

## Maternity Care Financing Challenges and Opportunities Highlighted by the COVID-19 Pandemic

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Maternal mortality and serious morbidity rates are considerably higher in the United States than in other wealthy nations, and women of color are bearing the brunt of this crisis.<sup>1</sup> Black and indigenous women<sup>2</sup> are two to three times more likely to experience poor maternal and infant outcomes than white women in the United States.<sup>3</sup> Even before the COVID-19 pandemic, structural racism—including in how maternity care is delivered and financed—has driven maternal health disparities.<sup>4–8</sup> In this brief, we identify emerging challenges and key priorities for financing maternity care and other services for pregnant and postpartum women in ways that promote health equity. To do so, we draw on a rapid assessment of maternal health care experiences during the pandemic. We find the pandemic has exacerbated existing deficiencies in maternity care financing in the United States in ways that could worsen maternal health outcomes. But, we also find it has created opportunities for addressing these deficiencies, including by keeping new mothers enrolled in Medicaid longer than they would otherwise be eligible. Ensuring access to Medicaid coverage is particularly important given that pandemic-induced health and financial consequences have disproportionately affected communities of color.<sup>9–16</sup> In the longer term, strategies such as expanding coverage and reimbursement of evidence-informed services, such as birth center care, and developing value-based payment models for maternity care could help reach maternal health equity.

Part of a larger [series](#) on the pandemic and maternal health equity, this analysis draws on interviews with maternal care stakeholders (Box 1) and an environmental scan of the literature and publicly available information to describe the strengths and deficiencies of maternal health care financing in the United States and the ways current policies and practices contribute to inequitable maternal health outcomes. We also consider how the pandemic is exacerbating these long-standing issues while simultaneously allowing policymakers, practitioners, and advocates to reevaluate how we approach and pay for maternal health care. Because Medicaid finances a disproportionate share of maternity care and covers a disproportionate share of pregnant women of color,<sup>17,18</sup> we focus on Medicaid policies and strategies that can better support perinatal health.<sup>19</sup> Key findings from this early work include the following:

- › Fragmented, inadequate, and biased funding for perinatal care and health-related social needs have contributed to long-standing inequities in maternal health outcomes.
- › Several preexisting funding deficiencies have been exacerbated by the pandemic and will likely be further strained by anticipated Medicaid budget cuts and provider shortages.

- However, one policy response spurred by the crisis, the Families First Coronavirus Response Act, prohibits disenrollment from the Medicaid program during the crisis, extending Medicaid-enrolled new mothers' coverage beyond the traditional 60 days after delivery.
- Further immediate policy changes to prevent worsening maternal health outcomes include permanently expanding access to Medicaid via extended postpartum coverage, adopting the Affordable Care Act Medicaid expansion, increasing funding for home visiting programs, and providing additional federal financial assistance to state Medicaid programs.
- To address the racial and ethnic inequities in maternal health outcomes predating the pandemic, recovery efforts will require additional changes to maternal care payment and delivery systems and investments in community-based social services.

### BOX 1. RESEARCH METHODS

In spring and summer 2020, we conducted individual and small-group interviews with 40 maternal health experts, perinatal care providers, consumer advocates, philanthropic funders, and frontline health workers serving pregnant women to identify and examine key concerns about maternal health equity and challenges raised by the pandemic. We also conducted, and periodically updated, a comprehensive scan of publicly available information on maternal health equity during the pandemic from national policy and research organizations, professional and provider trade organizations, and leading maternal and infant health advocacy groups. Our findings primarily reflect insights into and responses to the pandemic that emerged between March and September 2020.

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

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

\* What is racial equity? Center for Social Inclusion website. <https://www.centerforsocialinclusion.org/our-work/what-is-racial-equity/>. Accessed October 19, 2020.

## ***Background: Maternal Health Financing Is Fragmented, Inadequate, and Inequitable***

Vast inequities in maternal and infant outcomes preceded the pandemic.<sup>20–24</sup> Many experts have pointed to fragmented and biased care that is ill equipped to adequately address systemic inequality and disparate needs for medical and social supports as key contributing factors.<sup>5,25–27</sup> Similarly, key informants interviewed for this work repeatedly cited scarce and disjointed funding sources as barriers to delivering holistic and equitable care to pregnant and postpartum women.

### *Medicaid Plays a Dominant Role in Funding Maternal Health Care*

Through Medicaid and the Children’s Health Insurance Program (CHIP),<sup>28–30</sup> the Centers for Medicare & Medicaid Services (CMS) pays for nearly half of all births in the United States. It is also the largest payer for births among women of color: more than 65 percent of non-Hispanic Black women and indigenous women and 60 percent of Hispanic women who gave birth in 2018 were covered by Medicaid.<sup>18</sup> Medicaid coverage of specific perinatal services, however, varies by state, and provider reimbursement rates can be too low to ensure robust provider participation and broad access to care.<sup>31,32</sup> In addition, coverage of services addressing pregnant Medicaid enrollees’ health-related social needs is often limited and dependent on the availability of services in the community.<sup>33–36</sup>

How Medicaid pays for pregnancy-related services has also contributed to disparities in health outcomes. Both Medicaid managed-care organizations and fee-for-service programs typically provide a single bundled payment (traditionally called a “global fee”) for all maternity care services delivered during pregnancy (typically prenatal, labor and delivery, and at least some postpartum care).<sup>37</sup> The payment is often triggered by delivery and not tied to the length and quality of prenatal care or provision of postpartum care, because providers can bill at delivery regardless of whether the patient attends her visits.<sup>38</sup> Medicaid programs pay facility fees for the actual delivery separately, with much higher fees for hospital deliveries than birth center deliveries and, traditionally, higher fees for cesarean deliveries than vaginal births. This payment structure incentivizes hospital-based births and high-cost interventions that do not necessarily translate into better maternal health outcomes.<sup>37,39</sup>

In addition, Medicaid programs have historically provided less generous coverage of perinatal services and supports that do not conform with traditional medical models in the United States. For example, though birth center care has been shown to improve quality of care and maternal health outcomes,<sup>40</sup> only 33 state Medicaid programs covered birth center deliveries in 2018.<sup>41</sup> Even fewer Medicaid programs cover home births for women with low-risk pregnancies.<sup>31</sup> Even when

Medicaid covers out-of-hospital births, low reimbursement rates, administrative hurdles (e.g., difficulty contracting with managed-care plans), and restrictive licensing requirements often discourage birth centers and midwives from accepting Medicaid-enrolled pregnant women.<sup>42–44</sup> In addition, only a few states cover doula services,<sup>45</sup> another promising, high-value model for reducing maternal health disparities by providing support and advocating on behalf of women who may face poor health outcomes.<sup>46,47</sup> Medicaid beneficiaries may also have limited access to less traditional prenatal care models, such as group prenatal care (e.g., Centering Pregnancy), peer counseling, and maternity care homes.<sup>48</sup>

Finally, though evidence shows a third of pregnancy-related deaths occur within the year after giving birth,<sup>49</sup> postpartum Medicaid coverage lasts just 60 days in almost all states.<sup>50</sup> This leaves many women who qualify only for pregnancy-related coverage without alternative affordable coverage options, particularly in states that have not expanded Medicaid and have lower income eligibility thresholds for parents.<sup>51,52</sup> Though there have been recent federal and state efforts to extend postpartum coverage for up to 12 months,<sup>53,54</sup> the urgency of the health crisis threatens their implementation.

### *Funding to Address Pregnant and Postpartum Women’s Health-Related Social Needs Is Insufficient and Lacks Coordination*

Maternal morbidity and mortality in the United States cannot be divorced from preexisting burdens on women’s health and well-being, such as stress and depression related to poverty, poor housing conditions, family conflict, and neighborhood violence.<sup>55,56</sup> Addressing these factors requires access to a range of services (e.g., mental and behavioral health services, maternal and infant home visiting, care coordination) that can be instrumental in helping identify and address the needs of pregnant and postpartum women. Supports that link women with intimate partner violence interventions, help them secure housing and food, or provide transportation and communication assistance, child care services, and items needed to safely raise a baby (e.g., breast pumps, diapers, and formula) can reduce stress and anxiety and help women have a healthier pregnancy and care for their child. Incorporating wraparound services and linking women with social services are key components of holistic care, as recommended by Black Mamas Matter Alliance.<sup>57</sup>

Since the 1980s, states have been enhancing their Medicaid maternity care benefits by adding services such as targeted case management, nutritional counseling, health education, and home visiting.<sup>31,58</sup> However, as interviewees noted repeatedly, Medicaid coverage of these services often fails to meet patients’ needs and requires social service providers, and even health systems with integrated human services, to

solicit supplemental support from other sources, such as local foundations, or rely on community-based organizations that are already stretched thin. For example, a mix of federal, state, and local sources typically fund comprehensive home visiting programs to support pregnant and postpartum women and/or young children, but the funding has often been inadequate.<sup>59,60</sup> As one informant noted, despite home visiting being around for decades, Medicaid coverage of this service remains limited.<sup>61</sup> Caring for women's health-related social needs clearly extends beyond financing, but the ad hoc and unstable funding behind care coordination and wraparound services has undermined the effectiveness of such care.

Many communities with low incomes have faced years of disinvestment and poor public infrastructure, including lack of affordable housing, fresh-food supermarkets, public transportation, health care, and recreational facilities.<sup>62,63</sup> Such environmental conditions have been shown to negatively affect health.<sup>64-66</sup> Key informants emphasized that community-based social service organizations and supports often have limited capacity to meet the demand for their services, at least partially because of the lack of investment in such resources.

### ***Maternal Health Financing During COVID-19: Exacerbated Deficiencies and Emerging Solutions***

The pandemic has highlighted the need for greater investment in health care and social services, especially given that communities of color disproportionately face both the health and financial consequences of the crisis.<sup>9-16</sup> Though some public resources for perinatal health care and social services have been diverted to the emergency response, federal, state, and local governments have also increased investment in protecting public health and allowed for expanded and more efficient flow of COVID-19-related funding to aid individuals, families, and business.

#### ***The Pandemic Has Strained Existing Maternity Care Funding***

Little was known about the effects of the coronavirus on pregnant women in the pandemic's early days, but data available months into the crisis suggest pregnant women are more likely to experience severe illness from the virus than nonpregnant women.<sup>67</sup> Hispanic and Black women (like their communities at large) are more likely to be affected by COVID-19 infections, adding yet another risk for women already experiencing disproportionately poor birth outcomes. These disparities are largely attributable to social and economic inequities that have been exacerbated by the pandemic.<sup>68,69</sup>

In addition to an increased likelihood of COVID-19 infection, pregnant women of color with low incomes face greater risks of food insecurity, unstable housing, and depression and

anxiety<sup>70</sup>—at the same time that access to health care and social services are constrained by social distancing measures and increased demand for already limited resources. Before the pandemic, about a quarter of Americans living in poverty were disconnected from social safety net benefits for which they were eligible, such as nutritional, housing, food, and child care assistance.<sup>36</sup> And the economic fallout from the pandemic has only highlighted the inadequacy of the U.S. safety net.<sup>71-73</sup> Interviewees recounted that many state and local government resources, including staff and funding, were redirected to emergency health responses. Consequently, some perinatal health and social service programs have fewer resources while facing greater need for assistance from their clients, particularly with basics such as food, formula, and diapers.

Demand for both birth center deliveries and home births rose in the early days of the pandemic, when many states implemented stay-at-home orders to slow the spread of the coronavirus.<sup>74,75</sup> However, those out-of-hospital alternatives may have been inaccessible to women covered by a state Medicaid program that does not cover those services, or because supply has been limited by low reimbursement, burdensome licensing requirements, or contracting challenges imposed by Medicaid managed-care organizations.<sup>44</sup>

Further, maternal health and other safety net health care providers who rely on Medicaid reimbursement have experienced financial peril because of the pandemic, which may push some providers out of business and further constrain access to care for underserved communities.<sup>76</sup> These financial difficulties have stemmed from decreased use of services, as many patients have delayed preventive and nonurgent care because of concerns about exposure to the virus and out-of-pocket costs.<sup>77</sup> Particularly alarming are large reductions in primary and preventive health care use among 40 million infants and children enrolled in Medicaid and CHIP between March and May 2020; compared with the same period in 2019, 1.7 million fewer babies under age 2 received vaccinations, 3.2 million fewer children received developmental screenings, and 7.6 million fewer children received dental services, according to recently released CMS data.<sup>78</sup> Missing these critical services can negatively affect children's long-term development. And the safety net providers offering these services are experiencing revenue losses that may undermine their viability.

Though Congress allocated \$175 billion within the Coronavirus Aid, Relief, and Economic Security, or CARES, Act Provider Relief Fund to reimburse providers for lost revenue, among other objectives, these funds have been primarily directed to hospitals, rural health care providers, and nursing homes in COVID-19 hotspots.<sup>79,80</sup> Providers primarily serving Medicaid-enrolled and uninsured patients, such as community health centers, have been among the last to receive the federal assistance.<sup>81</sup> Across the country, nearly 2,000 community health centers have temporarily closed because of patient visit

declines and staffing challenges, and some may close their doors permanently absent federal financial aid.<sup>82,83</sup>

Unprecedented unemployment rates have resulted in more people becoming eligible for Medicaid as state spending to fight the pandemic has increased and state revenues have plunged because of falling income and declining sales tax revenues.<sup>84</sup> These forces present monumental challenges for policymakers planning and budgeting for programs focused on maternal health.<sup>85–87</sup> Tennessee, Virginia, and Washington State paused their proposals to extend postpartum Medicaid coverage for up to one year because of anticipated budget constraints.<sup>88,89</sup> Further, interviewees indicated they expect cuts in public funding for the next several budget cycles. Medicaid does not cover all of the health and health-related social services pregnant and postpartum women need, and when budgets are reduced, nonclinical services may be the first to be eliminated, particularly in fee-for-service reimbursement models. Moreover, Medicaid budget cuts may include provider payment reductions, which could worsen the financial position of many safety net health care providers and constrain already limited Medicaid provider networks.

#### *Silver Linings for Maternity Care*

After the national emergency declaration in early March, CMS began allowing states and providers additional flexibility to respond to the pandemic by temporarily waiving certain requirements in Medicaid and approving changes requested through Medicaid disaster relief state plan amendments.<sup>90,91</sup> State Medicaid programs began adopting measures intended to ease access to coverage and care previously restricted by Medicaid policy. Such measures have included removing cost-sharing requirements for certain services, suspending prior authorization requirements, and expanding provider capacity by allowing out-of-state providers to bill Medicaid and permitting some services to be provided in alternative settings.<sup>92,93</sup> Some states have also attempted to aid financially stressed providers through measures such as direct payments and increased reimbursement rates.<sup>76,94,95</sup> North Carolina's Medicaid program increased reimbursement for free-standing birth centers by 5 percent.<sup>96</sup>

In addition, to receive the temporary 6.2 percentage-point increase in the federal Medicaid matching rate made available by the Families First Coronavirus Response Act, states must provide continuous coverage for Medicaid beneficiaries during the pandemic, including women who enroll on the basis of

pregnancy. This effectively extends postpartum coverage beyond the 60-day limit for the duration of the public health emergency.<sup>97,98</sup> However, this requirement does not apply to separate state CHIP programs, meaning pregnant women receiving maternity care through these programs cannot maintain that coverage beyond 60 days postpartum.<sup>99</sup> But even as some states pause or reverse their plans to permanently extend postpartum coverage, others continue pursuing this option.<sup>50</sup> Georgia lawmakers approved a measure to apply for a waiver for extending postpartum Medicaid coverage to six months,<sup>100</sup> and states such as Illinois and New Jersey have proposed postpartum expansions in their Medicaid Section 1115 demonstration requests, which are currently under review at CMS.<sup>101,102</sup>

Some interviewees have noticed higher rates of virtual postpartum visits during the pandemic than in-person visits before the pandemic. This may be because virtual visits eliminate the need to secure child care and transportation and allow new mothers to focus on their newborns. Key informants therefore thought telehealth—which has grown exponentially during the pandemic, partially because of significant Medicaid flexibilities<sup>103</sup>—will remain an important tool for improving postpartum visit rates among Medicaid beneficiaries even after the pandemic. Many informants emphasized that virtual postpartum visits would need to incorporate the same services (e.g., depression screening, referrals) and continue to be reimbursed at the same rates as in-person visits. Some experts we spoke with believed some telehealth-facilitated maternity care should continue after the pandemic: though most prenatal care visits, particularly for women with high-risk pregnancies, should be conducted in person, components such as education or peer support may garner better participation virtually.<sup>104</sup> Many early childhood home visiting programs also reported increased participation in virtual home visits.<sup>105</sup>

Informants also reported that philanthropic donors were an important source of stability and added flexibility at the beginning of the pandemic. Foundations and other private funders quickly filled gaps left by diversion of public resources to acute care and were responsive to grantees' shifting priorities. Some organizations redirected funding from programs or activities effectively prohibited by stay-at-home orders (e.g., in-person support groups) to address families' immediate needs, such as assistance with food, diapers, and formula. Many foundations have pledged additional funding to support organizations serving individuals and families hit hard by the pandemic.<sup>106–108</sup>

## **Maternal Health Financing Priorities for the Pandemic and Beyond**

As the United States struggles to contain the pandemic and revive the economy, looming state Medicaid budget shortfalls threaten funding for maternal health care. Social service and health care provider shortages, workforce challenges, and financial pressures may also be exacerbating disparities in maternal health outcomes. By drawing attention to these long-standing issues, the pandemic presents an opening for the United States to reevaluate maternal care payment and delivery, address these challenges, and promote equity during and after the pandemic.

### *Immediate Maternal Health Financing Priorities During the Pandemic*

Some emergency policy responses that expanded access to Medicaid coverage during the pandemic could improve maternal outcomes broadly and could be maintained and expanded during and beyond the pandemic. Federal and state governments can look to the following to promote equitable maternal health outcomes:

- ▶ **Permanently extend postpartum Medicaid coverage beyond 60 days.** Uninsured new mothers face many challenges, including untreated pregnancy-related health conditions and unaffordable health care.<sup>109</sup> Thus, continuous Medicaid coverage after delivery could improve new mothers' health outcomes and access to needed care. Even when the public health emergency subsides, the economy may take years to fully recover, potentially leaving many Americans—disproportionately people of color, people living in poverty, and unemployed people—without access to health insurance. Policy analysts, providers, and advocates have therefore called for permanent expansion of postpartum Medicaid coverage beyond the federal emergency declaration period.<sup>110–112</sup> Given that many maternal deaths occur after delivery, several state maternal mortality review committees recommend extending Medicaid postpartum coverage beyond 60 days.<sup>113–118</sup> Further, Congress is considering the Helping MOMS Act, which would allow states to extend Medicaid and CHIP coverage to one year postpartum.<sup>53,119</sup>
- ▶ **Ensure broad access to Medicaid.** Access to health insurance coverage can help decrease maternal health disparities by increasing access to health care even before a woman becomes pregnant. Research shows women living in states that have expanded Medicaid under the Affordable Care Act have better access to preventive care, experience fewer adverse health outcomes during and after pregnancy, and have lower maternal mortality rates than women living in states that did not expand Medicaid.<sup>120</sup> Adopting the Medicaid expansion is an urgent priority for the remaining states that have not done so.<sup>121</sup> States can promote better
- ▶ **Increase federal assistance to states.** States face dire financial constraints, and expanding coverage for many more enrollees on Medicaid rolls could be nearly impossible without additional help from the federal government. The 6.2 percentage-point increase in the federal share of Medicaid spending is only about half of what states received during the Great Recession.<sup>123,124</sup> In addition, this temporary increase is set to expire at the end of the fiscal year quarter when the public health emergency ends, currently set for January 21, 2021.<sup>98,125</sup> Several organizations, including the American College of Obstetricians and Gynecologists, the National Governors Association, and America's Essential Hospitals, have asked Congress to increase federal assistance for Medicaid by at least 12 percentage points relative to prepandemic levels.<sup>126,127</sup> In addition, the U.S. Government Accountability Office recently recommended Congress use a Medicaid funding formula that accounts for states' current economic conditions to permanently provide more timely and better-targeted assistance to state Medicaid programs in future economic downturns.<sup>128</sup>
- ▶ **Ensure funding for home visiting programs.** Home visiting programs provide critical support to disadvantaged families at risk of poor maternal and health outcomes. These evidence-based programs have shown to improve maternal health and family economic security, as well as child health and school readiness.<sup>129</sup> Thus, they are critical during the pandemic, when so many families have been destabilized. Despite initial service disruptions, many home visiting programs have rapidly transitioned to a virtual environment, and they continue helping families navigate available assistance and secure their basic needs, as well as providing emotional support and domestic-violence interventions. In addition, home visitors help ensure pregnant women attend their prenatal appointments and newborns receive well-child visits and vaccinations.<sup>105,130,131</sup> Home visiting advocates are calling on federal and state governments to make immediate and long-term investments, such as increasing funding for the Maternal, Infant, and Early Childhood Home Visiting program, to provide vital support to families in need during and after the pandemic.<sup>132</sup>

### *Long-Term Maternal Health Financing Priorities Beyond the Pandemic*

The current and anticipated maternity care funding challenges highlight the need to ensure Medicaid covers care models and strategies that improve outcomes at a lower cost, and that Medicaid pays for maternity care in a way that promotes quality, equitable, and cost-effective care. Additionally, pregnant and postpartum women urgently require investments in social

services and supports that address their health-related social needs. To achieve these goals, the following strategies could be considered by state and federal policymakers:

- › **Ensure Medicaid provides reimbursement for evidence-informed care.** As states address forthcoming fiscal pressures, it is critical to focus on evidence-informed models and strategies, such as midwives, birth centers, and doulas, that have been shown to improve pregnant and postpartum women's health outcomes and meet their health-related social needs at a lower cost. A recently completed evaluation of enhanced prenatal care models for Medicaid beneficiaries implemented under the Strong Start for Mothers and Newborns initiative found that women receiving birth center and midwife care had better birth outcomes and less costly births than women who received traditional care.<sup>40</sup> Similarly, evidence suggests doula care improves maternal and infant health outcomes, including lower rates of cesarean deliveries and preterm births, and can reduce racial health disparities.<sup>46,133-136</sup> Maternal health equity activists and advocates have elevated these models as approaches that advance health equity.<sup>137-139</sup>
- › **Develop and implement value-based payment approaches for maternity care.** Many stakeholders agreed state Medicaid programs must reevaluate payment approaches for maternity care and implement value-based models that incentivize high-quality care and integrate wraparound social services by tying reimbursement to outcomes and measures that promote health equity. New payment models tied to structural, process, and performance measures are urgently needed. These measures include early-initiation prenatal care; number of prenatal care visits attended by patient; provision of health education; provision of linguistically and culturally specific care; care continuity; patient satisfaction; screenings for substance use disorder, health-related social needs, and postpartum depression; and referrals to address identified health and social needs. To reward narrowing racial and ethnic maternal health inequities, payment models tied to risk-adjusted mother and infant outcome measures, such as rates of postpartum complications, cesarean sections, preterm births, and newborns with low birth weight, must be developed. And to create and sustain these payment models, states will also need to invest in better data collection systems.<sup>140</sup>

- › **Promote high-quality maternity care through managed-care contracting.** To better integrate and coordinate care for pregnant enrollees and encourage use of alternative payment models for maternity care, state Medicaid programs could leverage their purchasing power and incorporate requirements or incentives in managed-care contracts. States could require that managed-care organizations screen for and address enrollees' social needs, contract with birth centers, or report on maternal health equity measures. An increasing number of states already uses managed-care contracts to address Medicaid beneficiaries' health-related social needs, such as by requiring managed-care organizations to screen beneficiaries for certain conditions and refer them to social services, or to collaborate with community-based organizations to address enrollees' social needs.<sup>141</sup>
- › **Shore up social safety net programs.** To improve the availability and capacity of social services and supports, including funding for housing, nutritional assistance, and child care, considerable investments are needed at the federal, state, and local levels. Though the health care sector has been increasing capacity for addressing patients' health-related social needs,<sup>142</sup> it is not clear that health care dollars are a viable or efficient source for ensuring all communities have the resources needed to meet needs of residents with low incomes, particularly amid the economic fallout from the pandemic.

## Conclusion

The COVID-19 crisis shed new light on the deep racial health disparities that have long manifested in poor maternal health outcomes and misaligned incentives for payment for maternity care services in the United States. Though the pandemic could detract attention and funding from maternal health and further worsen maternal health inequities, it could also catalyze a shift toward a health care system where egregious disparities are no longer tolerated. As the United States navigates the pandemic and plans for recovery, it has critical opportunities to prioritize changes that reduce maternal mortality and eliminate racial disparities in maternal and infant health outcomes.

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