular Division, Washington University School of Medicine, St. Louis, MO (J.P.L., D.Y.J., K.E.J.M., K.J.J.K.); and Center for Health Economics and Policy, Institute for Public Health at Washington University, St. Louis, MO (K.E.J.M.).

Disclosures

Dr Joynt Maddox receives research support from the National Heart, Lung, and Blood Institute (R01HL143421) and National Institute on Aging (R01AG060935, R01AG063759, and R21AG065526), and previously did contract work for the US Department of Health and Human Services. The remaining authors have no disclosures to report.

Supplementary Material

Table S1

REFERENCES


Luther et al Medicaid Extension: Reducing Cardiovascular Maternal Mortality


<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Income Eligibility Limits for Pregnant Women (% FPL)</th>
<th>Medicaid Income Eligibility Limits for Parents (% FPL)</th>
<th>Medicaid Expansion Status</th>
<th>Legislation Extending Postpartum Coverage</th>
<th>Legislation Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>146%</td>
<td>18%</td>
<td>Not Adopted</td>
<td>Pending</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
</tr>
<tr>
<td>Alaska</td>
<td>205%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>161%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>214%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>322%</td>
<td>138%</td>
<td>Adopted</td>
<td>Implementing (Limited Coverage Extension)</td>
<td>Passed legislation to extend postpartum Medi-Cal eligibility to one year for women diagnosed with a maternal mental health condition. The increased funding for postpartum care will be suspended after Dec. 31, 2021 unless it is funded by general fund revenue.</td>
</tr>
<tr>
<td>Colorado</td>
<td>265%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>263%</td>
<td>160%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Delaware</td>
<td>217%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>324%</td>
<td>221%</td>
<td>Adopted</td>
<td>Pending</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
</tr>
<tr>
<td>Florida</td>
<td>196%</td>
<td>31%</td>
<td>Not Adopted</td>
<td>No</td>
<td>Passed legislation to extend postpartum Medicaid coverage to six months, but requires funding from a Medicaid state plan amendment or waiver request to the US Department of Health and Human Services.</td>
</tr>
<tr>
<td>Georgia</td>
<td>225%</td>
<td>35%</td>
<td>Not Adopted</td>
<td>Pending</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
</tr>
<tr>
<td>Hawaii</td>
<td>196%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>138%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td>Pending CMS waiver to extend postpartum Medicaid coverage to one year for women earning up to 200% of the FPL.</td>
</tr>
<tr>
<td>Illinois</td>
<td>213%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Postpartum Percentage</td>
<td>Medicaid Expansion Percentage</td>
<td>Status</td>
<td>Legislation Details</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------</td>
<td>------------------------------</td>
<td>------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>218%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending CMS waiver to extend postpartum coverage to 365 days for mothers with opioid use disorder.</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>380%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>171%</td>
<td>38%</td>
<td>Not Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>200%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>214%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>214%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending legislation to extend postpartum MaineCare coverage to six months.</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>264%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>205%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>200%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending FY 2021 budget appropriations to extend postpartum Medicaid coverage to one year.</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>283%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>199%</td>
<td>26%</td>
<td>Not Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>305%</td>
<td>21%</td>
<td>Adopted but not yet implemented</td>
<td>Pending CMS waiver to extend MO HealthNet eligibility up to 12 additional months for pregnant women receiving substance abuse treatment within 60 days of giving birth. Pending legislation to extend postpartum coverage to one year for mothers in the Show Me Healthy Babies Program. Passed legislation to extend MO HealthNet benefits for mental health services up to 12 additional months for women diagnosed with a maternal mental health condition.</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>162%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>202%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>165%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>201%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>205%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending CMS waiver to extend postpartum NJ FamilyCare coverage to 180 days.</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>255%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>223%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending legislation to extend postpartum Medicaid coverage to one year.</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>201%</td>
<td>41%</td>
<td>Not Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>162%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>205%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Adopted %</td>
<td>Medicaid %</td>
<td>Action</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------</td>
<td>------------</td>
<td>----------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>210%</td>
<td>41%</td>
<td>Adopted, but not yet implemented</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>190%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>220%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>258%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>199%</td>
<td>67%</td>
<td>Not Adopted</td>
<td>Passed limited CMS waiver opening up 1000 spots to prioritize Medicaid coverage for pregnant women and parents of foster children receiving substance abuse treatment.</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>138%</td>
<td>48%</td>
<td>Not Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>255%</td>
<td>94%</td>
<td>Not Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>207%</td>
<td>17%</td>
<td>Not Adopted</td>
<td>Passed legislation allowing for extended postpartum coverage to one year for eligible women part of Health Texas Women, using state-only funding. Pending legislation to extend postpartum Medicaid coverage to one year for all mothers.</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>144%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>213%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>205%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>198%</td>
<td>138%</td>
<td>Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>305%</td>
<td>138%</td>
<td>Adopted</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>306%</td>
<td>100%</td>
<td>Not Adopted</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td>159%</td>
<td>53%</td>
<td>Not Adopted</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>