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Reducing Maternal Mortality in Texas: Analysis and Recommendations for State Maternal Health Policies

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Executive Summary

The United States is facing a maternal health crisis, with much higher rates of maternal mortality compared to those of other developed countries. Texas, in particular, faces severe challenges such as widespread rural maternity care deserts, racial and ethnic disparities, a restrictive political landscape for reproductive care, and gaps in coordination and access to care. Thus, this report analyzes the major social, structural, and healthcare system factors contributing to poor maternal health outcomes in Texas, identifying key gaps in the current policy landscape. It then offers evidence-based policy recommendations that strive to address disparities, improve access to care, and strengthen maternal health infrastructure in order to ultimately promote better outcomes for mothers in Texas. While this brief focuses on Texas, the recommendations may also act as a useful framework for addressing maternal health challenges across the US more broadly, especially for states facing similar challenges.

Introduction

Major Disparities in Maternal Health

When compared to other high-income countries, the U.S. has the highest rate of maternal deaths worldwide.[1] This discrepancy in care is a product of institutional barriers in healthcare created by geography, race, and restrictive lawmaking.

Geographically, pregnant individuals in rural areas have a 9% higher chance at facing maternal morbidity compared to their urban counterparts, as found in a nationwide analysis of maternal ICU admissions between 2016 and 2019.[2] More than 50% of rural counties have no access to maternal hospital care, and when at a rural hospital, these locations report significant rates of postpartum hemorrhage during labor and delivery.[3] Numerous tragedies occur due to these "healthcare deserts": mothers having to give birth in vehicles en route, missing prenatal and postpartum services that require resources and money these underserved communities lack. For instance, in New Mexico, one of three individuals who die during pregnancy and postpartum are not due to health complications, but due to car accidents while driving hundreds of miles to access care.[4]

Additionally, race remains a consistent discrepancy in maternal health, in both rural and urban communities. To provide some reference points from a study analyzing 207,016 hospital admissions in Maryland from 2017 to 2019: black women are six times more likely to develop cardiomyopathy (the leading cause of late maternal death) than white women. Relatedly, while the average for all U.S. women is 16.7 pregnancy-related deaths per 100,000 live births, black women face 40.8 deaths, while white women see 12.7 deaths per 100,000 live births.[5] On the patient side, understandably so, many pregnant women of color (Black women, in particular) see historical events like the Tuskegee Syphilis Trial (1932-1972) as an indicator that medical care towards individuals of color cannot be trusted. In a questionnaire given to Black female patients, many described receiving prejudiced treatment from both doctors and supporting staff, contributing to their hesitancy to even seek care in the first place. From the care-side, patients of color are historically less likely to receive certain diagnosis due to a prejudiced distrust or devaluing of their pain and respective symptoms.[6]

Finally, one of the primary perpetrators of maternal health discrepancies is the extreme variation and growing restriction in health policies (particularly regarding abortion) nationwide. As found in a report from Tufts University School of Medicine, these restrictions have created "geographic, transportation, and financial barriers…[resulting] in increased rates of maternal

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[1] kfflayotah, "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues | KFF," KFF, December 3, 2025, https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues/an .

[2] Katharine A. Harrington et al., "Rural–Urban Disparities in Adverse Maternal Outcomes in the United States, 2016–2019," American Journal of Public Health 113, no. 2 (February 2023): 224–27, https://doi.org/10.2105/ajph.2022.307134.

[3] Martha Hostetter and Sarah Klein, "Restoring Access to Maternity Care in Rural America | Commonwealth Fund," www.commonwealthfund.org, September 30, 2021, https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america.

[4] Hostetter and Klein, "Restoring Access to Maternity Care in Rural America."

[5] Fadia T. Shaya et al., "Disparities in Maternal Mortality," Journal of Clinical and Translational Science 7, no. 1 (April 20, 2023): 1–12, https://doi.org/10.1017/cts.2023.520.

[6] Rolanda L Lister et al., "Black Maternal Mortality - the Elephant in the Room," World Journal of Gynecology & Womens Health 3, no. 1 (November 22, 2019), https://doi.org/10.33552/wjgwh.2019.03.000555.

death…across all groups but especially among Black birthing people."[7] There is a strong parallel between states with aforementioned healthcare deserts and restrictive abortion laws, leading to a disproportionate amount of preventative tragedies. By analyzing data through the National Vital Statistics System on maternal deaths and live births, the Gender Equity Policy Institute (GEPI) found that in states where abortion was outlawed, mothers were 2x more likely to face pregnancy-related deaths compared to their legal counterparts.[8]

Previous Policy Solutions and Outcomes

In an attempt to increase maternal health coverage, in 2021, the American Rescue Plan Act extended Medicaid postpartum coverage to 12 months, which did successfully lower rates of uninsurance as intended. However, expanding coverage doesn't quite bridge the gap, as greater access to care doesn't equate to greater access to greater care. The American Rescue Plan Act didn't solve the innate racial biases within healthcare delivery, nor could it save those rural healthcare deserts, where sparseness weakness policy impact.[9]

More directly, as sponsored by Representative Lauren Underwood (D-IL-14) in May of 2024, H.R.3305, or the "Black Maternal Health Momnibus Act," aims to address social determinants of maternal health disparities (including race, socioeconomic status, nutrition, housing) by expanding related public education, research on maternal health, postpartum care, and programs for incarcerated populations.[10] Though well-intentioned and arguably more direct than Medicaid expansion, critics of the Momnibus Act argue that it still remains a "one-size-fits-all" attempt, as greater access to data and care does not achieve true healthcare reform. To do that, Ameneh Safarzadeh, a researcher at the University of Massachusetts Amherst, asserted that there must be a "fundamental shift in who holds power, whose knowledge is valued, and how care is delivered." [11]

Maternal Mortality in Texas

Texas, in particular, is disproportionately impacted by many of the previously mentioned factors. Due to restrictive abortion laws, if comparing Texas (where abortion is nearly banned) and California (where abortion is legal), the aforementioned Gender Equity Policy Institute found that women in Texas were 155% more likely to face maternal death than mothers in California, with Latina mothers, in particular, facing nearly triple the risk.[12]

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[7] Anna Kheyfets et al., "The Impact of Hostile Abortion Legislation on the United States Maternal Mortality Crisis: A Call for Increased Abortion Education," Frontiers in Public Health 11, no. 1291668 (December 5, 2023), https://doi.org/10.3389/fpubh.2023.1291668.

[8] gpmain@thegepi.org, "Maternal Mortality in the United States after Abortion Bans - Gender Equity Policy Institute (GEPI)," Gender Equity Policy Institute (GEPI), April 23, 2025, https://thegepi.org/maternal-mortality-abortion-bans/#elementor-toc__heading-anchor-6.

[9] "New Brief: Postpartum Medicaid Extension an Opportunity to Improve Maternal and Child Health, but Impact Limited without Medicaid Expansion," Center For Children and Families, July 15, 2022, https://ccf.georgetown.edu/2022/07/15/new-brief-postpartum-medicaid-extension-an-opportunity-to-improve-maternal-and-child-health-but-impact-will-be-limited-without-medicaid-expansion/.

[10] "H.R.3305 - 118th Congress (2023-2024): Black Maternal Health Momnibus Act," Congress.gov, 2023, https://www.congress.gov/bill/118th-congress/house-bill/3305.

[11] Ameneh Safarzadeh, "Dismantling Inequities to End the Black Maternal Mortality Crisis in the United States," International Journal for Equity in Health 24, no. 1 (April 28, 2025), https://doi.org/10.1186/s12939-025-02488-1.

[12] "Maternal Mortality in the United States after Abortion Bans," Gender Equity Policy Institute (GEPI).

Recently, Medicaid expansion was adopted in Texas law; specifically, in March 2024, HB 12 went into effect. HB 12 expands the Medicaid coverage window from 2 months to 12 months for those who were already enrolled in Medicaid or CHIP while still pregnant. This bill, however, has struggled in its implementation and impact due to a variety of factors including lack of awareness of resources, complicated application processes, quality of care, and scarcity of providers who accept Medicaid, especially in rural areas.[13]

Additionally, when considering race as a factor, women of color in Texas not only face those above prejudices, but the disparities are exacerbated even greater due to the high immigrant population in Texas (which comes with heightened racism and xenophobia). About three-quarters of the Texan population in border counties is Latinx, and due to the proximity (and understandably, comfort), many immigrants then chose the Mexican healthcare system for more accessible and affordable healthcare.[14] However, following the Trump administration's increased border control, this alternative for immigrant mothers has slowly dwindled, creating greater healthcare deserts for already struggling immigrant families. Immigrant populations struggle to view local American hospitals as safe spaces, due to the increased presence of Immigrations and Customs Enforcement (ICE) throughout Texas. Furthermore, not only does Texan healthcare see those same problems of racial bias as previously mentioned, upwards of 36% of Texas' population has limited English proficiency, thus creating a language barrier hospitals are slow to solve.[15]

All of these above factors come to a head in Texas, making it a critical pain point to analyze and create targeted policy for. Given that 80% of pregnancy-related deaths in Texas are considered to be preventable,[16] there remains an imminent need for targeted, comprehensive change.

Purpose Statement

This report seeks to analyze the current landscape of maternal health care within the United States. From this analysis, policy solutions are recommended with the goal of improving maternal health outcomes in Texas specifically. Research was organized into three main pillars:

1. Health Equity for Vulnerable Populations
2. Access to Maternal Healthcare
3. Models of Maternal Healthcare Delivery and Financing

These specific topics tackle the maternal health crisis from uniquely different perspectives, allowing for policy recommendations that are novel and implementable. Broadly, this report compiles data published by peer-reviewed journals, governmental organizations, and various hospital networks. Researchers from Texas A&M University, Tufts University School of Medicine, and the Centers for Disease Control and Prevention (CDC) were also interviewed to provide expert-level insights into the landscape of maternal health. From these sources, the

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[13] Cornelius, Chelsea. Initial Findings on Implementation of 12-Month Postpartum Health Coverage in Texas. 2024.

[14] Guerra, "Women & Birthing People in Border Communities Face Escalating Attacks on Health Care Access under the Trump Administration."

[15] Anna Kheyfets et al., "The Impact of Hostile Abortion Legislation on the United States Maternal Mortality Crisis: A Call for Increased Abortion Education," Frontiers in Public Health 11, no. 1291668 (December 5, 2023), https://doi.org/10.3389/fpubh.2023.1291668.

[16] Desiree Ingram, "Texas Maternal Health - Texas Women's Healthcare Coalition," Texas Women's Healthcare Coalition, December 21, 2024, https://www.texaswhc.org/activities/texas-maternal-health/.

current paper presents an overview of maternal healthcare in the United States, with a particular focus on policy interventions for the state of Texas.

Health Equity for Vulnerable Populations

Maternal Healthcare Disparities Among Immigrant Communities in Texas

I. Understanding current barriers for immigrants and other minority populations in maternal healthcare

With 1 in 3 births in Texas being from an immigrant mother, it is critical to be cognizant of the related socioeconomic, racial, and geographic disparities that govern the maternal health landscape in Texas. In a 2025 study conducted by the Department of Pediatrics at Johns Hopkins University School of Medicine, researchers highlighted that an innate difficulty of healthcare in immigrant communities is the cultural differences. Choices regarding sexual and reproductive health, contraceptives, and family planning frequently create tensions between doctor recommendations and patient desires. Oftentimes, because the communities are families that immigrated due to political violence, civil unrest, etc., they operate in a very "family-centered" manner, which can prove difficult when physicians are trying to collaborate with the patient, as families are quick to use their hesitations as barriers to treatment. Additionally, these communities struggle with a generational absence of institutional knowledge about healthcare, with many immigrant families forgoing conversations about menstruation, puberty, contraception, etc. This disconnect is understandable, given the lack of familiarity and comfort many of these families feel; this issue lies in the fact that hospitals often do not adjust their care to accommodate for these discrepancies.[17]

Furthermore, especially due to the high volume of immigrant families in Texas, their cultural disconnects are further exacerbated by language barriers. In a study conducted by Dr. Robert Weech-Maldonado, who focused on examining bilingual healthcare delivery, even if a control group was all collectively on Medicaid, the quality of care they were receiving heavily depended on their language capabilities. After surveying 50,000 adults on Medicaid, any linguistic minority received worse care than their white, English-speaking counterparts. Even though Medicaid decreased the financial barriers to care, it could not solve the language barriers.[18]

While there have been efforts, even at the nationwide level, to improve these gaps, interpretation services still struggle with quality and diversity. Title VI of the 1964 Civil Rights Act legitimized language assistance in a hospital setting, requiring that any patient with limited English proficiency (LEP) have the right to some sort of interpretation services. Though enshrined in law, this fails on two levels: access to interpretation services does not necessarily correlate with access to high-quality, accurate assistance; further, hospitals often are only equipped to deal with Spanish speakers, and while there are numerous families of that demographic in Texas, hospitals fail to address the hundreds of thousands of other Texans who speak Vietnamese, Chinese, Tagalog, French, Hindi, etc. For example, Texas has consistently had a high volume of refugees from Somalia and Myanmar. In practice, Texan hospitals have not

[17] Tania M Caballero et al., "Supporting Sexual and Reproductive Health for Immigrant Families across the Lifespan," Academic Pediatrics 24, inofthe fact o. 5 (July 1, 2024): 19–24, https://doi.org/10.1016/j.acap.2023.05in the021,.

[18] Deepali Bhandari, "Language Barriers for Texas Medicaid Patients," Medium (The Healthy City 2018 Spring, May 15, 2018), https://medium.com/the-heTexasalthy-city/language-barriers-for-texas-medicaid-patients-667436b76913.

been prepared. Teri Nuss, the Vice President of Patient Experience in North Texas' hospital system, noted that in the span of six months in 2022, they had "56,000 interpretation sessions with patients of more than 100 languages." Manuel Higginbotham, the manager of Language Access Services for the University of Texas Medical Branch, notes that hospitals absolutely need a standardization in terms of language assistance. In many cases, family members will try to interpret for their loved one, or a coincidentally bilingual staff member will intervene. However, Higginbotham notes this creates even greater inconsistencies in care, as the former often lacks proper medical terminology, while the latter still results in family members stepping in, since they might understand what is being said.[19]

II. Creating culturally competent care models

Before even addressing specific disparities such as language, as a whole, maternal healthcare for immigrants and other minority communities must not be a one-size-fits-all solution. In general, the approach must shift towards culturally competent and flexible models. This does not merely involve changing hospital frameworks and methods of care delivery, but also requires a shift in healthcare providers' views and approach towards immigrant patients. In a 2024 study analyzing maternal health policies for immigrant women in numerous high-income countries, global health researchers at the University College London argued that care must involve "multidisciplinary teams, in-person interpreting, maternal education, and social welfare support"—in other words, a multi-pronged approach.[20]

Dr. Shefaly Shorey, a women's health professor at the National University of Singapore, explains some of the most prominent models of culturally competent care. The Campinha-Bacote Model, a framework rooted in knowledge and awareness, calls on doctors to understand the "social and system factors" that determine community dynamics. This involves a grasp on viewpoints towards personal autonomy, family roles, and communication methods. This model directly ties to the aforementioned pain point, where doctors often find tension with administering care due to conflicting beliefs on family dynamics and responsibilities. Under this model, physicians ought to actually engage in training and education about their communities they serve, and actively think about how to incorporate those cultural factors into their delivery of treatment. Another highly applicable model is the Purnell Model for Cultural Competence, which similarly pushes for healthcare providers to not only understand family roles and dynamics like the Campinha-Bacote Model, but also advocates for a deeper understanding of "biocultural ecology" and workforce dynamics, seeing as occupational levels are so deeply intertwined with migrant and minority communities.[21] Both models are worth greater consideration when creating culturally competent maternal healthcare policies in Texas.

III. Combating language barriers in Texan healthcare systems

As mentioned previously, in addition to shifting towards more culturally competent care styles, greater accessibility alone is not enough; patients must be able to understand diagnoses and treatments and communicate their issues with their physicians. In a global health study

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[19] Luann Glowacz, "Bridging the Language Divide in Texas Hospitals - Texas Hospital Association," www.tha.org, May 3, 2022, https://www.tha.org/news-publications/texas-hospitals-magazine/2022-issues/march-april-2022/bridging-the-language-divide-in-texas-hospitals/of.

[20] Kerrie Stevenson et al., "Public Health, Policy, and Clinical Interventions to Improve Perinatal Care for Migrant Women and Infants in High-Income Countries: A Systematic Review," EClinicalMedicine 78 (November 19, 2024): 102938–38, https://doi.org/10.1016/j.eclinm.2024.102938.

[21] Shefaly Shorey, Esperanza Debby Ng, and Soo Downe, "Cultural Competence and Experiences of Maternity Health Care Providers on Care for Migrant Women: A Qualitative Meta-Synthesis," Birth 48, no. 4 (August 6, 2021): 458–69, https://doi.org/10.1111/birt.12581.

conducted by Dr. Allison Squires, a trained nurse and Professor at NYU Rory Meyers College of Nursing, notes that first and foremost, all language assistance must be standardized and trained. Squires states that the three times when proper, regulated interpretation matters the most are "admission, during patient teaching, and at discharge."[22] When crafting healthcare policy to address language barriers at these points, the intention should not lie merely in translation, but ensuring that patients can understand their diagnosis and medication management so they are comfortably equipped to exit the hospital at the end. While a patient's time in the hospital is critical, longevity of care is far more critical.

IV. Understanding the impact of the immigrant demographic in Texas

Without a doubt, immigrants—and thus immigrant mothers—make up a large portion of Texas' populations. More specifically, Texas is one of the leading states (alongside California) with the highest numbers of immigrant births, averaging 1 in 3 births in Texas being to an immigrant mother.[23] In practice, these staggering numbers highlight the importance of investing in immigrant maternal healthcare in Texas. Expanding access to preventative and maternal care for immigrant populations may help reduce long-term healthcare expenditures while improving maternal and infant health outcomes across the state.

In terms of strategy, any politician in Texas ought to recognize the growing impact on their voter base that immigrants have had. According to a 2022 population survey conducted by the American Immigration Council, a nonpartisan research group, eligible immigrant voters make up 11% of the Texan electorate. This is no small impact—Jeremy Robbin, director of the American Immigration Council, notes that this "rapid growth of different demographic groups will have an impact at the ballot box and on both major political parties."[24] Seeing as Texas, overall, is home to nearly 5 million immigrants—which accounts for 15% of all 28 million people in Texas—it is in any politician's interests to start thinking about catering their campaigns more towards this demographic. In a recent report sheet from the National Immigration Forum, they found that 2.5 million children in Texas have at least one immigrant parent, with 88% of those children being U.S. citizens, meaning pretty soon, these are more and more families who are becoming eligible to vote—votes that every Texan politician needs.[25] Even in the recent Texas primaries, Ashley Lopez, an NPR reporter, found that the Latinx immigrant vote was absolutely vital, and all politicians should've watched how that demographic of voters was key in President Trump's 2024 win, helping take on parts of the state that were historically blue.[26] If politicians focus more on uplifting immigrant healthcare and devoting campaigns and funding to the cause, that is a surefire way to help them win these invaluable votes.

V. The financial benefits of uplifting immigrant healthcare

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[22] Allison Squires, "Strategies for Overcoming Language Barriers in Healthcare," Nursing Management 49, no. 4 (April 2018): 20–27, https://doi.org/10.1097/01.numa.0000531166.24481.15.

[23] "Births to Legal and Illegal Immigrants in the U.S.," CIS.org, October 2018, https://cis.org/Report/Births-Legal-and-Illegal-Immigrants-US.

[24] Stella M Chávez, "The Number of Immigrant Voters Is Growing — and That Means a More Diverse Electorate in Texas," KERA News (KERA, November 2, 2022), https://www.keranews.org/texas-news/2022-11-02/the-number-of-immigrant-voters-is-growing-and-that-means-a-more-diverse-electorate-in-texas.

[25] "Fact Sheet: Immigrants in Texas - National Immigration Forum," National Immigration Forum, August 13, 2019, https://forumtogether.org/article/fact-sheet-immigrants-in-texas/.

[26] Ashley Lopez, "Texas Primaries Could Test Whether Latino Support for GOP Is Holding after 2024 Gains," NPR, March 2, 2026, https://www.npr.org/2026/03/02/nx-s1-5729467/texas-election-2026-latinos-ice-trump-vote-immigration.

Above any political gain, pouring money into immigrant healthcare has proven to have a highly successful return on investment. To start, maternal morbidity costs states more than it ought to. In a press release from The Commonwealth Fund, they find that for all births nationwide in 2019, costs accumulated to $32.3 billion; this included treatment and hospitalization costs, loss of economic productivity, and a rise in reliance on social services. Even with these staggering numbers, researchers at The Commonwealth Fund even noted that these values were likely severe underestimates, as they didn't take into account the "human toll" that maternal morbidity places on entire family members and societies. From these grandiose costs, maternal mental health disorders, in particular, were the highest drivers, accounting for $18.1 billion.[27]

Furthermore, Texas needs to address any maternal health disparities with better translation services, because communication is key to saving money. In a study done by Georgia State University, they found that whenever there was worsened prenatal care (which is a major issue in Texas' maternal health disparities), there were significantly higher rates of related emergency room visits, which all require pricier, more intensive interventions, or even surgeries.[28]

A primary aspect of solving these maternal health disparities is to provide more culturally competent care, such as better translation services. In recent Texas census records, it was reported that more than 1 in 3 Texan households speak a language that is not English, with 13% of Texans categorized as limited English proficiency, which the status quo does not seamlessly accommodate.[29] This is not only a critical pain point that must be addressed, but a financially beneficial one, too. Care to Translate, a medical translation app, reports "non-native speakers are 2-4 times more likely to experience [misdiagnoses] in their care."[30] This would not only generate more logistical challenges for any hospital, but also be a financial burden that is in Texas' best interest to resolve. Researchers at UCSF School of Medicine analyzed 31 studies regarding hospital readmissions, and in 11 of the 31, found that there was a "significant association between language discordance and hospital readmissions," with patients who were not native English speakers facing much higher likelihood of having to get readmitted to the hospital (which undoubtedly incurs higher costs for everyone involved).[31] Furthermore, in a report from the National Center for Biotechnology Information, they found patients who have limited English Proficiency (LEP), are "four times more likely to misunderstand prescription labels and/or have a bad reaction to medication, and nine times more likely to misunderstand a medical encounter." Similarly, the center reports that communication gaps in healthcare treatment, as a

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[27] The Commonwealth Fund, "NEW REPORT: Pregnancy and Delivery Complications Cost the United States Billions in Health Care Expenses, Lost Productivity, and Social Support Services," www.commonwealthfund.org, November 12, 2021, https://www.commonwealthfund.org/press-release/2021/new-report-pregnancy-and-delivery-complications-cost-united-states-billions.

[28] James Marton et al., "Group Prenatal Care and Emergency Room Utilization," Medical Care Research and Review, December 9, 2021, 107755872110599, https://doi.org/10.1177/10775587211059938.

[29] Karla Martinez, "Testimony to Texas House Human Services Committee on HB 5166 - Every Texan," Every Texan -, August 8, 2023, https://everytexan.org/2023/08/08/testimony-to-texas-house-human-services-committee-on-hb-5166/.

[30] "The Cost of Language Barriers in Health Care: A Case for Translation Support | Care to Translate," Caretotranslate.com, 2025, https://www.caretotranslate.com/news/the-cost-of-language-barriers-in-health-care-and-a-case-for-translation-support.

[31] Janet N. Chu et al., "Association between Language Discordance and Unplanned Hospital Readmissions or Emergency Department Revisits: A Systematic Review and Meta-Analysis," BMJ Quality & Safety, December 30, 2023, https://doi.org/10.1136/bmjqs-2023-016295.

whole, cost the US healthcare system over $8 billion annually.[32] Overall, investing into breaking down language barriers would prove to be a financial benefit for Texas and a completely worthwhile cause.

Policy Interventions for Immigrant Maternal Health

I. Amend Texas Human Resources Code (Chapter 32) to mandate Medicaid Reimbursements for Oral Language Interpreters in Hospitals

A. Background Research

For the 1 in 3 Texas births[33] that are to immigrant births in Texas, a significant barrier to equitable access is language. In a study conducted by Dr. Robert Weech-Maldonado, who focused on examining bilingual healthcare delivery, even if a control group was all collectively on Medicaid, the quality of care they were receiving heavily depended on their language capabilities. After surveying 50,000 adults on Medicaid,[34] any linguistic minority received worse care than their white, English-speaking counterparts. Even though Medicaid decreased the financial barriers to care, it could not solve the language barriers.

B. Current Legislation

Title VI of the 1964 Civil Rights Act legitimized language assistance in a hospital setting, requiring that any patient with limited English proficiency (LEP) had the right to some sort of interpretation services. Though enshrined in law, this fails when access to interpretation services does not necessarily correlate with access to high-quality, accurate assistance.

Despite this federal law, in practice, limited amounts of language service is provided. This stems from the following constraint: the Texas government only covers the cost of sign language services for Medicaid patients.[35] Using the Billing Code T1013, hospitals can get 50-75% of the cost reimbursed under an "administrative expense"; otherwise the cost falls under the hospital's own bill. This fails in numerous regards.

First, the current legislation in Texas disincentivizes hospitals from calling for translation services, even when needed. While it is undeniably valuable that sign language interpreters are fairly compensated, Texas hospitals find that Spanish is the primary language that is needed.[36] Secondly, this stipulation rests on the expectation that physicians are registered in the Texas Medicaid program, but many Texas OB-GYNs

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[32] Daniel Sanchez, "The Value of Culturally Competent Care: How Centering Health Equity Can Improve Quality and Lower Costs," The Philadelphia Sunday Sun, August 12, 2022, https://philasun.com/health/the-value-of-culturally-competent-care-how-centering-health-equity-can-improve-quality-and-lower-costs/.

[33] "Births to Legal and Illegal Immigrants in the U.S." 2018. CIS.org. October 2018. https://cis.org/Report/Births-Legal-and-Illegal-Immigrants-US.

[34] Bhandari, Deepali. 2018. "Language Barriers for Texas Medicaid Patients." Medium. The Healthy City 2018 Spring. May 15, 2018. https://medium.com/the-healthy-city/language-barriers-for-texas-medicaid-patients-667436b76913.

[35] "Medical Interpreting - Reimbursement State." 2026. Nobarrier.ai. 2026. https://www.nobarrier.ai/post/medical-interpreting-reimbursement-state.

[36] "News & Updates | Parkland Health." 2023. Parklandhealth.org. 2023. https://www.parklandhealth.org/news-and-updates/talking-to-patients-in-their-own-language-is-param-2027.

instead avoid treating Medicaid patients, as they want to sidestep the "complexities" that these "high-risk" patients bring.[37]

This legislative gap has dire implications for health outcomes in Texas. Specifically, miscommunication due to translation barriers results in misdiagnosis, misuse of prescriptions, and longer hospital stays (and consequently, higher costs). Parkland Health alone,[38] the hospital district governing Dallas County, reported 1,992,300 interpretations in just one year alone, highlighting how critical it is to address language barriers for all patients.

C. Case Studies

Currently, there are 14 states and 1 district that reimburse language services for Medicaid patients (e.g. Minnesota, Washington D.C., Iowa, Connecticut, New York).[39] Unlike these other states and district, Texas does not cover spoken language services, instead reimbursing for only sign language. For Minnesota,[40] who has used Billing Code T-1013 to reimburse hospital language interpreter services since February 2009, they cover both sign and oral language services, so long as the interpreter is on the state's "Enrolled Providers" list.[41] In order to be an interpreter on the reimbursed list, the interpreter must be "qualified and competent" per the Minnesota government's standards, which will incentivize high quality interpretation services. Furthermore, Minnesota's program has also been long-withstanding because the service links directly to clinical care administration with their "three-people rule," stipulating that a provider, patient, and interpreter all have to be present at all times of the translation.[42]

D. Implementation

Texas should expand its coverage to all language interpreters and utilize the successful model that Minnesota has had to ensure quality and accountability. Their funding structure is the same as Minnesota's, making this a feasible and scalable precedence to rely on. Like all Medicaid programs, Minnesota's is funded jointly by the federal government and the state;[43] with the Minnesota state government covering more (~37%) of Medicaid costs compared to Texas (~31%).[44]

This recommendation will also provide a return on investment. When researchers at UCSF School of Medicine analyzed 31 studies regarding hospital readmissions, they

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[37] Vox, Nina Martin, ProPublica, and Julia Belluz. 2019. "The Extraordinary Danger of Being Pregnant and Uninsured in Texas." The Texas Tribune. December 6, 2019. https://www.texastribune.org/2019/12/06/extraordinary-danger-being-pregnant-and-uninsured-texas/.

[38] "News & Updates | Parkland Health." 2023. Parklandhealth.org. 2023. https://www.parklandhealth.org/news-and-updates/talking-to-patients-in-their-own-language-is-param-2027.

[39] "Medical Interpreting - Reimbursement State." 2026. Nobarrier.ai. 2026. https://www.nobarrier.ai/post/medical-interpreting-reimbursement-state.

[40] "Translation and Interpretation Services | Medicaid." 2022. Medicaid.gov. 2022. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services.

[41] "Sec. 256B.0625 MN Statutes." 2021. Mn.gov. 2021. https://www.revisor.mn.gov/statutes/cite/256B.0625.

[42] pwsmn57, and mai.yang. 2023. "Provider Requirements." State.mn.us. 2023. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_157632.

[43] USAFacts. 2026. "Minnesota and Medicaid: What the Data Says." USAFacts. March 4, 2026. https://usafacts.org/articles/minnesota-and-medicaid-what-the-data-says/.

[44] USAFacts. 2023. "How Much Does Medicaid Cost in Texas?" USAFacts. 2023. https://usafacts.org/answers/how-much-does-medicaid-cost-in-the-us/state/texas/.

found in 11 of the 31 that there was a "significant association between language discordance and hospital readmissions," with patients who were not native English speakers facing much higher likelihood of having to get readmitted to the hospital (which undoubtedly incurs higher costs for everyone involved). Furthermore, the center reports that communication gaps in healthcare treatment, as a whole, cost the US healthcare system over $8 billion annually. Overall, investing into breaking down language barriers would prove to be a financial benefit for Texas and a completely worthwhile cause.

II. Amend Texas Health and Safety Code (Chapter 48) to Mandate Medicaid Reimbursement for Community Health Workers (CHWs), specifically for Maternal Health Services

A. Background

As a whole, maternal healthcare for immigrants and other minority communities must not be a one-size-fits-all solution. In general, the approach must shift towards culturally competent and flexible models. This does not merely involve changing hospital frameworks and methods of care delivery, but also requires a shift in healthcare providers' views and approach towards immigrant patients. In a 2024 study analyzing maternal health policies for immigrant women in numerous high-income countries, global health researchers at the University College London argued that care must involve "multidisciplinary teams, in-person interpreting, maternal education, and social welfare support"—in other words, a multi-pronged approach.[45]

As described by Dr. Linda Mobula, an Assistant Professor of Medicine at Johns Hopkins, Community Health Workers (CHWs) are meant to "serve as patient advocates, bridging cultural and social gaps between patients and healthcare providers by working with multidisciplinary teams to reduce health disparities." [46] CHWs help cultivate a standard of more culturally competent care—understanding a patient's home and personal environment and dynamics before a patient even arrives at the hospital. In a study from the Columbia Mailman School of Public Health,[47] they find that many CHWs are immigrants themselves, making it an easier bridge when the CHWs can connect with patients on shared experience and build up necessary trust. When patients engage deeper with the healthcare system through more continuous care models,[48] they'll be more inclined to attend follow-up appointments, follow prescriptions, etc.

B. Current Legislation

Currently, in the Texas state legislature, the Health and Safety Code's Chapter 48 emphasizes licensing and standardizing CHWs, *promotoras,* which are effectively CHWs

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[45] Kerrie Stevenson et al., "Public Health, Policy, and Clinical Interventions to Improve Perinatal Care for Migrant Women and Infants in High-Income Countries: A Systematic Review," EClinicalMedicine 78 (November 19, 2024): 102938–38, https://doi.org/10.1016/j.eclinm.2024.102938.

[46] Mobula, Linda M., Mekam T. Okoye, L. Ebony Boulware, Kathryn A. Carson, Jill A. Marsteller, and Lisa A. Cooper. 2014. "Cultural Competence and Perceptions of Community Health Workers' Effectiveness for Reducing Health Care Disparities." Journal of Primary Care & Community Health 6 (1): 10–15. https://doi.org/10.1177/2150131914540917.

[47] "Community Health Workers: Allies for Immigrant Health." 2015. Columbia University Mailman School of Public Health. July 14, 2015. https://www.publichealth.columbia.edu/news/community-health-workers-allies-immigrant-health.

[48] Saadi, Altaf, Rheanna E Platt, Fiona Danaher, and Jenny Zhen-Duan. 2024. "Partnering with Immigrant Patients and Families to Move beyond Cultural Competence: A Role for Clinicians and Health Care Organizations." Academic Pediatrics 24 (5): 6–15. https://doi.org/10.1016/j.acap.2023.06.016.

that cater to Latinx patients.[49] Yet in practice, in the standard payment plan from Texas Medicaid,[50] the global fee only covers routine pre- and post-natal visit, not accounting for care models that immigrant mothers disproportionately need, including CHWs and high-risk treatment (e.g. care for conditions like infections, bleeding).

C. Case Studies

When expanding CHW coverage, Texas can look to New York City's work in expanding CHW coverage and reimbursement.[51] Since 2023, in New York, CHW services are covered in Medicaid reimbursement to both pregnant and postpartum women. In particular, the Center for Healthcare Strategies (CHCS) created the New York Community Healthcare Worker Reimbursement and Sustainability Learning Collaborative.[52] As a 12-month initiative, this plan partners with numerous hospitals in the NYC area to equip CHWs with information including: how to get Medicaid reimbursement and technical assistance to become more effective and efficient CHWs. With all these initiatives to expand a structured Medicaid model with CHWs, New York state now has "41.3% of CHWs working with patients in languages other than English," a key shift that Texas and its high immigrant population would benefit from.[53]

D. Implementation

Texas should reframe Medicaid coverage, and ensure that reimbursement plans are included in the Health and Safety's Codes guidelines on *promotoras*. The Columbia study finds that CHWs are extremely cost-effective, as they will lead to less in-patient time and fewer visits to urgent care. In fact, CHWs are said to save $7 for every $1 invested in a CHW, giving this recommendation a meaningful return on investment.

Racial Disparities Among Black Mothers

I. Black Maternal Health Systematic Disparities

In the year 2021, Black women had a maternal mortality rate 2.6 times higher than their non-Hispanic white counterparts, with 69.9 deaths per 100,000 live births compared to 26.6, respectively.[54]

The reasons for this startling statistic are complex. For one, many black women face considerable socioeconomic challenges compared to their white counterparts. Multiple interview groups of black women found that a year before childbirth, they are more likely to experience

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[49] "Texas Constitution and Statutes." 2026. Texas.gov. 2026. https://statutes.capitol.texas.gov/?tab=1&code=HS&chapter=HS.48&artSec=.

[50] "Obstetrical Services Policy, Professional." n.d. Accessed May 26, 2026. https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Obstetrical-Services-Policy.pdf.

[51] Becker, Arielle. 2024. "Environmental Scan on Community Health Workers." https://www.cthealth.org/wp-content/uploads/2024/01/CHW-Medicaid-Policies-and-Reimbursement-Approaches-by-State.pdf.

[52] "New York Community Health Worker Reimbursement and Sustainability Learning Collaborative - Center for Health Care Strategies." 2026. Center for Health Care Strategies. January 22, 2026. https://www.chcs.org/project/new-york-community-health-worker-reimbursement-and-sustainability-learning-collaborative/.

[53] "Fact Sheet: Community Health Workers in New York State." n.d. New York Health Foundation. https://nyhealthfoundation.org/resource/fact-sheet-community-health-workers-in-new-york-state/.

[54] Hoyert, Donna L. 2023. "Maternal Mortality Rates in the United States, 2021." Centers for Disease Control and Prevention. March 16, 2023. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

extreme stressors (financial, emotional, partner-related) that negatively impact their pregnancy.[55] These women reported both personal barriers and systemic barriers ranging from substance usage and lack of family support to lack of affordable healthcare and accessible transportation. In fact, one study illustrated that 62% of rural black Americans and 53% of rural hispanic Americans are impoverished and face barriers to receiving adequate healthcare.[56]

Furthermore, minority women in the United States commonly report experiencing mistreatment (such as verbal abuse or privacy violations) while seeking treatment. 40% of black, hispanic, and multiracial respondents in one study reported discrimination based on race.[57] These challenges also don't simply go away as black women elevate their standing in society. Black women with college degrees still have higher maternal mortality rates than white women who only complete high school, supporting that there are clear systemic issues in the healthcare system rather than simply socioeconomic factors.[58]

A widespread systematic challenge commonly reported by women, especially black women, is dismissing reports of pain while visiting healthcare providers. Black patients are less likely to be given pain medications than white patients, and often are given lower quantities. Even when reporting similar feelings of pain, black patients were often not sent to the emergency room for treatment compared to their white counterparts (57% to 74%).[59] Even black children are less likely to receive painkillers.[60] Treatment of black patients in this manner stems back to racist, outdated beliefs that black people had less sensitive nervous systems [61]

These aforementioned factors culminate in black women being neglected during their pregnancy and/or avoiding seeking treatment, leading to increased risk of complications.

Policy Interventions for Black Maternal Health

I. Expand the Texas Joint Admission Medical Program through a specialized track for students committed to working in underserved areas and interested in maternal health related careers

As previously discussed, two key reasons as to why minority women typically face greater challenges with maternal health is that they typically live in underserved areas that lack adequate healthcare providers and often face discrimination within the healthcare system. Utilizing scholarships and mentorship support to encourage future maternal health providers to

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[55]Crandall, Katherine. 2021. "Pregnancy-Related Death Disparities in Non-Hispanic Black Women." Women's Health 17 (January): 174550652110198. https://doi.org/10.1177/17455065211019888.

[56] National Rural Health Association. "NRHA's Rural Health Voices Blog | National Rural Health Association - NRHA | NRHA." National Rural Health, 2017, www.ruralhealth.us/blogs/2018/04/national-minority-health-month-health-disparities-in-rural-america.

[57] Mohamoud, Yousra A. 2023. "Vital Signs: Maternity Care Experiences — United States, April 2023." MMWR. Morbidity and Mortality Weekly Report 72 (35). https://doi.org/10.15585/mmwr.mm7235e1.

[58] kfflayotah. 2025. "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues | KFF." KFF. December 3, 2025. https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues/.

[59] Hoffman, Kelly M., Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. 2016. "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites." *Proceedings of the National Academy of Sciences* 113 (16): 4296–4301. https://doi.org/10.1073/pnas.1516047113.

[60] Goyal, Monika K., Nathan Kuppermann, Sean D. Cleary, Stephen J. Teach, and James M. Chamberlain. 2015. "Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments." JAMA Pediatrics 169 (11): 996. https://doi.org/10.1001/jamapediatrics.2015.1915.

[61] Cartwright, Samuel A. "'Report on the Diseases and Physical Peculiarities of the Negro Race'." (2004).

work in underserved and often minority dominated areas could improve long term accessibility of underserved populations to maternal care while also providing opportunities for minority populations to enter the healthcare workforce and alleviate systematic discrimination through representation.

A. Current Texas Policy: Joint Admission Medical Program (JAMP)

Texas' HB 5154 was created to expand the Joint Admission Medical Program (JAMP), which was designed to increase medical school access to economically disadvantaged students.[62] HB 5154's key goals are to expand outside of JAMP's primary goal of guaranteeing medical school acceptance, which includes addressing physician shortages and updating its framework to strongly align with Texas workforce improvement goals. Additionally, it has the goal of increasing both availability and amount of scholarships awarded to those who become JAMP Scholars. Currently, the requirements to become a JAMP Scholar are typical, such as living in Texas, having exceptional grades, and overall having a strong application.[63]

A. Case Study 1: Massachusetts' MRLP

The Massachusetts Loan Repayment Program (MLRP) mandates that physicians work in an underserved area to be eligible for loan repayment, which would allow for more people in Health Provider Shortage Areas (HPSA) to have access to high quality medical treatment and care.[64] While MLRP utilizes loan repayment to increase numbers of physicians in underserved communities, Texas could adapt the underlying service-commitment model by expanding JAMP and creating an optional specialized JAMP scholarship track for students who commit to practicing in HPSAs after their education and training. If this expansion of Texas HB 5154 implemented similar service requirements as MRLP, not only would it accomplish its primary goal of providing a pathway for low-income (often minority) students to go to medical school, but it would also improve access to and equitable treatment in areas that are disproportionately affected by lack of healthcare providers and systematic discrimination.

B. Case Study 2: National Health Service Corps

One of the largest loan forgiveness programs, the National Health Service Corps (NHSC), provides loan forgiveness if an individual commits to working in a high-need area. One study found that 82.2% of early career NHSC participants practiced in underserved areas compared to only 24.2% of participants in another federal loan repayment program, the Public Service Loan Forgiveness program, and it also found that physicians of color were more likely to participate in NHSC.[65] Additionally, another study reported that minority patients reported higher satisfaction, reduced discrimination and found their physicians to be more participatory when the professionals they visited

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[62] Wilson, Terry. 2025. "89(R) HB 5154 - House Committee Report Version - Bill Text." Texas.gov. 2025. https://capitol.texas.gov/tlodocs/89R/billtext/html/HB05154H.htm.

[63] Joint Admission Medical Program. 2026. "Program Criteria and Guidelines." Texasjamp.org. March 24, 2026. https://www.texasjamp.org/applying-to-jamp/criteria-guidelines.html.

[64] Mass.gov. n.d. "Massachusetts Loan Repayment Program (MLRP) for Health Professionals | Mass.gov." Www.mass.gov. https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals.

[65] Davis, Caitlin S, Peter Meyers, Andrew Bazemore, and Lars E Peterson. 2023. "Impact of Service-Based Student Loan Repayment Program on the Primary Care Workforce." Annals of Family Medicine 21 (4): 327–31. https://doi.org/10.1370/afm.3002.

were also minorities.[66] Since NHSC was successful in attracting minority students, similar initiatives but through a workforce pipeline rather than a loan forgiveness program can help increase the diversity of providers in underserved communities in the long run, which can ultimately also contribute to reduced discrimination and higher patient satisfaction as seen in the study.

C. Cost Benefit Analysis

For the academic year 2024-2025, 150 students were admitted into JAMP, an increase from the typical 100 students that had been admitted into every cohort for the past 10 years.[67] That same year, total expenditures for JAMP were around $6.3 million, which included undergraduate student summer stipends, undergraduate student scholarships, and its largest expenses being medical school scholarships and medical school summer internship program ($1.2 million and $1.7 million, respectively).[68] JAMP Scholars receive various benefits such as scholarships, two internships, clinical experiences and shadowing opportunities, and more.[69] Assuming that the amount of funding between each scholar is equal, dividing the total expenditures by the 150 students means that each admitted student JAMP Scholar costs $42,000 in supporting them. If cohort sizes increased to 300-500 students, expenditures would then rise to $12.6-$21 million.

The precise economic benefits are difficult to estimate exactly. However, there is considerable evidence supporting the expansion of healthcare access and provider availability translating to long term economic benefits. For example, one study found that expanding Medicaid which subsequently expanded access to healthcare led to a $2.08 million relative increase in Medicaid revenues, leading to benefits for community health centers.[70] Other benefits included reductions in unpaid medical bills, improved credit, and higher workforce participation.[71] Furthermore, a study in 2022 found that by expanding primary care capacity, or increasing the amount of primary care visits a patient can receive, healthcare costs are reduced on average by $721 per visit, and patient outcomes are significantly better.[72] These results demonstrate that increasing the number of practicing physicians in HPSAs could help not just improve access to maternal health services and reduce disparities in care, but also result in overall long term economic benefits by improving population health as a whole.

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[66] Cooper, Lisa A., Debra L. Roter, Rachel L. Johnson, Daniel E. Ford, Donald M. Steinwachs, and Neil R. Powe. 2003. "Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race." Annals of Internal Medicine 139 (11): 907. https://doi.org/10.7326/0003-4819-139-11-200312020-00009.

[67] Joint Admissions Medical Program. 2024 JAMP Program Report. 2025.

[68] Joint Admissions Medical Program. 2024 JAMP Program Report. 2025.

[69] Joint Admissions Medical Program. 2024 JAMP Program Report. 2025.

[70] Luo, Qian, Ali Moghtaderi, Anne Markus, and Avi Dor. 2021. "Financial Impacts of the Medicaid Expansion on Community Health Centers." Health Services Research 57 (3). https://doi.org/10.1111/1475-6773.13897.

[71] Baten, Abdul, et al. "Affordable Care Act Medicaid Expansion, Access to Health Care, and Financial Behavior of the United States Adults." Journal of Public Health Policy, vol. 45, no. 4, 23 Sept. 2024, pp. 740–756, https://doi.org/10.1057/s41271-024-00522-0.

[72] Gao, Jian, Eileen Moran, Rachel Grimm, Andrew Toporek, and Christopher Ruser. 2022. "The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration." Journal of Primary Care & Community Health 13 (January): 215013192211417. https://doi.org/10.1177/21501319221141792.

Access to Maternal Healthcare

Maternal Care Deserts

I. Rural Disparities in Texas

Throughout the last decade, a severe deficit of OB-GYN practitioners and a reduction in available labor and delivery centers have plagued Texas, with rural regions suffering the most. Data from 2024 indicates that seven out of ten Texas OB-GYNs feel the state's restrictive abortion legislation has further damaged an already struggling workforce.[1] With physicians opting for early retirement or moving to different states, there is an urgent need to prioritize the recruitment and retention of maternity specialists alongside[73] the enhancement of medical

[73] Center for Reproductive Rights, "NYT Daily: Cox v. Texas," Center for Reproductive Rights, accessed May 29, 2026, https://reproductiverights.org/news/nyt-daily-cox-v-texas/.

infrastructure.

At the same time, limited rural health access remains a major challenge in Texas. Nearly 47% of Texas counties are classified as maternity care deserts, meaning they lack maternity care services such as hospitals with obstetric care, birth centers, or practicing maternity care providers.[74]

Access to maternal healthcare is essential for reducing maternal mortality, yet women in rural areas face higher rates of inadequate prenatal care compared to their urban counterparts.[75] These maternity care deserts disproportionately affect low-income and uninsured families, who already experience significant barriers to healthcare access.[76]

Furthermore, with the sharp decline in OB-GYN providers and the closure of local labor and delivery clinics in Texas, the quality of maternal care has degraded in several measurable ways.[77] Nurses and midwives are able to provide important assistance, but there are frequent cases in which routine complications or emergencies require specialized obstetric care. A possible solution would be to train ER physicians in obstetric techniques. However, several challenges arise from this approach because obstetric emergencies require specific protocols that an ER physician may not regularly practice. Furthermore, local emergency units also may not have the adequate equipment that is often needed, such as obstetric hemorrhage carts or advanced fetal monitoring technology.

Therefore, it is imperative to focus specifically on OB-GYN shortages, rural health infrastructure, and the policies and practices that most directly affect the access to maternal health in rural communities.

Policy Interventions for Maternal Care Deserts

I. Expanding Tele-Maternal Health Infrastructure to Address Maternal Care Deserts in Texas

A. Introduction to Telehealth

The use of telehealth, particularly tele–Maternal-Fetal Medicine (Tele-MFM), could drastically transform the way Texas hospitals handle obstetric medicine.[78] Because rural Texas clinics may not have the personnel to manage pregnancy complications or the staff needed to maintain 24/7 coverage, technology could bridge this gap. Organizations such as Access TeleCare are already doing this very thing.[78] Telehealth programs allow doctors and providers to virtually assist patients and guide them through pregnancy to ensure that everything progresses successfully.

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[74] Policy Center for Maternal Mental Health, "Maternal Mental Health Provider Shortages and Population Risk Report," Policy Center for Maternal Mental Health, accessed May 29, 2026, https://policycentermmh.org/maternal-mental-health-provider-shortages-population-risk-report/.

[75] Commonwealth Fund, "Insights into the U.S. Maternal Mortality Crisis: An International Comparison," Commonwealth Fund, June 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.

[76] Texas Medical Association, "The Uninsured in Texas," Texas Medical Association, accessed May 29, 2026, https://www.texmed.org/uninsured_in_texas/.

[77] Texas Women's Healthcare Coalition, "Texas Maternal Health," Texas Women's Healthcare Coalition, accessed May 29, 2026, https://www.texaswhc.org/activities/texas-maternal-health/.

[78] Access TeleCare, "teleMaternal-Fetal Medicine Services & Solutions," Access TeleCare, accessed May 29, 2026, https://accesstelecare.com/specialties/telematernal-fetal-medicine/.

Some pilot programs in the South are even establishing dedicated tele–OB emergency department programs. If an ER doctor suspects an obstetric emergency, they do not rely solely on standard ER protocols. Instead, they use specialized obstetric equipment, such as advanced fetal monitors, that are directly linked to an urban medical center.[79] At the urban medical center, the specialist can watch the fetal heart rate and maternal vital signs alongside the local ER physician. This enables both providers to assess the situation simultaneously and make decisions together. This evaluation would be more accurate and immediate since the specialist can see the data live rather than relying on secondhand descriptions.

This type of program has numerous benefits, one of which is that patients would be able to stay in their local communities with friends and families by their side and avoid the stress or risk of a dangerous ambulance or helicopter ride as well as provide access to specialized maternal care for those who do not have the resources to be transported to a large healthcare facility. Moreover, there are instances in which tele-ultrasound allows high-resolution images to be transmitted, which has enabled critical abnormalities to be detected in 6 to 9 percent of scans that were initially classified as normal by local staff.[78]

B. Case Study: UAMS High-Risk Pregnancy Program (ANGELS) in Arkansas

A notable example of maternal telehealth is the UAMS High-Risk Pregnancy Program (ANGELS) in Arkansas.[80] Both Arkansas and Texas have large rural populations, making Arkansas a very relevant reference study. The Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) is a collaborative initiative between the University of Arkansas for Medical Sciences (UAMS) and the Arkansas Medical Society.[81] The program functions through several core components, including statewide telemedicine and clinical networks for real-time consultations, an education and support system for obstetric providers, a 24/7 call center, and a free mobile-friendly repository of over 170 evidence-based guidelines covering obstetric and neonatal conditions.[82] These components work together to create a coordinated system of care, particularly for high-risk pregnancies, allowing rural providers to access specialist input and standardized protocols in real time. Some additional specific procedures and aspects the ANGELS program implements are the viewing of ultrasounds in real time, the ability for prenatal consultation, care coordination for fetal anomalies, genetic counseling, and nutritional education for diabetes.

C. Implementation in Texas

Texas should model the ANGELS' program and implement a statewide maternal telehealth hub-and-spoke network system that would be able to connect rural hospitals and clinics to existing academic medical centers such as UT Southwestern, Baylor College of Medicine, and UT Health Houston. Because these institutions have such a large existing medical network, they would be the perfect fit to act as hubs that can

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[79] Access TeleCare, "teleMaternal-Fetal Medicine Services & Solutions," Access TeleCare, accessed May 29, 2026, https://accesstelecare.com/specialties/telematernal-fetal-medicine/.

[80] "High-Risk Pregnancy Program," UAMS Institute for Digital Health & Innovation, accessed May 29, 2026, https://idhi.uams.edu/high-risk-pregnancy-program/.

[81] "ANGELS," UAMS Institute for Digital Health & Innovation, accessed May 29, 2026, https://idhi.uams.edu/programs/angels/.

[82] "ANGELS," UAMS Institute for Digital Health & Innovation, accessed May 29, 2026, https://idhi.uams.edu/programs/angels/.

provide continuous support—through tele-MFM consultations, remote ultrasound review, a 24/7 maternal call center, and standardized clinical guidelines for high risk pregnancies—to hospitals and clinics that lack OB-GYN specialists. Texas could thus replicate ANGELS' care coordinate system model for high-risk pregnancies which would ensure that patients with fetal anomalies or complications are identified early and referred to the adequate facilities.

From a policy standpoint, Texas would need to explicitly establish reimbursement mechanisms and support the creation of a centralized maternal call system and clinical guidelines. In terms of reimbursement, Texas Medicaid policy could be explicitly expanded to reimburse tele-maternal-fetal medicine (Tele-MFM) services, ultrasound interpretations, and remote patient monitoring for high risk conditions such as diabetes or hypertension. This would allow patients in rural areas to access necessary care more easily without needing to travel long distances. To support creation of a call system and centralized guidelines, initial funding would be needed and partnerships with aforementioned "hubs" (academic medical centers).

Moreover, rural providers could be incentivized to adopt the ANGELS-style guideline system through state-funded grants, institutional partnerships, and performance-based bonuses, which would encourage widespread participation and adherence. ANGELS, if implemented in Texas, should also be overseen by the Texas Department of State Health Services, as this would provide a strong statewide coordinating body and ensure consistency across regions.

D. Costs and Challenges

Scaling ANGELS to Texas, a state that is over 11 times the size of Arkansas, is bound to bring forward large-scale logistical and financial challenges that require significant initial investment. There would need to be substantial technological infrastructure, including secure video platforms, ultrasound transmission tools, and telehealth integration across rural sites. Additionally, the program reimbursement forms another major expense.

E. Benefits

Despite costs, evaluations of the ANGELS program have shown improvements in prenatal regionalization, with an increase in the number of preterm and low-birthweight infants being delivered at appropriate NICU-equipped facilities.[83] This shift led to better outcomes overall, including declining trends in neonatal mortality and postpartum complications.[2] As a result, Arkansas was able to reduce overall Medicaid costs, since better-managed pregnancies reduced the need for emergency interventions and high-cost complications. These savings could then be reinvested back into sustaining and expanding the program.

If Texas achieved improvement in prenatal regionalization and care coordination similar to that of the ANGELs program, it could have a significant impact on both patient outcomes and healthcare costs since such a reduction would decrease the number of emergency room visits, inter-hospital transfers, and preventable complications. Because many rural patients are from low-income populations and are covered by Medicaid, these improvements would work to directly reduce state healthcare expenditures. By treating

[83] Annual Reports and Newsletters," UAMS Institute for Digital Health & Innovation High-Risk Pregnancy Program, accessed May 29, 2026, https://idhi.uams.edu/high-risk-pregnancy-program/annual-reports/annual-reports-and-newsletters/.

the root causes in a timely manner through remote monitoring, specialist consultation, and standardized care guidelines, Texas could avoid prolonged ER visits, hospital readmissions, and poorly managed high-risk cases.

F. Program Quality Evaluation Metrics

It's necessary to establish various metrics that could gauge the success of the policy. The monitoring system to determine the progress of the policy could be measured through various key indicators. Upon six months of the project being initiated, maternal health outcomes data before and after implementation in the areas that this telehealth system was introduced can be collected and analyzed. For instance, we could study factors such as rates of maternal morbidity and mortality, clinical indicators such as preeclampsia and gestational diabetes, as well as neonatal outcomes including preterm birth and low birthweight. Additionally, there could be metrics measured in the sheer number of services used, such as the time to specialist consultation, the number of tele-MFM visits conducted, and patient travel distances. Another important factor is to consider the fact that patient-centered measures are also vital to overall satisfaction, utilizing measures such as patient satisfaction, continuity of care, and adherence to prenatal visit schedules.

G. Potential Future Directions

If the initial steps of the project were to be successful, the project would get traction within many of the major healthcare centers in Texas and serve to be greatly beneficial. The state could then invest further in the establishment of regional maternal health clinics connected to telehealth hubs, creating more of a hybrid system that can combine both local in person care with specialist care and coordination.

Harmful Impacts of Pregnancy Crisis Centers

I. Structure and Purpose of Pregnancy Crisis Centers

Crisis Pregnancy Centers (CPCs) are facilities that represent themselves as legitimate providers of reproductive care.[84] However, underneath the veneer of seemingly well-meaning organizations lie an ulterior motive of dissuading pregnant individuals from accessing certain types of reproductive care, most notably abortions.[85] Staff members at CPCs are i) not regulated by HIPAA guidelines, ii) not legally required to provide pregnant individuals with accurate or up-to-date information surrounding pregnancy, pre-natal care, post-natal care, pregnancy complications, abortions, or reproductive/gynecological care in general.[86] Furthermore, many CPCs are tied to larger, parental non-profit organizations aimed at helping "abortion-vulnerable[87]" individuals, "rescuing" individuals (including both pregnant individuals and unborn zygotes or fetuses), and sharing "Christ-centered support" with individuals seeking

[84] *Crisis Pregnancy Centers* (American College of Obstetricians & Gynecologists, 2022), https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-crisis-pregnancy-centers.
[85] *Crisis Pregnancy Centers*.
[86] *Crisis Pregnancy Centers*.
[87] "Naitonal Institute of Family and Life Advocates (NIFLA)," About NIFLA, National Institute of Family and Life Advocates, https://nifla.org/about-nifla/.

reproductive care.[88, 89] CPCs are not spontaneously spawning institutions; instead they are often members of strategically-funded and top-down managed organizations with strengths in message strategy. Such facilities and organizations purposefully share and engage in manipulative and deceptive practices that spread misinformation regarding sexual health and abortion.[90] Despite much research on the dangers of CPCs, very little literature exists detailing patient experiences with and understanding of such organizations.[91]

II. Distribution of Pregnancy Crisis Centers

CPCs are not defined to one particular region of the United States; they span nearly the entire nation, but CPCs are particularly concentrated in three distinct regions: the northern midwest, Appalachia and Texas.[92] See Figure 1 for a detailed map of CPCs and abortion facilities. As of 2021, there are 198 operating CPCs strictly within the state of Texas.[93] Additionally, Texas's ratio of CPCs to abortion facilities is 9.0.[94] Though few studies have conducted a ratio survey of operating CPCs to abortion facilities following the 2022 *Dobbs v. Jackson Women's Health Organization*, Texas' ratio of CPCs to abortion facilities is likely significantly higher than 9.0 today. Furthermore, it is important to note that CPCs often operate strategically near abortion facilities and thus tend to be concentrated in urban areas—such is evident in Texas, where CPCs are concentrated in metropolitan areas of the state (San Antonio, Dallas, Fort Worth).[95, 96] Such facilities often hope to discourage pregnant individuals seeking urgent or necessary reproductive care even up to the moment when the individual walks to the front doors of an abortion or reproductive healthcare facility.

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[88]"Heartbeat International," About Heartbeat International, Heartbeat International, https://www.heartbeatinternational.org/about-us.

[89]"Care Net," About Care Net, Care Net, https://care-net.org/about/.

[90]Melissa N. Montoya et al., "The Problems with Crisis Pregnancy Centers: Reviewing the Literature and Identifying New Directions for Future Research," *International Journal of Women's Health* 14 (June 2022): 757–63, https://doi.org/10.2147/IJWH.S288861.

[91]Montoya et al., "The Problems with Crisis Pregnancy Centers: Reviewing the Literature and Identifying New Directions for Future Research."

[92]Andrea Swartzendruber and Danielle N. Lambert, *Crisis Pregnancy Center Map*, January 22, 2025, https://www.cpcmap.com.

[93]Andrea Swartzendruber et al., "Spatial Analyses of Crisis Pregnancy Centers and Abortion Facilities in the United States, 2021 (Pre-Dobbs): Cross-Sectional Study," *JMIR Publications* 10 (November 2024), https://doi.org/10.2196/60001.

[94]Swartzendruber et al., "Spatial Analyses of Crisis Pregnancy Centers and Abortion Facilities in the United States, 2021 (Pre-Dobbs): Cross-Sectional Study."

[95]Swartzendruber and Lambert, *Crisis Pregnancy Center Map*.

[96]Swartzendruber et al., "Spatial Analyses of Crisis Pregnancy Centers and Abortion Facilities in the United States, 2021 (Pre-Dobbs): Cross-Sectional Study."

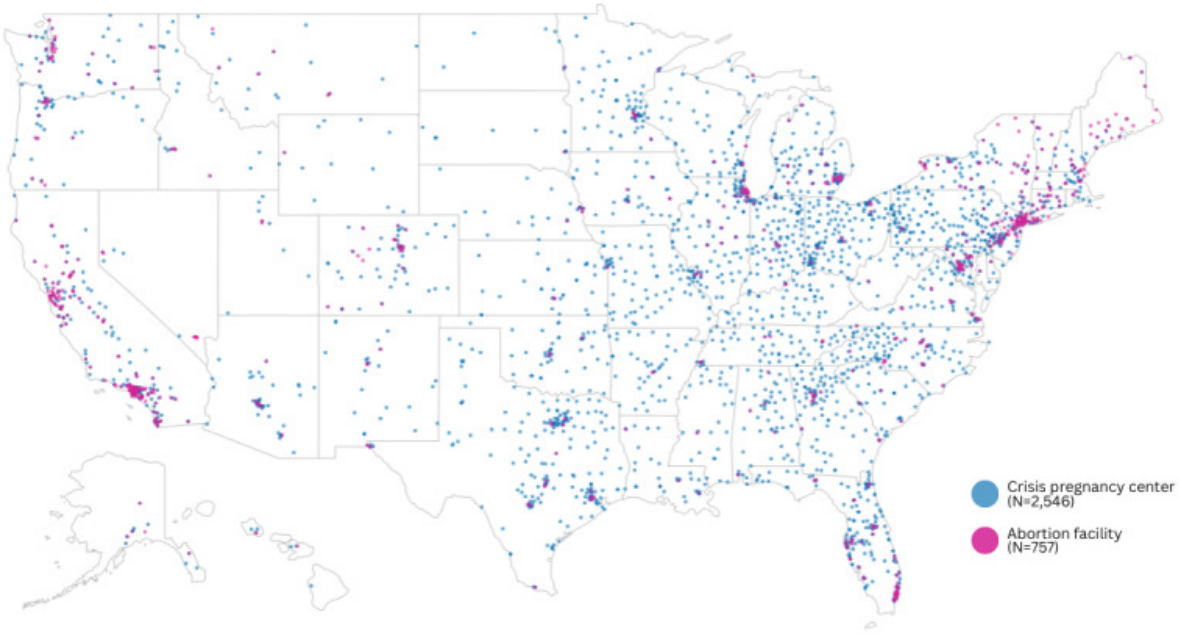


Figure 1. Crisis pregnancy centers (CPCs) and brick-and-mortar abortion facilities in the United States, 2021.[97]

As of 2024, 2633 CPCs operate within the United States which is a 3.3% increase from the number of CPCs operating within the United States in 2021, before the *Dobbs* decision.[98]

III. Medical Concerns of Crisis Pregnancy Centers

Many CPCs offer services including non-diagnostic ultrasounds, testing for sexually-transmitted infections or diseases (STIs/STDs), STI treatment, and even unproven, on-site "abortion reversals."[99] Additionally, following the *Dobbs* decision, some states have funnelled public funds into either CPCs directly or into parental organizations connected to the management and strategy of CPCs. For example, following the *Dobbs* decision in Texas, legislative officials committed about $140 million in public funds to such CPC or CPC-related programs such as "Alternatives to Abortion" which is now called "Thriving Texas Families."[100]

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[97] CPC Map; Advancing New Standards in Reproductive Health Abortion Facility Database.

[98] Danielle N. Lambert et al., "Crisis Pregnancy Centers in the United States: Post-Dobbs Characteristics and Changes," *American Journal of Public Health* 115, no. 6 (2025): 924–35, https://doi.org/10.2105/AJPH.2025.308055.

[99] Lambert et al., "Crisis Pregnancy Centers in the United States: Post-Dobbs Characteristics and Changes."

[100] Cassandra Jaramillo et al., "Texas Funnels Millions to Anti-Abortion Groups with Little Oversight," *The Texas Tribune*, July 9, 2024.

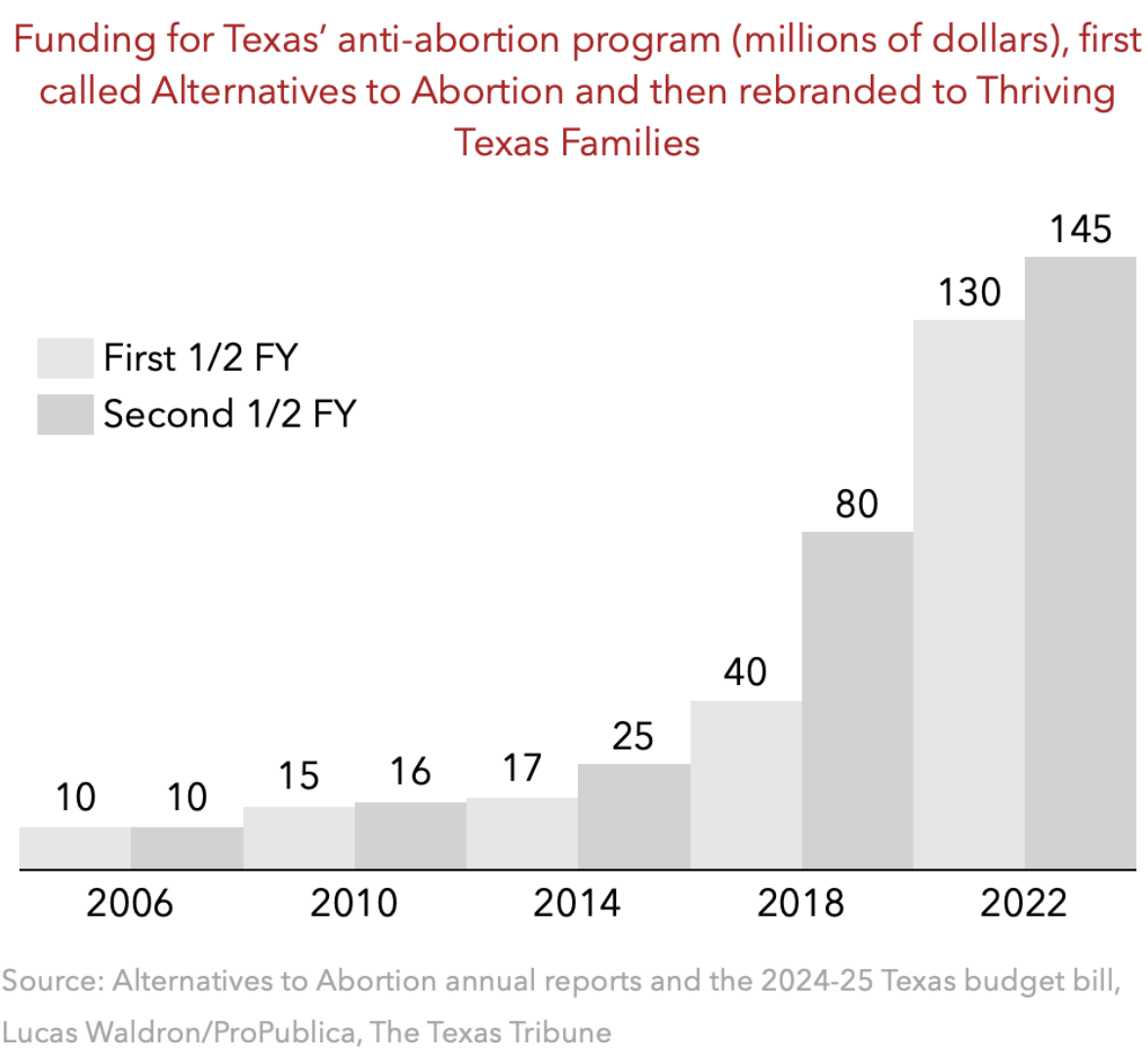


Figure 2: Funding for Texas' Anti Abortion Program

Numerous experts have named CPCs to be a public health risk.[101] Because pregnant individuals who may seek care at CPCs are more likely to be further along in their pregnancies,[102] such individuals who may require immediate medical intervention resulting from a pregnancy complication will not receive the care that they need, potentially resulting in more serious complications including sepsis.[103] Following Texas' ban on abortion, the rate of sepsis increased by over 50% among patients who were hospitalized for second trimester pregnancy loss .[104] Taken together with the increasing concentration of CPCs in states such as Texas, the reproductive health of millions of pregnant individuals is in serious jeopardy.

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[101]Joanne D. Rosen, "The Public Health Risks of Crisis Pregnancy Centers," *Perspectives on Sexual and Reproductive Health* 44, no. 3 (2012): 201–5, https://doi.org/10.1363/4420112.
[102]Rosen, "The Public Health Risks of Crisis Pregnancy Centers."
[103]Lizzie Presser et al., "Texas Banned Abortion. Then Sepsis Rates Soared," *Propublica*, February 20, 2025, https://www.propublica.org/article/texas-abortion-ban-sepsis-maternal-mortality-analysis#:~:text=Texas%20Banned%20Abortion.,—%20ProPublica.
[104]Presser et al., "Texas Banned Abortion. Then Sepsis Rates Soared."

Policy Interventions for Accountability of Pregnancy Crisis Centers

I. Adapt and Codify Disclosure Statement Requirements by Pregnancy Crisis Centers

A. Case Study: California's Reproductive FACT Act

CPCs are incredibly difficult to regulate because they do not charge for their services and are not medical practices.[105] Additionally, much of their work is protected as an exercise of free speech under the First Amendment.[106] One particularly compelling law implemented in California in 2015 titled the "Reproductive FACT Act" required CPCs to produce information to patrons about where they may obtain full-scope, low-cost or free reproductive care.[107] Additionally, the law required CPCs without a physician on staff to disclose so.[108] However, in 2018, the Supreme Court ruled in a 5-4 vote in *National Institute of Family and Life Advocates v. Becerra* that the law's disclosure requirements violated the First Amendment.[109] The Court justified their ruling by claiming that by forcing CPCs to disclose state-sponsored reproductive healthcare information, they would be infringing on the free speech rights of CPCs by forcing them to disclose information they disagree with. Additionally, the justices noted that such disclosures are still subject to First Amendment protections despite them being "professional regulations."

B. Recommendation

In the current political climate of Texas, eliminating or imposing sweeping regulations on CPCs is unlikely. However, to combat their demonstrated harm to pregnant individuals in Texas, action must be taken. The Texas Legislature should implement a law which solely requires CPCs to verbally disclose to patrons that they i) are not recognized as healthcare providers in the state of Texas, ii) are not regulated by HIPAA guidelines, and iii) are not required to adhere to standards of care for OB/GYNs set by the American College of Obstetricians and Gynecologists. Such a law would be enforced by local city councils as well as the Texas Attorney General. This intervention requires CPCs to present only facts about their regulatory and licensure status in the state of Texas. Most importantly, this recommendation does not interfere with the protected speech of CPCs because it is not a content-based regulation. This recommendation would ensure pregnant individuals in crises are made abundantly aware of the lack of regulation over CPCs, allowing them to make a more informed and health-centered decision about their pregnancy.

Restrictive Reproductive Laws & Resulting OBYGN Provider Shortage

I. Introduction

Following the 2022 *Dobbs v. Jackson Women's Health Organization* decision handed down by the Supreme Court of the United States which eliminated federal abortion protections,

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[105]Amy G. Bryant and Jonas J. Swartz, "Why Crisis Pregnancy Centers Are Legal but Unethical," *American Medical Association Journal of Ethics* 20, no. 3 (2018): 269–77, https://doi.org/10.1001/journalofethics.2018.20.3.pfor1-1803.

[106]Bryant and Swartz, "Why Crisis Pregnancy Centers Are Legal but Unethical."

[107]Reproductive FACT Act, 775, California State Assembly, Division 106 of the Health and Safety Code, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB775.

[108]Reproductive FACT Act.

[109]"National Institute of Family and Life Advocates v. Becerra," Oyez, https://www.oyez.org/cases/2017/16-1140.

the state of Texas has implemented some of the most strict abortion policies in the United States. The resulting legislative landscape includes near-total bans and novel civil enforcement tactics, all of which have immense implications for maternal mortality and the reproductive health provider workforce at large.

II. Impacts of Abortion Ban on OBGYN Workforce and Maternal Health Outcomes

A statewide survey of OB/GYNs in Texas indicates that a majority feel unable to practice evidence-based care due to the state's vast abortion restriction, with some reporting that they have at times considered leaving the state with hopes of rounding out their full scope of practice or even retiring early.[110] Further, a 2024 Manatt Health study on the Texas OB/GYN physician workforce shows a steady decline in applications to OB/GYN residency programs within the state[111]. As Texas abortion laws have become more strict following the 2022 *Dobbs* decision, Texas has become far less competitive for the OB/GYN specialty and is increasingly unable to retain the talent it once held. OB/GYNs provide a broad range of reproductive health services far beyond abortion care, and any threats to their retention in the state of Texas could drastically jeopardize maternal health outcomes across the state.

Concomitantly to the decrease in applications to OB/GYN residency programs within the state of Texas and decreased ability to retain physician talent, maternal mortality in the state has increased significantly, with the sepsis rate among births increasing by about 3% since the 2022 Supreme Court decision.[112] In response to the increasing maternal mortality rate, physicians have widely spoken out about the detriment it causes in their daily practice, with 111 physicians writing to the state legislature testifying that the Texas abortion ban prevented them from providing life-saving care that would have significantly altered a patient's outcome.[113] National research parallels the recent observations in Texas: restrictive abortion laws are consistently associated with higher mortality rates across states, as well as increased mortality associated with early gestational limits and clinic closures.[114]

Policy Interventions for Mitigating Provider Shortage from Restrictive Reproductive Laws

I. Implement legislation that shields practitioners from civil or criminal liability under compliance with standards from the American College of Obstetricians and Gynecologists.

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[110] Eleanor Klibanoff, "Texas' Abortion Laws Are Straining the OB-GYN Workforce, New Study Shows," *The Texas Tribune*, October 8, 2024, https://www.texastribune.org/2024/10/08/texas-obstetrics-gynecology-abortion-survey.

[111] Alex Morin et al., *The Texas OB/GYN Physician Workforce: Early Assessment of the Impact of Abortion Restrictions on the Workforce Pipeline* (Manatt Health, 2024), https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/34392fc8-1c9a-48a2-be8f-3f79d8a4a7d5/FINAL-TX-OBGYN-Workforce-Study_2024-10_f.pdf.

[112] Alex Morin et al., *The Texas OB/GYN Physician Workforce: Early Assessment of the Impact of Abortion Restrictions on the Workforce Pipeline* (Manatt Health, 2024), https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/34392fc8-1c9a-48a2-be8f-3f79d8a4a7d5/FINAL-TX-OBGYN-Workforce-Study_2024-10_f.pdf.

[113] Alex Morin et al., *The Texas OB/GYN Physician Workforce: Early Assessment of the Impact of Abortion Restrictions on the Workforce Pipeline*

[114] Andrea Suozzo et al., "Rates of Pregnancy-Related Sepsis and Deaths Grow in Texas after Abortion Ban," *The Texas Tribune*, February 20, 2025, https://www.texastribune.org/2025/02/20/texas-abortion-ban-impact-death-hospitalization.

In order to ensure that OB/GYN physicians in the state of Texas are safely allowed to act within the full scope of care set by American College of Obstetricians and Gynecologists, Texas lawmakers must act rapidly. Research shows that many OB/GYN physicians in abortion-ban states have been confined to delaying medically-necessary care until patients were at risk of death or permanent impairment or upon the lack of a fetal heartbeat.[115] The lack of ability to provide full-scope care to patients—especially those in crisis—discourages physicians from training and practicing in the state of Texas, contributing to the worsening OB/GYN shortage. This landscape of reproductive care is incredibly dangerous for pregnant individuals in Texas. In order to protect Texas OB/GYN physicians, lawmakers should implement a law which shields practitioners from civil or criminal liability if they can document compliance with published guidance/standards from the American College of Obstetricians and Gynecologists.

This intervention is entirely different from the current "medical emergency exception" model utilized by most abortion-ban states which allows a court to retroactively review circumstances post-abortion and rely on the testimony of other medical experts to determine whether the standard was met.[116] This method is structurally incompatible with how emergency medicine works. By forcing physicians' judgement to be reviewed against arbitrary standards, patient care is directly put at risk. Instead of acting proactively, the current framework encourages physicians to act within their interest rather than the patient's because their medical license is not subject to uniform scrutiny.

By moving away from the current standard, physicians would be able to practice medicine with the knowledge that their judgement will consistently be held to the same scrutiny no matter the case.

In 1990, Maine lawmakers enacted legislation to test whether defensive medicine tactics (such as delaying medically-necessary care) could be reduced by providing protection to physicians who complied with guidelines established by their peers and national specialty organizations.[117] The law allowed physicians to use adherence to guidelines as an affirmative defense in malpractice lawsuits to stop the "battle of experts" which normally defines malpractice proceedings.[118] Such legal protection, when applied to OB/GYNs, could significantly deter litigation because prosecution would have to prove that the physician acted out of a set standard-of-care. Physicians, unwilling to lose their medical license, will act i) within standards of care set by their peers and ii) knowing that their actions are legally protected. As long as physicians can prove that their decisions are supported by standards of practice set by the American College of Obstetrics and Gynecologists, they will act to save patient lives knowing that the law will protect them.

Paid Maternal Leave Policies

I. Introduction

[115]Erika L. Sabbath et al., "US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans," *JAMA Network Open* 7, no. 1 (2024): e2352109–e2352109, https://doi.org/10.1001/jamanetworkopen.2023.52109.

[116]Mabel Felix et al., *Criminal Penalties for Physicians in State Abortion Bans* (KFF, 2025), https://www.kff.org/womens-health-policy/criminal-penalties-for-physicians-in-state-abortion-bans/.

[117]Gordon H. Smith, "Maine's Medical Liability Demonstration Project-Linking Practice Guidelines to Liability Protection," *AMA Journal of Ethics* 13, no. 11 (2018): 792–95, https://doi.org/10.1001/virtualmentor.2011.13.11.pfor1-1111.

[118]Smith, "Maine's Medical Liability Demonstration Project-Linking Practice Guidelines to Liability Protection."

One major barrier to postpartum care utilization is the lack of paid family leave. The US is the only member of the Organisation for Economic Co-operation and Development (OECD) to not establish a uniform paid family leave program – instead, it relies on individual state policies.[119] Thirteen US states and the District of Columbia have paid family and medical leave programs; Texas is not one of them.[120] Even when postpartum care visits are insured, mothers are not able to attend doctor appointments without paid family leave, and are therefore more prone to postpartum risks. Research demonstrates that women with shorter durations of leave are less likely to attend postpartum visits. Introducing a paid leave policy could increase the duration of leave, and with that, improve attendance for postpartum visits.[121]

II. State-level Programs

Thirteen states and the District of Columbia have implemented statewide paid family and medical leave programs, as shown in Figure 3.[122]

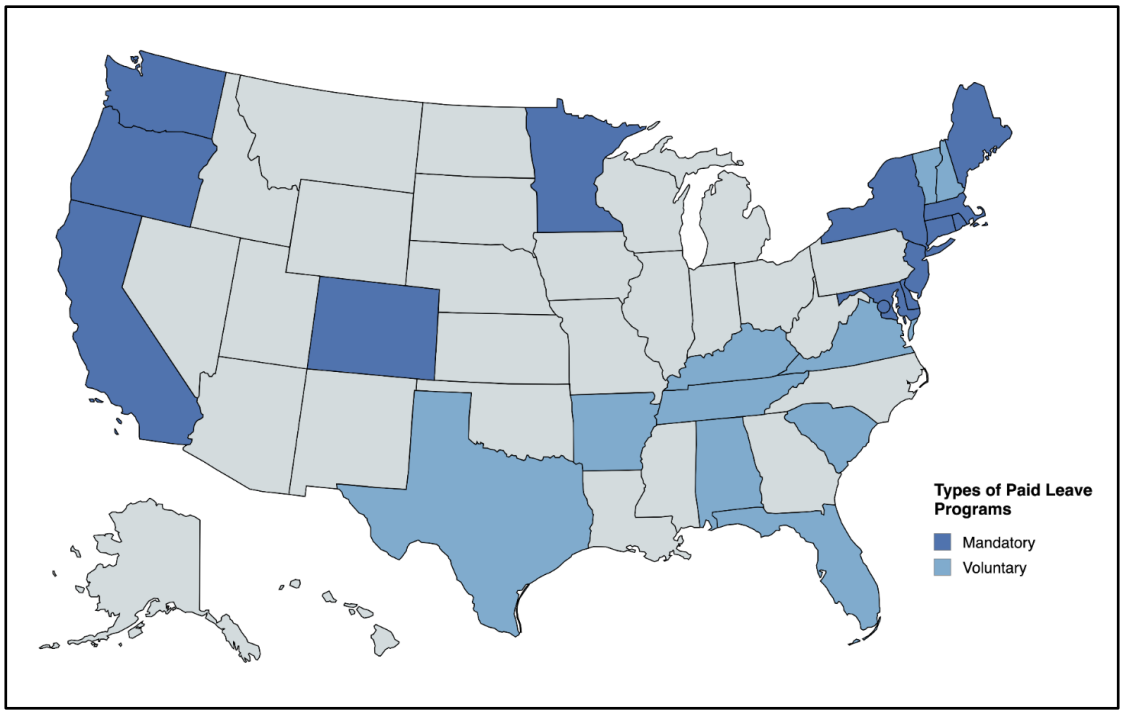


Figure 3: Status of State Paid Family Leave Programs in the United States

Typically, these programs operate by allowing workers to take extended time off work for eligible reasons and providing wage replacement while on leave.[123] In California, after implementing a paid leave policy, the average length of maternity leave increased from 3 weeks to 6 weeks.[124] Expanding this access also increased the growth for black, non-college educated,

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[119]"A National Paid Leave Program Would Help Workers, Families | Center on Budget and Policy Priorities," April 27, 2021, https://www.cbpp.org/research/economy/a-national-paid-leave-program-would-help-workers-families.

[120]"Paid Leave," DOL, accessed March 1, 2026, https://www.dol.gov/agencies/wb/featured-paid-leave.

[121]Brianna Keefe-Oates et al., "Disparities in Postpartum Care Visits: The Dynamics of Parental Leave Duration and Postpartum Care Attendance," Maternal and Child Health Journal 28, no. 9 (2024): 1506–16, https://doi.org/10.1007/s10995-024-03929-z.

[122]"Paid Leave," DOL, accessed March 7, 2026, https://www.dol.gov/agencies/wb/featured-paid-leave.

[123]DOL, "Paid Leave."

[124]Maya Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes," *Journal of Policy Analysis and Management : [The Journal of the*

unmarried, and Hispanic mothers, who tended to take much shorter leave periods than more advantaged mothers. After paid leave became available, these mothers went from taking only 1-2 weeks of leave to 4-6 weeks, narrowing the gap between disadvantaged mothers and more advantaged mothers.[125]

III. Health Benefits and Postpartum Care Utilization

Additionally, paid family leave has been proven to be associated with improved health outcomes. Individuals are more likely to breastfeed and also have lower odds of postpartum depression when they have access to strong paid family and medical leave policies. These associations are especially strong for Medicaid-insured mothers, suggesting that paid leave may be most beneficial for low-income families.[126] Along with this, the length of leave has an impact on maternal health. Longer paid leave, especially longer than 12 weeks, is associated with improved mental health, especially for mothers returning to work full-time.[127]

More broadly, more generous leave policies also improve utilization of postpartum resources. A shorter leave length increases the likelihood of not attending postpartum care appointments, especially for lower incomes.[128] After implementing a paid family leave policy in New York, outpatient visits increased by 8.6% among women with pregnancy-induced hypertension and by 3.7% among women with chronic hypertension, demonstrating an increase in postpartum care utilization.[129] It was also associated with improvements in long-term care; paid family leave led to a 1.5% decrease in inpatient admissions within 42 days postpartum, and a 7.1% increase in adherence to prescribed antihypertensive medications 6 months after delivery.[130]

IV. Paid Family Leave Policy in Texas

Texas has several other laws implementing paid leave policies. In 2023, Texas SB 222 was passed, granting 8 weeks of family leave for state employees, and 4 weeks for "non-birthing parents."[131] Later that year, Texas voted in House Bill 1996, allowing private employers to voluntarily purchase paid family leave insurance plans from private insurers.[132] However, access to paid leave is still inconsistent because participation is optional.

Association for Public Policy Analysis and Management] 32, no. 2 (2013): 224–45, https://doi.org/10.1002/pam.21676.

[125]Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."

[126] "Obstetrics & Gynecology," accessed March 7, 2026, https://journals.lww.com/greenjournal/abstract/2024/01000/association_between_state_paid_family_and_medical.6.aspx.

[127]Bidisha Mandal, "The Effect of Paid Leave on Maternal Mental Health," Maternal and Child Health Journal 22, no. 10 (2018): 1470–76, https://doi.org/10.1007/s10995-018-2542-x.

[128]Brianna Keefe-Oates et al., "Disparities in Postpartum Care Visits: The Dynamics of Parental Leave Duration and Postpartum Care Attendance," Maternal and Child Health Journal 28, no. 9 (2024): 1506–16, https://doi.org/10.1007/s10995-024-03929-z.

[129]Donglan Zhang et al., "New York State's Paid Family Leave Improved Postpartum Health Care among Women with Hypertensive Disorders in Pregnancy," *Health Affairs Scholar* 3, no. 10 (2025): qxaf190, https://doi.org/10.1093/haschl/qxaf190.

[130]Zhang et al., "New York State's Paid Family Leave Improved Postpartum Health Care among Women with Hypertensive Disorders in Pregnancy."

[131]"88(R) SB 222 - Enrolled Version - Bill Text," accessed March 7, 2026, https://capitol.texas.gov/tlodocs/88R/billtext/html/SB00222F.htm.

[132]"Texas - State Disability & Paid Family Leave - LiDAC," accessed March 7, 2026, https://lidac.com/state-disability-paid-family-leave/texas/.

In 2018, the city of Austin attempted to pass a similar law not for maternal leave, but for sick leave. The law required private employers to provide paid sick leave for employees, but was struck down by the Texas Supreme Court for being in conflict with the Texas Minimum Wage Act, demonstrating the difficulties of introducing policies of this sort.[133]

One of the primary barriers for implementing paid leave laws are employers' concerns about potential disruptions and financial costs.[134] However, research demonstrates that these concerns would be minimal and employers may actually benefit. In California, researchers examined the paid family leave policy and found it has placed little to no financial burden on employers.[135] Funding such a program with payroll contributions or disability insurance systems would minimize the financial burden placed on employers, but would still provide workers with wage replacement during leave.[136] There is a bill introduced to the Texas legislature in 2025, HB 3059, that proposes creating a state-administered paid parental leave program, but it has not yet been voted on.[137]

In conclusion, it is important to increase the length of maternal leave because of the positive impacts on maternal and infant health outcomes.[138] However, evidence has demonstrated that in order to increase the amount of time mothers take off of work, paid leave is crucial.[139] The absence of a comprehensive paid leave program in Texas means that many families still lack access to these benefits, especially those with lower incomes who face the greatest barriers to postpartum care.[140, 141]

V. Summary of Leave Policies in Selected States

[133]"Texas Supreme Court Blocks Austin's Paid Sick Leave Rule, Blocks Appeal," accessed March 7, 2026, https://www.texastribune.org/2020/06/05/texas-supreme-court-austin-sick-leave/.
[134]Andrew Weiss, PAID FAMILY LEAVE: STRIKING A BALANCE BETWEEN THE NEEDS OF EMPLOYEES AND EMPLOYERS, n.d.
[135]Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."
[136]Weiss, PAID FAMILY LEAVE: STRIKING A BALANCE BETWEEN THE NEEDS OF EMPLOYEES AND EMPLOYERS.
[137]"Texas HB3059 | 2025-2026 | 89th Legislature," LegiScan, accessed March 7, 2026, https://legiscan.com/TX/drafts/HB3059/2025.
[138]"Obstetrics & Gynecology."
[139]Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."
[140]DOL, "US Department of Labor Announces New Research That Underscores Benefits of Paid Family and Medical Leave."
[141] "Obstetrics & Gynecology."

Each state below have implemented different types of paid family leave programs that provide a model for what Texas could adopt.

	Texas (no mandatory program)	**California** (since 2004)	**New York** (since 2018)	**New Jersey** (since 2009)	**Washington** (since 2020)	**Delaware** (since 2026)
Program type How the program is administered	Voluntary only	Mandatory (SDI)	Mandatory (private ins.)	Mandatory (TDI)	Mandatory (social ins.)	Mandatory (social ins.)
Who is covered Share of private-sector workforce eligible	~25%	~97%	~90%	~85%	~90%	~80%
Leave Duration Maximum paid weeks after birth for birthing parent	0 weeks	8 weeks	12 weeks	12 weeks	12 weeks	12 weeks
Replacement rate % of prior wages replaced during leave	None mandated	70–90% sliding scale	67% flat (capped at state AWW)	85% flat	90% / 60–70% sliding (90% below AWW; blended above)	80% flat
Payroll contribution rate % of wages paid into the fund	0% (HB 3059 proposed 0.15%)	1.3% (employee only)	0.43% (employee only)	0.09% (employee only)	0.74% (shared)	0.80% (shared)

Sources: New America, Paid Leave Programs in the United States: Benefits and Funding Explainer (Jan. 2026); CDC Maternal Mortality Review (2022); NY State Dept. of Financial Services (2025); Rossin-Slater, Ruhm & Waldfogel, Journal of Policy Analysis and Management 32, no. 2 (2013); Zhang et al., Health Affairs Scholar 3, no. 10 (2025); U.S. Census Bureau; LegiScan TX HB3059 (2025); Every Texan (2025); Third Way, Progress on Paid Leave: Lessons from the States (Jan. 2026)

Figure 4: Comparison of State-Paid Family Leave Programs

Policy Interventions for Parental Leave Programs

I. Implement Texas Paid Family Leave Act (Amendment to HB 3059)

The Texas Legislature should pass and amend HB 3059 to create a mandatory, state-administered paid parental leave program covering all Texas public sector and private sector employees. The program should provide at least 12 weeks of paid leave for parents, with wage replacement funded through a combination of employee and employer contributions.[142,143] Currently, Texas's SB 222 only provides paid leave to state employees, which leaves the majority of Texas workers without access.[144] Texas's opt-in approach with HB 1996 has also not addressed many concerns related to postpartum complications.

A. Background Research & Case Study

Implementing a paid leave policy in Texas is crucial to improving health outcomes in mothers, especially low-income communities. Access to paid leave is associated with higher breastfeeding rates and lower odds of postpartum depression—key indicators of positive maternal health outcomes. However, these benefits are not distributed evenly: they are especially significant for Medicaid-insured and lower-income mothers, who are disproportionately affected by postpartum depression and lower breastfeeding rates.[145] Paid leave has also been linked to lower infant mortality as well as

[142] "Paid Family Leave Benefits and Payments FAQs," accessed April 10, 2026, https://edd.ca.gov/en/disability/faq_pfl_benefits_payments/.
[143] Bidisha Mandal, "The Effect of Paid Leave on Maternal Mental Health," Maternal and Child Health Journal 22, no. 10 (2018): 1470–76, https://doi.org/10.1007/s10995-018-2542-x
[144] "88(R) SB 222 - Enrolled Version - Bill Text," accessed March 7, 2026, https://capitol.texas.gov/tlodocs/88R/billtext/html/SB00222F.htm
[145] "Obstetrics & Gynecology," accessed March 7, 2026, https://journals.lww.com/greenjournal/abstract/2024/01000/association_between_state_paid_family_and_medical.6.aspx.

reduced rates of preterm birth and low birth weight, particularly among Black and unmarried mothers, who are among the highest-risk groups.[146] After New York implemented paid family leave, outpatient visits rose 8.6% among women with pregnancy-induced hypertension and 3.7% among those with chronic hypertension, suggesting improved access to routine follow-up care and early intervention. At the same time, inpatient admissions within 42 days postpartum fell by 1.5%, which indicates that the improved outpatient engagement may have helped prevent more serious complications that require hospitalization. Adherence to antihypertensive medications six months after delivery increased by 7.1%, reinforcing the pattern of improved management of postpartum conditions.[147]

There are also economic benefits that come with implementing a paid family leave policy. After states implemented a paid leave program, they found a 20% reduction in the number of women leaving jobs within the first year of welcoming a child, and after five years, up to a 50% reduction.[148] With this, employers don't need to bear the high costs of training new workers.[149] In California and New Jersey, paid leave increased women's long-term attachment to the labor force, with effects on the labor force participation rate lasting up to 8 years.[150] Most employers across Rhode Island, California, and New York have reported positive or neutral impact on productivity and costs, and no significant impact on operations.[151,152,153] Improved maternal health outcomes at the state level reduce the costs of postpartum complications and mental health crises. This is especially relevant in Texas, considering 80% of maternal deaths are considered preventable.[154] A state-funded program also reduces the risk from potential federal Medicaid cuts that threaten postpartum coverage that Texas has worked to expand through HB 12.[155] A payroll-contribution program would diversify its funding sources and make them less dependent on federal Medicaid.

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[146] Jenna Stearns, "The Effects of Paid Maternity Leave: Evidence from Temporary Disability Insurance," Journal of Health Economics 43 (September 2015): 85–102, https://doi.org/10.1016/j.jhealeco.2015.04.005.

[147] Donglan Zhang et al., "New York State's Paid Family Leave Improved Postpartum Health Care among Women with Hypertensive Disorders in Pregnancy," Health Affairs Scholar 3, no. 10 (2025): qxaf190, https://doi.org/10.1093/haschl/qxaf190.

[148] Woods, Lea. New Study Reveals Paid Family Leave Policies Lead to 20 Percent Fewer Women Leaving the Workforce - IWPR. January 3, 2020. https://iwpr.org/new-study-reveals-paid-family-leave-policies-lead-to-20-fewer-women-leaving-the-workforce/.

[149] "The Economic Benefits of Family and Medical Leave Insurance." Center for American Progress, December 12, 2013. https://www.americanprogress.org/article/the-economic-benefits-of-family-and-medical-leave-insurance/.

[150] Kelly Jones and Britni Wilcher, "Reducing Maternal Labor Market Detachment: A Role for Paid Family Leave," Labour Economics 87 (April 2024): 102478, https://doi.org/10.1016/j.labeco.2023.102478.

[151] Ann Bartel et al., "The Impact of Paid Family Leave on Employers: Evidence from New York," Community, Work & Family 28, no. 2 (2025): 153–71, https://doi.org/10.1080/13668803.2023.2168516.

[152] Ann Bartel et al., *Assessing Rhode Island's Temporary Caregiver Insurance Act: Insights from a Survey of Employers*, n.d.

[153] "Leaves That Pay: Employer and Worker Experiences With Paid Family Leave in California," *CEPR*, January 11, 2011, https://cepr.net/publications/leaves-that-pay-employer-and-worker-experiences-with-paid-family-leave-in-california.

[154] "CDC Newsroom," CDC, January 1, 2016, https://archive.cdc.gov/www_cdc_gov/media/releases/2022/p0919-pregnancy-related-deaths.html.

[155] Medicaid Cuts in the One Big Beautiful Bill Act Leave 3 in 10 Young Adults Vulnerable to Losing Health Care Access | Urban Institute," accessed March 1, 2026, https://www.urban.org/urban-wire/medicaid-cuts-one-big-beautiful-bill-act-leave-3-10-young-adults-vulnerable-losing.

California's Paid Family Leave program provides the most direct evidence of what a well-implemented program can accomplish, and is the most relevant comparison to Texas. Both of the states are nearly identical in racial and ethnic composition: according to the U.S. Census Bureau, 39.1% of Californians identify as Hispanic compared to 39.4% of Texans, and both states are minority-majority.[156] Along with this, a study on California's paid family leave program used Texas mothers as one of its control groups, meaning the effects analyzed in the study were calculated partially relative to Texas women who did not have access to paid leave.[157] This makes California's outcomes a close estimate of what a paid leave program would produce in Texas specifically. After California's Paid Family Leave program was implemented in 2004, the average length of maternity leave doubled from 3 to 6 weeks overall.[158] Among historically disadvantaged groups (Black, non-college-educated, unmarried, and Hispanic mothers), the average length of leave increased from 1-2 weeks to 4-6 weeks, narrowing the gap in care between disadvantaged and more advantaged mothers.[159] With California's program, researchers found that there was little to no financial burden on employers, and a payroll-contribution model would distribute costs and minimize disruptions to businesses.[160,161]

The proposed Texas program is also more fiscally modest than California's current program, and designed to be more cost-efficient than many existing state models. Texas's HB 3059 includes funding the Texas Family Fund at a payroll contribution rate of 0.15% of wages, which is significantly lower than any other program nationally, where contribution rates are around 1%.[162] If payroll contributions were split equally between employers and employees, a worker who earned the median salary in Texas of $78,476 would pay just over $58 per year, or $4.90 per month.[163] This implies that a statewide paid leave program can be implemented at relatively low individual cost while still generating public health and economic benefits similar to those seen in other states who have implemented similar programs.

II. Implement a minimum leave duration of 12 weeks for mothers in any Texas paid parental leave program

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[156] "California Vs. Texas: Jobs — Comparing The Two States 1 In 5 Americans Call Home - Texas Public Policy Foundation," Texas Public Policy Foundation -, October 24, 2018, https://www.texaspolicy.com/california-vs-texas-jobs-comparing-the-two-states-1-in-5-americans-call-home/.

[157] Maya Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes," Journal of Policy Analysis and Management : [The Journal of the Association for Public Policy Analysis and Management] 32, no. 2 (2013): 224–45, https://doi.org/10.1002/pam.21676.

[158] Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."

[159] Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."

[160] Weiss, PAID FAMILY LEAVE: STRIKING A BALANCE BETWEEN THE NEEDS OF EMPLOYEES AND EMPLOYERS.

[161] Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."

[162] "Explainer: Paid Leave Benefits and Funding in the United States," *New America*, April 15, 2026, https://www.newamerica.org/insights/explainer-paid-leave-benefits-and-funding-in-the-united-states/.

[163] "U.S. Census Bureau QuickFacts: Texas," accessed April 13, 2026, https://www.census.gov/quickfacts/fact/table/TX/BZA210223.

With any paid family leave program, including the one in Recommendation I, Texas should include a minimum leave duration of 12 weeks for birthing parents. This includes amendments to HB 1996, which allows private employers to voluntarily offer paid leave and seek state tax incentives.[164] This minimum duration is important because insufficient leave length undermines the benefits of paid family leave presented in Recommendation I.[165] Without an explicit minimum, programs are vulnerable to potential cost-cutting policies in the future that would disproportionately harm low-income mothers.

A. Background Research & Case Study

Many studies on paid leave demonstrate that meaningful outcomes are determined directly by the duration of the leave. Paid leave exceeding 12 weeks is associated with significantly improved maternal mental health, especially for mothers returning to full-time employment after giving birth.[166] When mothers take short periods of leave, they are more likely to miss postpartum care appointments.[167] The American College of Obstetricians and Gynecologists (ACOG) recommends postpartum care contact within 3 weeks of birth and a comprehensive visit by 12 weeks, and to meet these standards, it's essential that mothers are not returning to inflexible or physically demanding jobs within the first few weeks after giving birth.[168]

California started with 55% of wages replaced during paid leave periods, but later increased to 60-70% wage replacement in 2018, which still was not enough for the lowest-wage workers.[169] In 2025, California raised rates to 70–90% on a sliding scale, which started to show meaningful impact among lower-wage workers.[170] Delaware set a flat 80% wage replacement rate because researchers found that was the minimum level necessary for lower-wage workers to use leave without falling into poverty.[171] Washington created a structure that replaces 90% of wages for the lowest-wage workers.[172] Having a sliding scale in Texas, where lowest-wage workers receive 80% replacement if they earn below the state average weekly wage, and higher earners receive 50-60% replacement, would make the program sustainable while also creating meaningful impact for workers who need it most.

Including the minimum duration ensures the equity gap within leave policies themselves is considered. Disadvantaged mothers have historically taken shorter leave periods due to workplace pressure, income insecurity, and lack of job protection, even

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[164] "Texas - State Disability & Paid Family Leave - LiDAC," accessed March 7, 2026, https://lidac.com/state-disability-paid-family-leave/texas/

[165] Brianna Keefe-Oates et al., "Disparities in Postpartum Care Visits: The Dynamics of Parental Leave Duration and Postpartum Care Attendance," Maternal and Child Health Journal 28, no. 9 (2024): 1506–16, https://doi.org/10.1007/s10995-024-03929-z

[166] Bidisha Mandal, "The Effect of Paid Leave on Maternal Mental Health," Maternal and Child Health Journal 22, no. 10 (2018): 1470–76, https://doi.org/10.1007/s10995-018-2542-x.

[167] Keefe-Oates et al., "Disparities in Postpartum Care Visits."

[168] "Optimizing Postpartum Care." Accessed April 10, 2026. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.

[169] "Explainer: Paid Leave Benefits and Funding in the United States," *New America*, April 15, 2026, https://www.newamerica.org/insights/explainer-paid-leave-benefits-and-funding-in-the-united-states/.

[170] "Explainer."

[171] "Explainer."

[172] "Explainer."

when they are covered under Medicaid.[173] In California, before paid leave was available, the most disadvantaged mothers took only 1-2 weeks of leave despite needing more.[174] Paired with Recommendation I, this recommendation ensures that low-income and minority mothers are actually able to use the leave they are entitled to.

[173] Keefe-Oates et al., "Disparities in Postpartum Care Visits."
[174] Rossin-Slater et al., "The Effects of California's Paid Family Leave Program on Mothers' Leave-Taking and Subsequent Labor Market Outcomes."

Models of Maternal Health Care Delivery

Safety Net Systems

I. Introduction

As the intersection of a variety of health fields, from obstetrics-gynecology and pediatric care to mental health and chronic illness, maternal health is specifically vulnerable to a variety of environmental determinants, many of which feed into outcome inequalities. Notably, recent literature highlights that to fully understand the factors that shape maternal health and identify solutions that meet the real needs of communities, the biosocial lens must be used, elucidating the historical, structural, and political forces that remove autonomy from health and its outcomes.[175]

A. Social Determinants of Health in Texas

In 2021, the average maternal morbidity rate in Texas was 85.5 cases per 10,000 delivery hospitalizations. For Black Texan women, it was 134.4 per 10,000 delivery hospitalizations.[176] To clarify, the morbidity rate indicates severe, unintended outcomes that pose a detriment to the mother's health. As for the mortality rate, it was similarly reported that the maternal death rate was highest among Black women (Figure 5), women with a high school education or equivalent, and women ages 40 years and older.

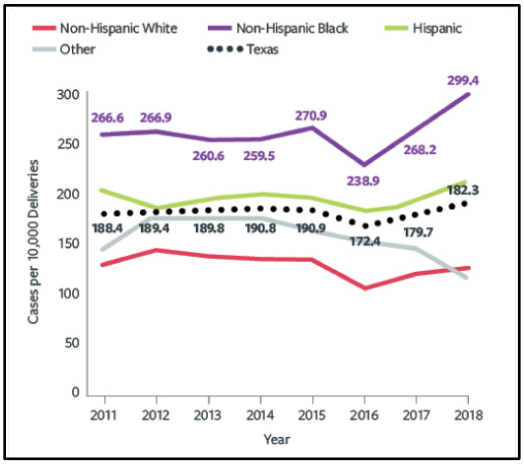


Figure 5: Black patients had higher and increasing rates of severe maternal morbidity from 2011-2018.[177]

Given the disproportionately poor outcomes for Black women, an understanding of the social and structural determinants that shape health experiences for Black mothers

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[175] Joia Crear-Perry et al., "Social and Structural Determinants of Health Inequities in Maternal Health," *Journal of Women's Health* 30, no. 2 (February 2, 2021): 230–35.

[176] Texas Health and Human Services, "Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2024," September 1, 2024, https://www.dshs.texas.gov/sites/default/files/legislative/2024-Reports/MMMRC-DSHS-Joint-Biennial-Report-2024.pdf.

[177] Akilah Wise, "Texas Hospitals Address Disparities in Maternal Morbidity and Mortality - Texas Hospital Association," Texas Hospital Association - Texas Hospital Association, November 21, 2022, https://www.tha.org/news-publications/texas-hospitals-magazine/2021-issues/march-april-2021/texas-hospitals-address-disparities-in-maternal-morbidity-and-mortality/.

is necessary. One emerging framework is the "Restoring Our Own Through Transformation (ROOTT) theoretical framework," which elaborates on causative relationships between structural factors and health outcomes (Figure 6).[178] This framework is advised for usage in identifying solutions to unequal maternal mortality.

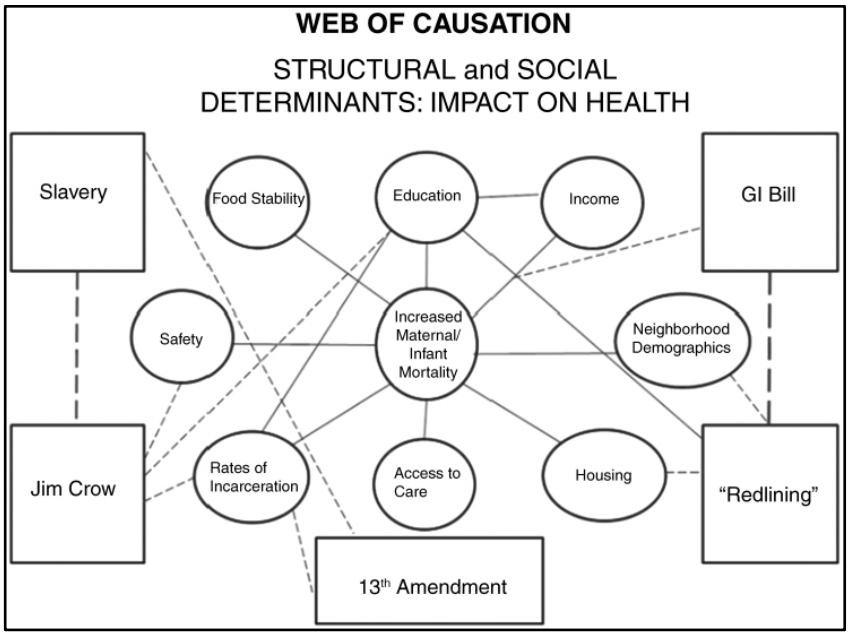


Figure 6: Structural factors have perpetuated disparities in care, leading to worsened health outcomes and higher maternal mortality rates.

B. Transportation & Access

Transportation factors significantly into the maternal care experience, especially in light of the fact that more than a quarter of women live more than 30 miles from the nearest provider.[179] For any mother, let alone families sharing one car, this furthers stress and higher cortisol levels, which can precipitate comorbidities and complications.

Simultaneously, innovations have been made in response to these challenges. The UMC (University Medical Center) system has initiated a free-of-charge doula program, allowing families to prepare for birth, and has also partnered with non-governmental organizations, such as the Ronald McDonald House, to connect families with places to stay overnight.

C. Continuity of Care

Texas lawmakers have recognized the issues in maternal mortality. In 2024, HB 1575 was enacted, requiring screenings for all pregnant women, specifically for non-medical needs, such as housing, transportation or nutrition.[180] Notably, this bill allowed

[178] Joia Crear-Perry et al., "Social and Structural Determinants of Health Inequities in Maternal Health."

[179] Stephen Simpson, "Maternal Health Care Experts Say the Needs in the Rural Parts of Texas Are Vast, but Can Be Addressed with Help," The Texas Tribune, April 2025, https://www.texastribune.org/events/2025/04/01/texas-maternal-health-care/.

[180] Eleanor Klibanoff, "The Push to Cover Non-Medical Pregnancy Services in Texas," The Texas Tribune, January 29, 2025, https://www.texastribune.org/2025/01/29/texas-pregnant-medicaid-insurance-doula/.

for Medicaid reimbursements to doulas, who had previously been generally excluded from the state's Medicaid program.

To provide actual medical care, and allow for families to continue receiving care, Texas has Federally Qualified Health Centers (FQHCs), which provide health care services to underserved communities, and are not allowed to deny services based on ability to pay.[181] Secondarily, existing literature proposes solutions such as paid family leave, basic insurance coverage, and culturally responsive care, which implicitly support care continuity, not only by ensuring that individuals can access quality and affordable care, but also by ensuring that they feel safe and comfortable doing so.[182]

However, these initiatives' impact is lessened in rural care settings, where the issue is much simpler – physicians are not available, and maternal care wards are being shut down. 55% of rural hospitals are at risk of closing down, which implies that a greater number of hospitals are at risk of losing their maternity department.[183] In fact, 60% of rural hospitals no longer provide obstetrics care. Further, for rural health settings, a lack of physicians, but also nurses and Medicaid reimbursement worsens this issue.

II. Disadvantages of Case Management for Children and Pregnant Women Services

A. Introduction on HB 1575

House Bill 1575 (HB 1575) was passed by the 88th Texas Legislature in 2023 and sought to target social determinants of health, particularly for low-income pregnant women.[184] One mechanism that achieved this was through the expansion of provider eligibility for Case Management for Children and Pregnant Women (CPW) services; previously, only licensed nurses and community health workers were eligible to receive Medicaid reimbursement.[185] HB 1575 expanded this to community health workers (CHWs) and doulas, providing state certification routes for both professions. Importantly, the inclusion of community health workers and doulas is known to decrease psychological or cultural barriers to care, as existing research has identified a causal relationship between access to doulas/CHWs and better maternal outcomes.[186] With this expansion, training for CPW service providers was expanded to include trauma-informed care that equipped providers with the knowledge and skills to navigate complex issues, such as social security, domestic violence, and informed consent.[187]

B. Impacts and Successes

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[181] "Federally Qualified Health Centers (FQHCs) | Texas DSHS," Texas.gov, 2018, https://www.dshs.texas.gov/center-health-statistics/texas-primary-care-office-tpco/federally-qualified-health-centers-fqhc.

[182] Joia Crear-Perry et al., "Social and Structural Determinants of Health Inequities in Maternal Health."

[183] "Maternity Deserts: Fewer Rural Hospital Delivering Babies," www.texmed.org, n.d., https://www.texmed.org/MaternityDeserts/.

[184] "Implementation of House Bill 1575 - Texas Women's Healthcare Coalition," Texas Women's Healthcare Coalition, February 28, 2025, https://www.texaswhc.org/activities/implementation-of-house-bill-1575/.

[185] "Texas Legislature Takes 'Monumental Step' to Improve Health, Not Just Health Care in Addressing Maternal Health Crisis - Episcopal Health Foundation," Episcopal Health Foundation, June 5, 2023, https://www.episcopalhealth.org/news-release/texas-legislature-takes-monumental-step-to-improve-health-not-just-health-care-in-addressing-maternal-health-crisis/.

[186] Julie Mottl-Santiago et al., "Effectiveness of an Enhanced Community Doula Intervention in a Safety Net Setting: A Randomized Controlled Trial," Health Equity 7, no. 1 (September 1, 2023): 466–76, https://doi.org/10.1089/heq.2022.0200.

[187] "Implementation of House Bill 1575 - Texas Women's Healthcare Coalition," Texas Women's Healthcare Coalition

HB 1575 also mandated that state-funded providers must screen all consenting pregnant women for non-medical needs, such as food, transportation, housing, or childcare.[188] This includes providers under Medicaid MCOs (Managed Care Organizations) and the Thriving Texas Families Program, which began as the "Alternatives to Abortion" program, and now seeks to promote healthy childbirth and parenthood as an alternative to abortion.[189] Importantly, HB 1575 mandates that these providers coordinate follow-up service, which directly works to prevent mothers from being sidelined by bureaucratic shortcomings.

C. Remaining Gaps

While the implementation of HB 1575 marks a significant step towards building better, more comprehensive safety net systems, the reality of healthcare access is that this only improves conditions, marginally, for a small subset of the individuals most impacted by and vulnerable to maternal mortality. To elaborate, in the month following the March 2023 expiration of the state's Medicaid expansion during the COVID-19 pandemic, more than 500,000 Texans lost their Medicaid eligibility. In the year following, 2.5 million Texans were disenrolled.[190]

In parallel, an important distinction must be made: HB 1575 allows for doulas/CHWs to receive Medicaid reimbursement for their services coordinating non-medical services (i.e. addressing social determinants of health). It does not, however, allow for actual doula services to be reimbursed.[191] This lapse, then, neglects a significant solution that could stand to significantly improve the birth experience and birthing results for vulnerable mothers. To reiterate, this is a significant gap, especially given research which indicated that for pregnant women in California and Florida, women who received doula care had 52.9% lower odds of cesarean delivery and 57.5% lower odds of postpartum depression/anxiety.[192]

III. Landscape of Federally Qualified Health Centers

Federally qualified health centers, also known as FQHCs or community health centers, are non-profit clinics that accept all patients, regardless of their ability to pay, thereby acting as a

[188] Texas Health and Human Services, "State Efforts to Address Maternal Depression, Mortality , and Morbidity in Texas," 2024.

[189] "Thriving Texas Families | Texas Health and Human Services," www.hhs.texas.gov, n.d., https://www.hhs.texas.gov/services/health/women-children/thriving-texas-families.

[190] Legislative Study Group, "The Texas Healthcare Crisis: Millions Uninsured, Physician Shortages, and the Fight for Women's Care – Texas Legislative Study Group," Texaslsg.org, February 18, 2025, https://texaslsg.org/2025/02/18/the-texas-healthcare-crisis-millions-uninsured-physician-shortages-and-the-fight-for-womens-care/.

[191] Legislative Study Group, "The Texas Healthcare Crisis: Millions Uninsured, Physician Shortages, and the Fight for Women's Care – Texas Legislative Study Group"

[192] April M. Falconi et al., "Doula Care across the Maternity Care Continuum and Impact on Maternal Health: Evaluation of Doula Programs across Three States Using Propensity Score Matching," *EClinicalMedicine* 50, no. 50 (August 2022): 101531, https://doi.org/10.1016/j.eclinm.2022.101531.

safety net for uninsured and under-insured individuals.[193] There are 73 such centers, with over 700 locations throughout urban and rural communities (Figure 7).[194]

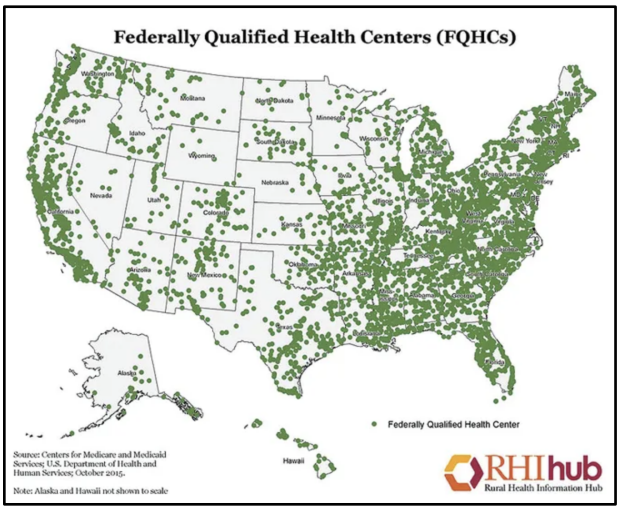


Figure 7: Map of FQHCs in the United States

Importantly, these centers face the complex task of providing, or connecting, uninsured patients – who oftentimes face more complex and delayed prognoses as a result of their insurance status – to specialists (Figure 8). Further, this task is made more difficult by a decreasing number of specialists willing to provide care to uninsured or Medicaid-eligible patients.[195] This is a result of a perceived unprofitability in this population, especially with restrictive Medicaid reimbursement.

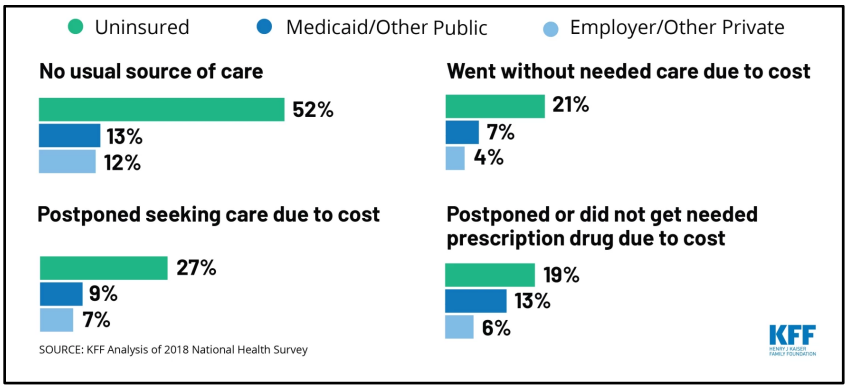


Figure 8: Uninsured Most Likely to Delay or Go Without Care or Prescription Drugs Due to Cost

[193] Elena Rivera and Yfat Yossifor, "Texas Refuses to Expand Medicaid. Community Health Centers and Uninsured People Suffer," KERA News, August 17, 2023, https://www.keranews.org/health-wellness/2023-08-17/texas-community-health-center-medicaid-expansion.
[194] "Federally Qualified Health Centers (FQHCs) | Texas DSHS," Texas.gov, 2018, https://www.dshs.texas.gov/center-health-statistics/texas-primary-care-office-tpco/federally-qualified-health-centers-fqhc.
[195] Elena Rivera and Yfat Yossifor, "Texas Refuses to Expand Medicaid. Community Health Centers and Uninsured People Suffer"

Simultaneously, because of their reliance on state grants and the fact that they largely treat individuals unable to pay for care, these centers face "razor-thin margins," which inherently introduces complications in the quality of care and staffing. This is problematic in that it still worsens inequity, simply by scarcity and despite the positive intentions behind the centers.

In terms of location, it is clear that Texas FQHCs do not comprehensively cover all populations, particularly with gaps in certain regions of rural East Texas, and more metropolitan areas throughout western and northern Texas (Figure 9). We can see that existing locations map well to documented areas with high maternal mortality – which is important – but the concern lies in the gray areas where data is "suppressed," meaning data is either not collected or deliveries are below 100. Importantly, the unavailability of data does not mean that there are no pregnant women in these areas, who are facing extreme lack of access to care as a result of the dearth of FQHCs.

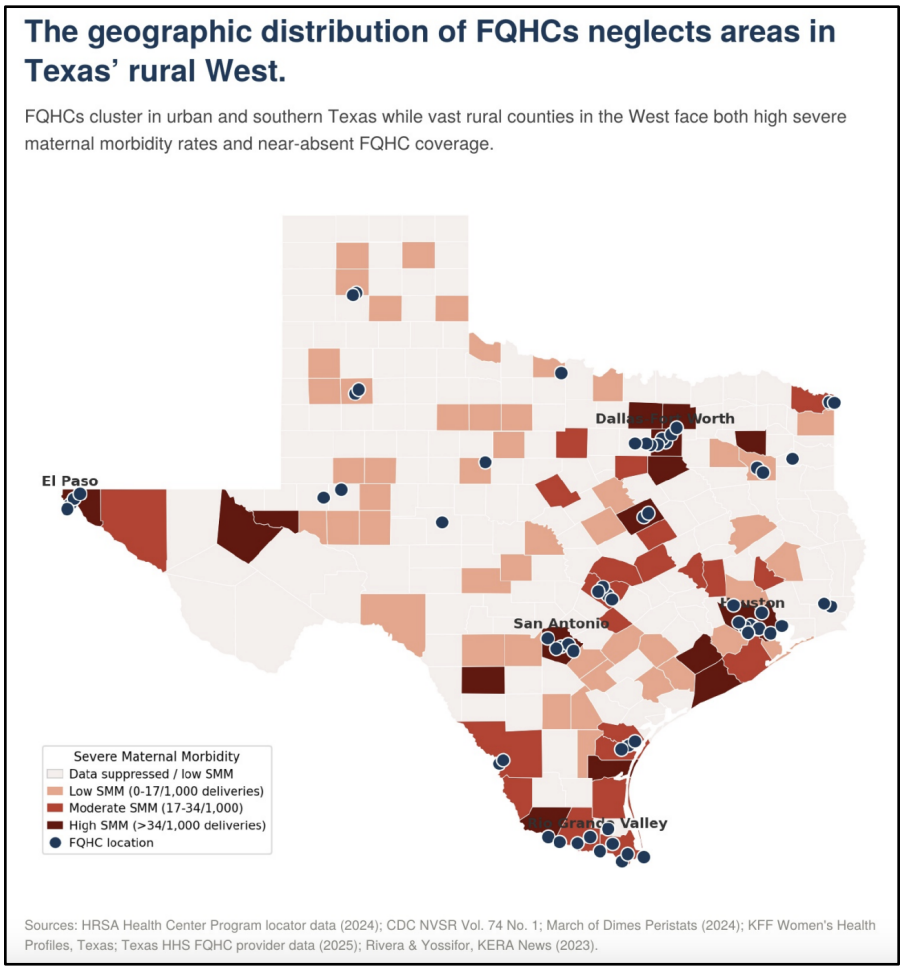


Figure 9: Visual Summary of FQHC Regional Disparities

Ultimately, with regards to both HB 1575 and FQHCs, meaningful change has occurred, but this does not discount the fact that there are still significant systemic gaps in care access and quality. While the passage of HB 1575 signals important shifts in the existing political landscape on maternal health, the lack of further action is both problematic and concerning, especially when considering the efficacy of doulas for pregnant women-of-color. With regards to FQHCs,

these act as another strong safety net system that, if funded, could meet the social and medical needs of their patients. However, a present lack of funding, a gap from preventative/primary care at FQHCs to more specialized care, and a geographical barrier are actively impeding the efficacy of these centers.

Policy Interventions for Safety Net Systems

I. Expand HB 1575 to include reimbursement eligibility for doulas and community health workers (CHWs) for provision of maternal health care or social services

A. Introduction

The Texas State Legislature should implement an amendment to H.B. 1575, to expand reimbursement eligible services for doulas or community health workers. The current bill only expands reimbursement for the screening of social determinants, but does not incentivize supporting mothers in overcoming any barriers to health. The expansion of reimbursement eligibility to include maternal health or social services, as provided by doulas or CHWs, would allow for more robust social safety nets that better safeguard mothers against structural inequities.

B. Background Research & Case Study

H.B. 1575, passed in 2023, was one of the first attempts by the Texas Legislature to recognize the role of social determinants of health in shaping disproportionate maternal mortality results for low-income women.[196] It expanded eligibility for Case Management for Children and Pregnant Women (CPW) services to include doulas and CHWs, increasing safety nets to prevent pregnant women from falling through care gaps.[197]

Importantly, however, the bill did not expand reimbursement eligibility for the main function of doulas and community health workers, which is to provide maternal healthcare and connect mothers to social services, respectively. Existing research indicates a causal relationship between care from doulas and CHWs and better maternal outcomes – in cesarean births, preterm births, and breastfeeding outcomes.[198]

Hence, the progress achieved through H.B. 1575, in recognizing structural barriers to health, can be furthered by reshaping these structural barriers. To elaborate, the role of a doula extends beyond support throughout the birthing process, but continuous physical and psychological support in the lead-up, process, and aftermath of birth.[199] Further, doulas' roles in facilitating culturally congruent care and advocacy underscore their role in supporting improved maternal outcomes. This motivates the expansion of Medicaid eligibility to include doulas, which would make their services much more accessible to mothers who can benefit most from their services.

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[196] "Implementation of House Bill 1575 - Texas Women's Healthcare Coalition," Texas Women's Healthcare Coalition, February 28, 2025, https://www.texaswhc.org/activities/implementation-of-house-bill-1575/.

[197] "Texas Legislature Takes 'Monumental Step' to Improve Health, Not Just Health Care in Addressing Maternal Health Crisis - Episcopal Health Foundation," Episcopal Health Foundation, June 5, 2023, https://www.episcopalhealth.org/news-release/texas-legislature-takes-monumental-step-to-improve-health-not-just-health-care-in-addressing-maternal-health-crisis/.

[198] Julie Mottl-Santiago et al., "Effectiveness of an Enhanced Community Doula Intervention in a Safety Net Setting: A Randomized Controlled Trial," Health Equity 7, no. 1 (September 1, 2023): 466–76, https://doi.org/10.1089/heq.2022.0200.

[199] Stephanie Arteaga et al., "'They're Gonna Be There to Advocate for Me so I'm Not by Myself': A Qualitative Analysis of Black Women's Motivations for Seeking and Experiences with Community Doula Care," Women and Birth 36, no. 3 (September 2022), https://doi.org/10.1016/j.wombi.2022.08.007.

II. Amend reimbursement rules for FQHCs to provide a supplemental rate for specialist services delivered at or through a FQHC

A. Introduction

Reimbursement rules for Federally Qualified Health Centers (FQHCs) are listed in Title 1 of the Texas Administrative Code (Part 15, Chapter 355, SubChapter J, Division 14, Rule 8261).[200] In Texas, FQHCs operate under pay-per-encounter, where a qualifying Medicaid visit will be reimbursed with a single rate that covers all services provided during the visit – which does not recognize the additional costs associated with specialty care delivery. To better ensure that patients receiving care at FQHCs, often the most vulnerable populations, can receive continued and necessary services, Medicaid reimbursement must be amended with a specialist-differentiated pay-per-encounter rate.

B. Background Research & Case Study

Federally Qualified Health Centers are non-profit clinics that accept all patients, regardless of their ability to pay.[201] They stand as an important safety-net system for the uninsured, but often face the financially difficult task of providing care for uninsured patients. On the provider's end, these patients, as a result of their insurance status, face more complex and serious diagnoses, requiring specialist intervention and continued specialist care.

In community health centers, the greatest barrier to specialty care is observed to be low Medicaid specialist payment rates.[202] There is a decreasing number of specialists who are willing to provide care to uninsured or even Medicaid-eligible patients.[203]

In Texas FQHCs, the issue is compounded by Texas' current FQHC reimbursement rules, which feature a general pay-per-encounter rule. To incentivize and increase specialist treatment for the communities served by FQHCs, and make specialty care more accessible for pregnant women, Texas can adopt a specialist-differentiated pay-per-experience rate, by amending Rule 8261 and specifying rates for each specialty.

As seen in Figure 10, reimbursement rates differ widely, but generally cluster around $250 per encounter. They are particularly low for suburban FQHCs, and with the exception of an outlier in the urban classification, will be generally below $400 per encounter.

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[200] "Federally Qualified Health Centers | Provider Finance Department," pfd.hhs.texas.gov, n.d., https://pfd.hhs.texas.gov/hospitals-clinic/clinic-facility-services/federally-qualified-health-centers.

[201] Elena Rivera and Yfat Yossifor, "Texas Refuses to Expand Medicaid. Community Health Centers and Uninsured People Suffer," KERA News, August 17, 2023, https://www.keranews.org/health-wellness/2023-08-17/texas-community-health-center-medicaid-expansion.

[202] Karoline Mortensen, "Access to Primary and Specialty Care and Emergency Department Utilization of Medicaid Enrollees Needing Specialty Care," Journal of Health Care for the Poor and Underserved 25, no. 2 (2014): 801–13, https://doi.org/10.1353/hpu.2014.0097.

[203] Elena Rivera and Yfat Yossifor, "Texas Refuses to Expand Medicaid. Community Health Centers and Uninsured People Suffer"

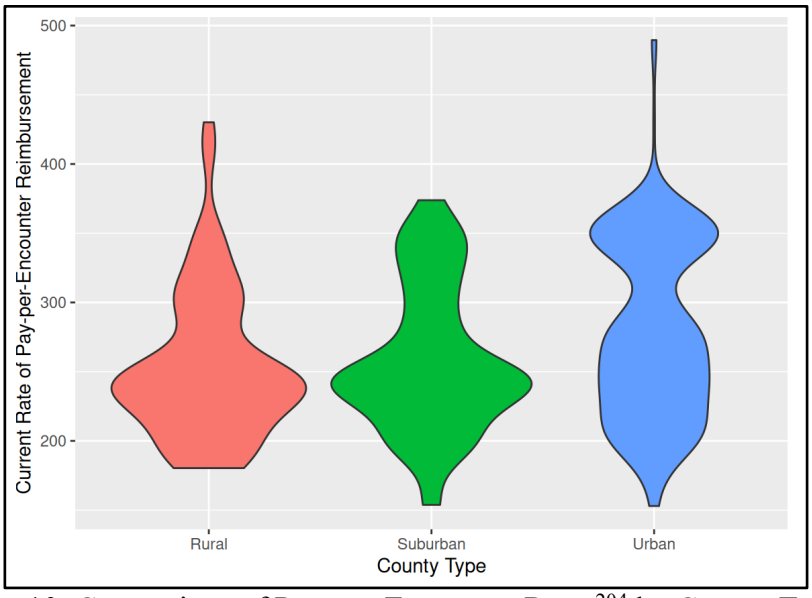


Figure 10: Comparison of Pay-per-Encounter Rates[204] by County Type[205]

Specialist-differentiated Pay-per-experience Rates

Specialist-differentiated pay-per-experience rates can look like the following: a standard OB/GYN visit pays an additional $150–$175, a cardiology consultation pays an additional $180–$250, and a behavioral health session pays an additional $130–$150. These fees could be added to the existing base rate, to decrease the burden that specialists face when providing care through FQHCs.

Another, and perhaps more compelling, option for reimbursement models is seen in California's FQHCs, where the state's new Alternative Payment Methodology includes a lump sum payment to participating FQHCs, equivalent to the estimated pay-per-encounter payments. If this lump sum payment is inadequate for the services provided, the state pays the difference.[206] To remain in this program, a FQHC must meet specific metrics of care quality – so care must be improved to qualify for this enhanced reimbursement structure. Through this method, FQHCs are incentivized not to maximize the number of encounters they have, which has often had problematic implications for quality care, but are instead incentivized to commit resources, including medical assistants and community health workers, to provide patient-centered care (see Figure 11).[207]

[204] Texas HHS, "FQHC Reimbursement Rates," n.d., https://pfd.hhs.texas.gov/sites/default/files/documents/hospital-svcs/2025/2025-04-fqhc-rates.pdf.
[205] "USDA ERS - Rural-Urban Continuum Codes," www.ers.usda.gov, n.d., https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/.
[206] California Department of Health Care Services, "Federally Qualified Health Centers Alternative Payment Methodology," Ca.gov, 2025, https://www.dhcs.ca.gov/services/Pages/FQHC_APM.aspx.
[207] Greg Howe et al., "California Federally Qualified Health Center Alternative Payment Model Implementation Guide," 2023, https://www.chcf.org/wp-content/uploads/2023/03/CAFQHCAPMImplementationGuide.pdf.

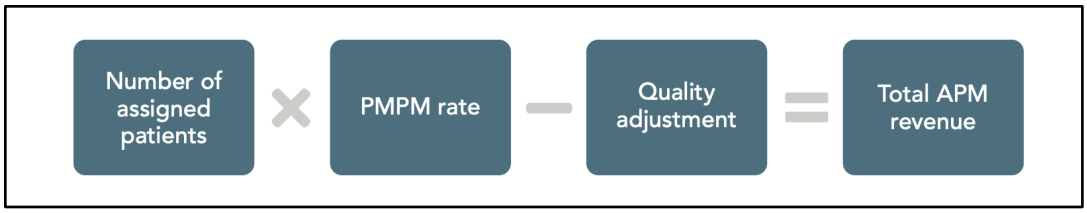


Figure 11: FQHC APM Revenue formula in the California Federally Qualified Health Centers Alternative Payment Model.

To further elaborate the consequences of inadequate specialist reimbursement, Medicaid fee-for-service payments are nearly 30 percent below Medicare rates.[208] This has created a financial disincentive for specialists to accept Medicaid patients, as seen in a 2019 meta-analysis, which found that Medicaid patients face a 3.3-fold lower likelihood of successfully scheduling a specialty appointment compared to privately insured patients.[209] This reiterates the need for greater efforts to improve financial incentives for specialists, as the underprovision in FQHCs does not only impact mothers, but also children and more broadly, underserved populations.

Therefore, while there are options for how the Texas legislature might specifically amend reimbursement to recognize increased costs of specialty care, it is necessary that Medicaid reimbursement is amended to properly compensate providers for the care they provide. This is important in ensuring that specialist care is available to Medicaid-eligible or FQHC-reliant patients, advancing continuity of care. Notably, the issue of specialty care is especially important for pregnant women, who require access to not only OB-GYNs, but also cardiologists, therapists, etc.

C. Graphical Summary of Policy Recommendation

[208] Cindy Mann and Adam Striar, "How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost," www.commonwealthfund.org (The Commonwealth Fund, August 17, 2022), https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

[209] Walter R. Hsiang et al., "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis," Inquiry: A Journal of Medical Care Organization, Provision and Financing 56 (April 5, 2019), https://doi.org/10.1177/0046958019838118.

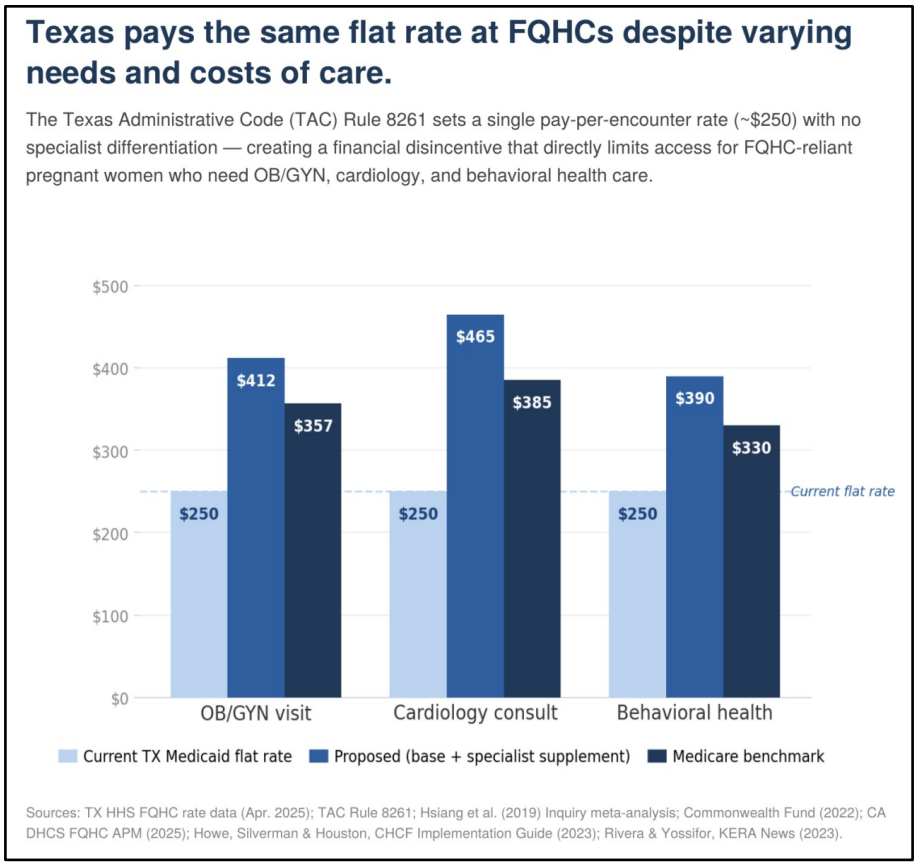


Figure 12: Texas Pays the same flat rate at FGHCs despite varying needs and costs of care

Payment Models

I. Introduction to Community Based Care

Although concerns around maternal health often focus on hospital-provided care during pregnancy, attention must be paid to community-based care services and post-partum assistance. The importance of having access to these resources cannot be understated. A 2022 Lancet study found that women who received doula assistance, a service that falls under the larger umbrella of community-based maternal care, had a 52.9% lower chance of having a cesarean delivery, which can put pregnant people at greater risk for life-threatening complications.[210,211]

A. Benefits of Community-based Care Services

In the context of maternal health, community-based care services can take the form of doula and midwifery access, lactation support, and home visiting programs. Each of these services has proven to provide respective benefits. As mentioned above, doula assistance has been found to decrease rates of cesarean sections among pregnant individuals, subsequently lessening the risk of health issues during delivery and post-

[210] April M. Falconi et al, "Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching," *The Lancet* 50, (2022).
[211] "U.S. Women More LIkely to Die in Pregnancy and Childbirth and Skip Care Because of Cost, Multi-Nation Survey Finds; C-Section Rates Rank Among Highest," The Commonwealth Fund, accessed February 28, 2026, https://www.commonwealthfund.org/press-release/2018/us-women-more-likely-die-pregnancy-and-childbirth-and-skip-care-because-cost.

partum. Additionally, countries including Burkina Faso, Cambodia, Indonesia, and Morocco have all examined a reduction in maternal mortality as a result of expanding their midwifery workforce.[212] Midwives are also crucial to improving long-term maternal health outcomes, especially considering that childbirth has an effect on pregnant people long after they deliver—however, this aspect of reproductive health has been largely neglected. Consequently, midwives are an excellent source for pregnant individuals during the postpartum period as they can inform them about common health problems and how to seek effective care if such issues do arise.[213] By the same vein, home visiting programs can provide a similar level of support and preventative screening measures for postpartum health complications. Further, access to lactation services—which include resources like lactation consults and breast pumps—can increase a postpartum person's commitment to breastfeeding and increase success rates. Breastfeeding is an important aspect of both child and maternal health, with the practice being linked to reduced risks for a variety of conditions (e.g. gastrointestinal infections, respiratory tract diseases) in infants. Further, mothers who breastfeed have been seen to have reduced incidence of Type 2 diabetes, hyperlipidemia, hypertension, and breast and ovarian cancers. In fact, a population study of breastfeeding initiation after the Affordable Care Act mandate for lactation support services' coverage found that rates increased by 2.5% after the intervention.[214]

B. Financial Obstacles to Access

While there are several barriers that limit access to maternal health services, economic barriers are one of the most prominent obstacles for pregnant individuals. In specific, poor insurance coverage and financial restrictions have been found to be the two major blockades, especially for those living in more remote and rural areas.[215] For instance, a study of Ethiopian pregnant women found that those who had covered health insurance were almost two times more likely to utilize skilled birth attendants (SBAs), which aligned with findings from Ghana and India. SBAs are similar to midwives in that they provide medical care for pregnant individuals throughout the pregnancy, childbirth, and immediate postnatal period.[216] Research has shown that expanding health insurance has decreased neonatal deaths, which is generally linked with better physical and mental outcomes for the mother. In addition, low reimbursement rates can severely limit a pregnant individual's access to health services, as was found in a study of Chinese women. Moreover, this study found that women paying out of pocket were 4.54 times more likely to experience adverse birth outcomes—like miscarriages and stillbirths—than

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[212] Petra ten Hoope-Bender et al., "Improvement of maternal and newborn health through midwifery," *The Lancet* 384, no. 9949 (2014): 1226-1235.

[213] Mary Anne Biro, "What has public health got to do with midwifery? Midwives' role in securing better health outcomes for mothers and babies," *Women and Birth* 24, (2011): 17-23.

[214] Kandice A. Kapinos, Lindsey Bullinger, & Tami Gurley- Calvez, "Lactation Support Services and Breastfeeding Initiation: Evidence from the Affordable Care Act," *HSR: Health Services Research* 52, no. 6 (2017): 2175-2196).

[215] Yaser Sarikhani, Seyede Maryam Najibi, & Zahra Razavi, "Key barriers to the provision and utilization of maternal health services in low-and lower-middle-income counters; a scoping review," *BMC Women's Health* 24, no.325 (2024): 1-15.

[216] Berhanu Teshome Woldeamanuel, Merga Abdissa Aga, "Trends, regional inequalities and determinants in the utilization of prenatal care and skilled birth attendant in Ethiopia: A multilevel analysis," *Clinical Epidemiology and Global Health* 11, no. 1100771 (2021):.

insured women, further highlighting how financial barriers prevent care access and can cause maternal health disparities.[217]

C. Insurance Reimbursement & Funding

There are several reimbursement methods that could potentially fund access to these services. For instance, capitation payments and case-based and fee-for-service arrangements are possible avenues. Capitation payments essentially give insurance providers a set amount of funding in advance per patient to cover services, which in turn can incentivize prenatal, pregnancy, and postnatal care utilization. Case-based arrangements set aside a fixed amount of money for a complete episode of care—in the case of a pregnancy, that would hypothetically cover the prenatal, pregnancy, and postnatal periods. Finally, a fee for service arrangement pays providers for each individual test, procedure, or visit. In fact, evidence from countries like South Korea and China have found that fee for service arrangements account for cost escalation as well, ensuring the provision of maternal health services is fully funded. In addition, case based systems have been found to reduce procedure costs. In Taiwan, for instance, the length of stay and cost per cesarean section fell within six months of the introduction of a case based system.[218]

D. Obstacles in Expanding Services

This past July, the Trump administration cut approximately $1 trillion of Medicaid funding over the next decade. It is estimated that over 10 million people could lose their health insurance by 2034.[219] Currently, 24 million women rely on Medicaid for basic maternal health services.[220] Current cuts to Medicaid would, in addition to widening existing disparities within maternal health, utterly prevent funding and expansion of community-based services.

II. Characterizing Maternal Health Payment Models

A. Fee-for-Service Reimbursement Model

Although the most commonly used, fee-for-service reimbursement models place the majority of financial risk on patients. Within a fee-for-service system, health care providers are paid a predetermined amount for each individual test, procedure, or office visit delivered, irrespective of the quality of that care.[221] Consequently, providers are incentivised to prioritize volume over the kind of care, leading to an excess of low-value services in order to maximize profit gain. For instance, in a study of a fee-for-service model within California's Medi-Cal, it was found that 17.7% of women had a cesarean section, a procedure that is often followed by a greater risk of pregnancy complications, both during delivery and the postpartum period. Within the same study, around 1.7% of

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[217] Alison B. Comfort, Lauren A. Peterson, & Lauren E. Hatt, "Effect of Health Insurance on the Use and Provision of Maternal Health Services and Maternal and Neonatal Health Outcomes: A Systematic Review," *Journal of health, population, and nutrition* 41, no. 4 (2013): 81.

[218] Tim Ensor & Jeptepkeny Ronoh, "Effective financing of maternal health services: A review of the literature," *Health Policy* 75, no. 1 (2005): 49-58.

[219] "4 'Big, Beautiful Bill' changes that will reshape care in 2026'," The American Medical Association, accessed March 1, 2026, https://www.ama-assn.org/health-care-advocacy/federal-advocacy/4-big-beautiful-bill-changes-will-reshape-care-2026.

[220] "Medicaid Cuts Could Increase Maternal Mortality and Jeopardize Women's Health," The Commonwealth Fund, accessed March 1, 2026, https://www.commonwealthfund.org/blog/2025/medicaid-cuts-could-increase-maternal-mortality-and-jeopardize-womens-health.

[221] De Vries et al., "A Scoping Review," 2.

mothers on the fee-for-service model experienced adverse outcomes. Further, 2.7% of newborns exhibited adverse outcomes as well.[222] Additional evidence from a study of Brazil pregnant individuals marked a high level of cesarean sections and episiotomies in part due to fee-for-service models utilizing mechanisms used by private insurers.[223]

B. Case-based Reimbursement Model

Similar to fee-for-service models, case-based reimbursement burdens patients with financial risk. In this model, providers are given a predetermined, fixed fee for an entire episode of care versus paying the provider for each procedure completed. Within a maternal health context, this kind of payment model can discourage excessive treatment and improve efficiency of care. For instance, after the introduction of a case-based reimbursement method in Taiwan, the length of stay and cost per cesarean section fell within six months. However, this model may also cause underservice as providers are incentivized to spend as little as possible on treatments. Therefore, the case-based reimbursement model holds both benefits and limitations for delivering effective maternal health care. While mothers may experience shorter hospital stays and fewer unnecessary tests, there is also the possibility that they will not receive the extent of treatment they require. For instance, lactation consultations, prenatal visits, and other helpful services that are not utilized during the crucial end-of-pregnancy and labor period will likely not be reimbursed, leaving everyday mothers without this supplementary yet essential care.[224]

C. Capitation Reimbursement Model

Another reimbursement model that has been in high use among Medicaid patients is the capitation method, where providers receive a fixed, pre-paid amount per patient for a set timeframe. Unlike in the fee-for-service model, this financial compensation is provided regardless of the volume of care provided. Further, these payments are often risk-adjusted for factors like patient age, health status, and other demographics. As a result, providers receive higher reimbursement payments for treating sicker patients. The capitation reimbursement model has been lauded for shifting financial risk from insurance companies to providers, thus promising greater participation on the part of providers, reduced fees for services, and greater quality of care delivered. This was seen in part in the aforementioned MediCal study, where 1.4% of mothers experienced adverse outcomes. However, 4.5% of newborns exhibited adverse outcomes, indicating there are still issues with the implementation of the capitation reimbursement model.[225]

D. Pay-for-performance Reimbursement Model

Fitting under the value based payer model, the pay-for-performance method pays an added bonus for providers who attain a certain quality threshold for each service delivered. Alternatively, they can penalize providers with lower payments for not reaching a certain standard. However, most states are not interested in implementing such punitive measures. These additional payments can also be received for improved care coordination, care efficiency, and accessibility of care. This method directly increases

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[222] Denise M. Oleske et al., "A Comparison of Capitated and Fee-for-Service Medicaid Reimbursement Methods on Pregnancy Outcomes," *HSR: Health Services Research* 33, no. 1 (1998): 55-73.

[223] Tim Ensor & Jeptepkeny Ronoh, "Effective financing of maternal health services: A review of the literature," *Health Policy* 74, no. 1 (2005): 49-58.

[224] Ensor & Ronoh, "Effective financing of maternal health services," 54.

[225] Oleske et al., "A Comparison of Capitated and Fee-for-Service," 63.

provider risk, creating an incentive to more efficiently coordinate the delivery of care.[226] The pay-for-performance model has increased both structural and process quality within the maternal health sphere. For instance, the availability of qualified staff increased by 15% and the availability of drugs by 37% after the implementation of a pay-for-performance model. Further, a study in Egypt showcased an increase in providers asking about pregnant individuals' medical history, testing blood and urine, and measuring blood pressure, all of which are methods of early detection for adverse maternal outcomes like preeclampsia and gestational hypertension. In addition to improvements in structural and process quality, utilization of the pay-for-performance model was also associated with improvements in quality outcomes. Some examples include Egyptian women showcasing a better understanding of prenatal drug usage, reduced out-of-pocket expenses for patients in the DRC, and increased patient satisfaction among patients in the DRC as well.[227]

E. Summary of Reimbursement Models

	Fee-for-service	Case-based	Capitation	Pay-for-performance
Definition	Providers are reimbursed for each individual test, procedure, or office visit performed	Providers receive fixed, pre-agreed fee for entire episode of care vs. separate payments per service	Providers receive set, fixed amount of money per patient for a specific period, regardless of whether the patient seeks care	Ties provider compensation to quality, efficiency, and safety of care vs. just volume of services
Who assumes the financial risk?	Patients	Providers	Providers	Providers
Pros	Providers are directly rewarded for effort, leading to higher-income for higher volume of services	Incentivizes providers to manage resources effectively and reduce unnecessary tests and longer hospital stays	Providers are incentivized to keep patients healthy via preventative care to avoid high-cost, acute interventions	Providers are incentivized to adhere to quality standards and better health outcomes for patients
Cons	Incentivizes performing more procedures, regardless of whether they are necessary	Providers may avoid providing essential services to keep costs below the reimbursement level	Providers may limit necessary care to save costs; may also cherry-pick healthier patients to avoid costs	Have previously not accounted for patient differences, depriving practices serving low-income populations of important resources
In Maternal Health Context	Providers bill each visit, procedure, or test Many insurers use a "global fee" that bundles all services (prenatal, pregnancy, & postpartum), leaving providers to split money across all services	Single bundled payment is made to hospital, and providers are responsible for allocating payment among themselves based on respective roles and services in pregnancy care	Providers receive a prepaid, per-member-per-month (PMPM) amount, designed to cover routine pregnancy care and routine lab tests	Providers will receive extra funds—usually as annual, retrospective lump-sum bonuses—for meeting care delivery targets (e.g. low complication rates) Sometimes, payments can be withheld until provider meets quality standards

Sources: *NIH*, *Journal of Global Health*, *Canadian Medical Association Journal*, *Pediatric Clinics of North America*

Figure 13: Types of Reimbursement Models in Maternal Health

F. Analysis and Conclusion

There are various reimbursement models that can be explored to improve the quality of maternal care providers are able to deliver to patients. Each model is fundamentally tied to the distribution of financial risk, which subsequently determines how willing providers are to provide sufficient and high-quality care throughout the pregnancy and postpartum periods. Understanding these different payment methods, including their strengths and weaknesses, can allow for policymakers to devise a model that will be beneficial for both providers, and consequently, patients.

[226] De Vries et al., "A Scoping Review," 3.

[227] Ashis Das, Saji S. Goplan, & Daniel Chandramohan, "Effect of pay for performance to improve quality of maternal and child care in low and middle-income countries: a systematic review," *BMC Public Health* 16, no. 321 (2016): 1-11.

G. Graphical Comparison of Reimbursement Models

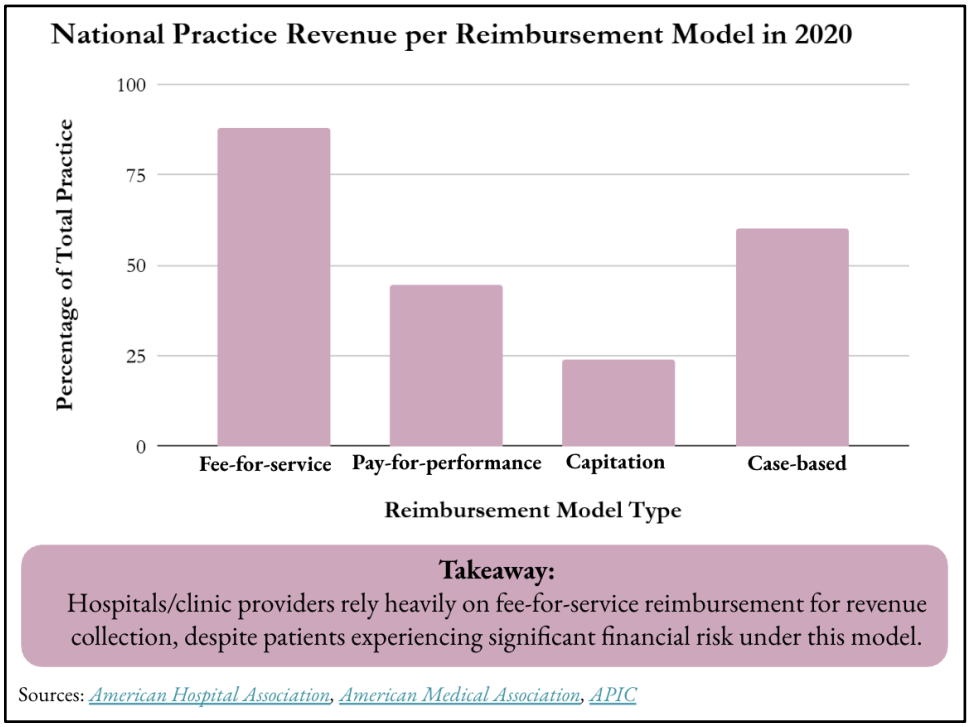


Figure 14: Revenue Collection by Reimbursement Model

Policy Interventions for Maternal Healthcare Payment Models

I. Adopt a Hybrid Model of Pay-for-Performance and Tiered Capitation Reimbursement

Methods of payment during the prenatal, pregnancy, and postpartum period play a critical role in shaping maternal and neonatal outcomes. Considering how various models differ in where they place financial risk, some models can hinder multidisciplinary collaboration among providers and lead to over-provision of unessential services, subsequently reducing quality of care. A current analysis of existing reimbursement models shows that while some may prove more successful than others, each model still has its own drawbacks that complicate equitable care delivery. This suggests that instead of legislating the use of one of these models, a hybrid version combining aspects of pay-for-performance and capitation reimbursement should be adopted to ensure that high-quality patient-centered care is prioritized.

A. Background Research: Pay-for-Performance

Pay-for-performance reimbursement has been lauded as a potential strategy to improve availability, quality, and utilization of healthcare services. By rewarding practices that are able to effectively deliver high-quality patient-centered care, the model aims to increase client uptake of essential treatments. A case of four intervention studies found success with this program in the DRC, Egypt, the Philippines, and Rwanda, where a positive effect on process quality—or in other words, how care is provided—of maternal care was observed. Further research found the implementation of pay-for-performance to have positive effects on quality, costs, and clinical outcomes by significantly improving institutional deliveries and increasing access to medicines and medical supplies in 86.7% of participating institutions. Moreover, the payment model has been found to increase the frequency of prenatal visits, which are essential in monitoring

for complications in higher-risk pregnant individuals.[228] However, the intervention also found weak evidence for a positive effect on maternal health outcomes and out-of-pocket expenses. Further, the study also saw a few negative effects on structural quality of care after implementation of pay-for-performance.[229] These unsatisfactory outcomes can be attributed to structural issues with the model that exacerbate disparities between lucrative and under-resourced hospitals. In fact, a report by Harvard Medical School affiliate Jake Miller found a previous rollout of pay-for-performance reimbursement contributed to greater healthcare inequality among poorer hospitals and clinics because the model failed to consider the fact that different populations experience varying health outcomes. Considering that underfunded hospitals have reduced access to testing equipment, room space, and other essential amenities, these hospitals systematically have worse health results. Consequently, applying pay-for-performance does not reward these institutions because they fundamentally lack the resources to improve their quality of care, regardless of whether their physicians and nursing staff are committed to providing patient-centered help.[230]

B. Background Research: Capitation

Capitation reimbursement has also been considered as an alternative to the weaker fee-for-service model. Instead of being reimbursed for each service—as with fee-for-service—providers receive a set, fixed amount of money per patient for a specific period of time, regardless of whether the patient seeks care or not. The use of this model has been encouraged by physicians, who have recommended the use of capitation systems within primary care to ensure patient and provider satisfaction. In particular, the use of risk-adjusted capitation payments have been suggested as a way for physicians and practices who disproportionately take care of sicker patients/patients who are more likely to experience worse health outcomes to be sufficiently reimbursed.[231] In a maternal health context, base payments in the capitation reimbursement model could cover a comprehensive selection of care, including the prenatal, pregnancy, and postpartum periods. In order for these payments to sufficiently cover costs for underfunded hospitals that structurally lack maternal health resources, they should be adjusted per clinic based on availability of existing materials. As a result, underresourced hospitals would be able to purchase needed testing/care materials and also hire healthcare workers who prioritize patient-centered care that contributes to reduced maternal mortality rates, like doulas and midwives. Further, these reimbursements could be tiered to reward hospitals that better integrate community-based care, like meeting a certain quota of doulas and midwives for their maternal care staff. Further, capitation payments have been found to significantly reduce the hospital length of stay for pregnant individuals, which is often associated with

[228] Zakieh Ostad-Ahmadi et al., "Effects of different payment methods on perinatal care outcomes: a systematic review," *BMC Health Services Research* 25, no. 1 (2025): 1065.
[229] Ashis Das, Saji S. Gopalan, Saji S. Gopalan, and Daniel Chandramohan, "Effect of pay for performance to improve quality of maternal and child care in low- and middle-income countries: a systematic review," *BMC Public Health* 16, no. 1 (2016): 321.
[230] "Pay-for-Performance Fails to Perform," Harvard Medical School, accessed April 11, 2026, https://hms.harvard.edu/news/pay-performance-fails-perform.
[231] John D. Goodson et al., "The Future of Capitation," *Journal of General Internal Medicine* 16, no. 4 (2001): 250-256.

the need for minimally invasive procedures—in other words, a reduced need for cesarean sections.[232]

C. Benefit of a Hybrid Reimbursement Model

In applying this version of capitation reimbursement alongside pay-for-performance, hospitals with reduced access to essential maternal health resources would be able to sufficiently improve the quality of care they provide. Consequently, these hospitals would be able to benefit substantially from pay-for-performance reimbursements. Although pay-for-performance and tiered/risk-based capitation have not been tested as a hybrid reimbursement model, previous studies have observed beneficial outcomes in cases where other forms of hybrid models have been utilized. For instance, the use of a blended ½ capitation and ⅔ fee-for-service model was found to reduce premature birth rates by 1.9% in comparison to those under a solely capitation-based reimbursement model. Moreover, those under the capitation payment system experienced 1.3% lower birth rates than those in the blended model.[233]

D. Economic and Public Health Benefits for Texas

Applying these results to Texas statewide, we can observe a substantial improvement in infant, and by extension, maternal outcomes. In 2023, Texas observed 387,945 live births, with 43,344 being considered as preterm (around 11.1% of live births).[234] If a hybrid reimbursement model were to reduce premature births by even the 1.9% observed in the study, this would translate to approximately 823 fewer preterm births. Given that preterm births can cost upwards of $50,000 dollars more than normal births, this reduction could yield around $38 million in annual savings in addition to improved health outcomes among pregnant individuals resulting from less complicated delivery.[235] These estimates highlight how a hybrid reimbursement model may be advantageous in Texas both in terms of cost savings and improved maternal health outcomes.

II. Expand & Strengthen Texas' Existing Medicaid Pay for Quality Program

Given the existing Texas Pay for Quality program, an avenue to improve maternal outcomes for Medicaid users in particular is to amend current prenatal and postpartum performance metrics in the current payment model, in order to ensure adequate standardization of postpartum and prenatal care. Specifically, this can be done by tying greater financial incentives and accountability to evidence based maternal health standards.

A. Background Research: Medicaid Outcomes in Texas

Texas's Medicaid system is managed by various managed care organizations, otherwise known as MCOs. Texas state authority over Medicaid flows from the Texas Health and Human Services Commission (HHSC) to Medicaid managed care under the MCOs.[236] Pregnant mothers can get health insurance for themselves and their children

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[232] Carlotta A. Gabard, *Obstetrical care under capitation,* University of Michigan, School of Public Health, 2001.
[233] Zakieh Ostad-Ahmadi et al., "Effects of different payment methods on perinatal care outcomes: a systematic review," 1065.
[234] Data For Texas," March of Dimes, Accessed April 12, 2026, https://www.marchofdimes.org/peristats/data?reg=48&top=2&stop=10&lev=1&slev=4&obj=3&sreg=48.
[235] Norman J. Waitzman, Jalali Ali, and Scott D. Grosse, "Preterm birth lifetime costs in the United States in 2016: an update." *Seminars in perinatology* 45, no.3 (2021): 151390.
[236] "Texas Medicaid Provider Procedures Manual — April 2026." Accessed April 9, 2026. https://www.tmhp.com/sites/default/files/microsites/provider-

through Texas' Medicaid program STAR or the Children's Health Insurance Program (CHIP) Perinatal. Once approved for Medicaid, individuals can choose which insurance provider to partner with depending on their location. Below is the map dictating the providers in each region.[237]

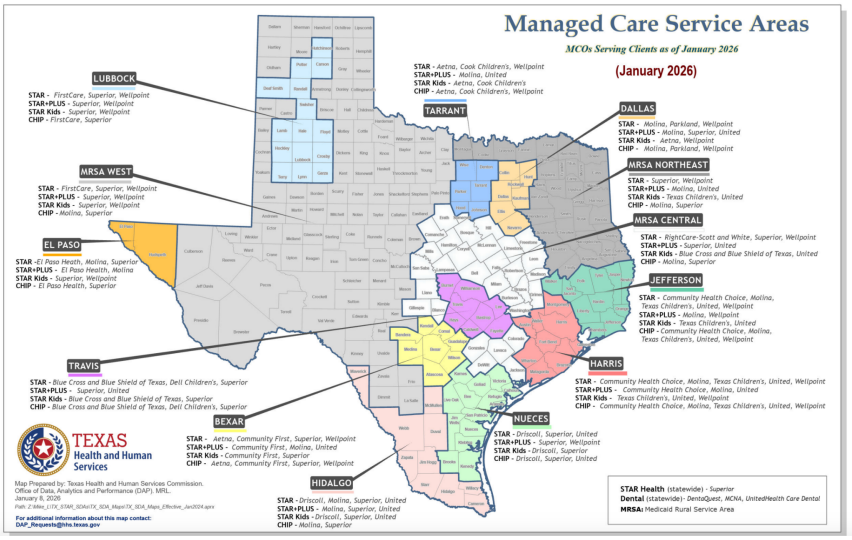


Figure 15: Managed Care Service Areas

However, access to Medicaid does not automatically translate to the best health outcomes. Health disparities persist between Medicaid users and those with privatized/commercialized insurance. A study by the Medicaid and CHIP Payment Access Commission found that women on Medicaid were 82% more likely to experience an incidence of severe maternal morbidity (SMM).[238] This heightened risk of SMM extends from during pregnancy, childbirth, with postpartum mothers on Medicaid reporting poor treatment from providers, lack of support, and struggles attending follow-up visits.[239] This indicates that a contributing factor to detrimental maternal health outcomes is a lack of adequate standardization of care in regards to both prenatal and postpartum care for individuals covered under Medicaid.

B. <u>Background Research: Pay for Performance System in Texas</u>

As previously discussed, Pay for Performance models are a value based program that provides financial incentives for providers reaching a certain quality of care.[240] States like Connecticut and Colorado have implemented a pay for performance program and seen increased adherence to health standards and outlined metric; however, these

manuals/tmppm/html/index.html#t=TMPPM%2F2_12_Medicaid_Managed_Care%2F2_12_Medicaid_Managed_Care.htm%231842639&rhtocid=_23.

[237]"STAR Medicaid Managed Care Program | Texas Health and Human Services." Accessed April 9, 2026. https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/star-medicaid-managed-care-program?

[238] MACPAC. "Maternal Morbidity among Women in Medicaid." January 24, 2020. https://www.macpac.gov/publication/maternal-morbidity-among-women-in-medicaid/.

[239] "Maternal Mortality in the United States: A Primer." December 16, 2020. https://doi.org/10.26099/ta1q-mw24.

[240]Zettle, Amy. Value-Based Payment for Maternity Care in Medicaid: Findings from Five States. n.d.

standards are to ensure individuals receive certain care not to make changes in delivery systems or quality. For example, in Connecticut with the implementation of their pay for performance program in obstetric health, the percentage of reported full-term, vaginal delivery after spontaneous labor rates rose from 34.19% in 2013-2014 to 48.48% in 2018-2019.[241] In some metrics, there was year to year variation with no consistent upwards trend; however, this is attributed to the introduction of new providers into the program who started with lower rates, which significantly pulled down the average on some metrics.

Currently, Texas has standards that each insurance provider uses to make a Pay for Quality Program for their partnered healthcare providers. The full list of standards are listed below in the most recent (2023) Pay for Quality outcomes breakdown.[242]\

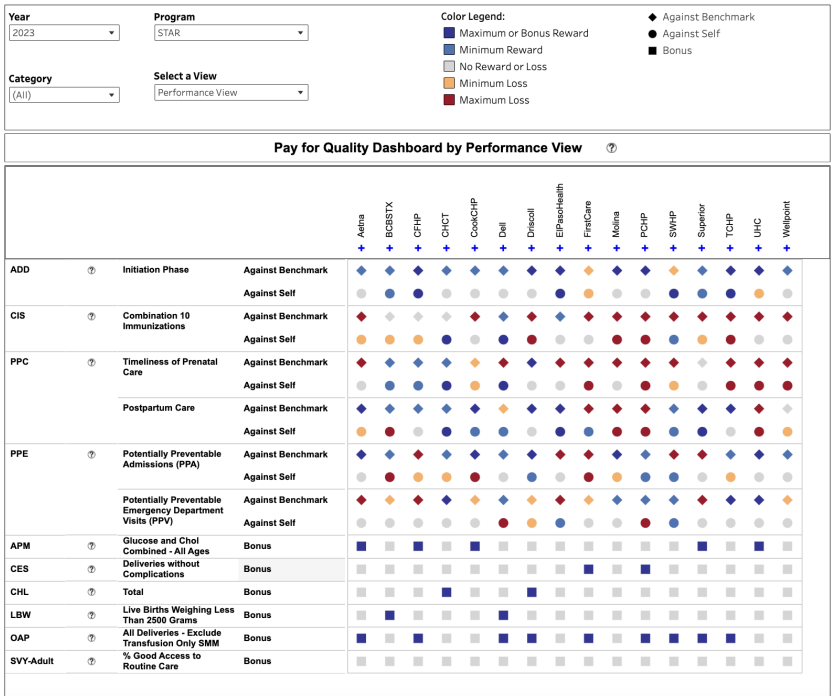


Figure 16: Pay For Quality Dashboard By Performance View

As seen on the table, there are 4 metrics relating to maternal health: timeliness of prenatal care and postpartum care, instances of severe maternal morbidity, cesarean section rate, and rate of live births weighing less than 2500 grams. The timeliness of prenatal care metric evaluates the percentage of deliveries that received a prenatal care visit within the first trimester or at least within 42 days of enrollment in the insurance program. The current postpartum care metric captures the percentage of deliveries that had at least one postpartum care visit within 7-84 days after delivery. These first two metrics are punitive ones. If providers fail to meet the benchmark then they stand to lose

[241]MACPAC. "Connecticut Pay for Performance in Obstetrics Care Program." September 9, 2021. https://www.macpac.gov/publication/connecticut-pay-for-performance-in-obstetrics-care-program/.
[242]"Medicaid Quality Performance." Texas.gov, 2026, mqp.hhs.texas.gov/applications/tableauEmbedding?name=P4Q. Accessed 29 May 2026.

money. However, there is also the incentive of financial gain with ensuring dissemination of important care characteristics like prenatal and postpartum visits.

Maintaining a cesarean section rate and live births under 2500 grams below the benchmark is a rewarded or incentivized metric, not a punitive one. Therefore, there is less pressure for providers to strive for these metrics since they stand to lose nothing. Furthermore, based on the aforementioned Connecticut and Colorado model, we can assume that incentivized metrics can see great success.

Additionally, this model of pay for quality programs has proven to be particularly effective over a long term period, especially in decreasing the number of potentially preventable hospital admissions and potentially preventable emergency department visits. Millwee et. al, attributes the success of the value based program (VBP) model to the high financial incentives and penalties.[243] Therefore, maternal health in Texas can be improved by implementing more stringent requirements.

C. Recommendation: Pay for Performance Standards - Postpartum Care

Therefore, considering both the issue of standardization of care despite Medicaid access as well as the current Pay for Performance model in Texas, the first amendment that should be made to the pay for quality standards is to tighten the standards around postpartum care visits. Providers should be striving for mothers to have 3 postpartum visits. One visit should happen around 3 weeks postpartum, another comprehensive visit should happen before 12 weeks postpartum, and finally another visit should happen anywhere from 12 weeks postpartum to one year postpartum, which is when many mothers may lose their insurance. These parameters are based on recommendations by the American College of Obstetricians and Gynecologists which recommends contact with an obstetric care provider within 3 weeks and a comprehensive visit within 12 weeks.[244] Additionally, the first year postpartum is incredibly vital and formative to maternal health and well-being, physically and emotionally. Note, a comprehensive visit is different from a standard postpartum visit. A comprehensive visit includes "a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance" as defined by the American College of Obstetricians and Gynecologists. This is to ensure that the postpartum visit mothers receive is meaningful and serves to actually catch and address any issues that could lead to maternal mortality.

D. Recommendation: Pay for Performance Standards - Prenatal Care

Secondly, the prenatal care metric should also be further narrowed to ensure mothers are receiving key clinical screenings, given that they consent to it. Pregnant women should all be given a comprehensive prenatal needs assessment as part of their required visit to determine the level of support they will need throughout their pregnancy and any major health risk factors. The American College of Obstetricians and Gynecologists defines a comprehensive prenatal needs assessment as one that includes

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[243] Millwee et al., "Achieving Improved Outcomes Through Value-Based Purchasing in One State."

[244] The American College of Obstetricians and Gynecologists. "Optimizing Postpartum Care." Www.acog.org, May 2020, www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.

the "medical, social, and structural drivers of health."[245] The below table provides a more in-depth description of what that entails.

Table 1. Sample Components of Maternal Risk Assessment

Obstetric or Gynecologic	Medical	Family History	Social Drivers of Health*
Prior pregnancies and outcomes Menstrual history Infertility, ART Current pregnancy symptoms EDD confirmation Gynecologic history, including PAP testing and results Sexual history, including past STIs and current risk Teratogen exposures since pregnancy and ongoing risk	Chronic conditions History of mental health diagnoses and treatment, including substance use and substance use disorder and eating disorders Surgeries Allergies Immunizations Medications and supplements Oral health Infectious diseases—past and ongoing risk	Genetic or congenital defects or conditions in the genetic family of the fetus Recurrent pregnancy loss Pregnancy complications Chronic conditions Cancer	Demographic characteristics and identities associated with health outcomes and experience of marginalization (eg, race, ethnicity, gender identity, sexual orientation, religion, nationality, geographic location, primary language) Social network and support (eg, family structure, partner, father of baby if applicable, individuals in the home, history of trauma or intimate partner violence) Material needs (eg, housing, access to nutritious foods, transportation, financial resources strain, health care affordability) Education and employment (eg, highest school completed, health literacy, current work)

ART, assisted reproductive technology; EDD, estimated due date; STI, sexually transmitted infection.

Data from: American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 8th ed. American Academy of Pediatrics, American College of Obstetricians and Gynecologists; 2017.

*Obstetrician–gynecologists and other maternity care professionals can refer to standardized tools for assessing unmet social needs (47).

Figure 17: Sample of Maternal Risk Assessment[124]

E. Implementation:

These recommendations build off existing infrastructure by bolstering existing performance metrics. These managed care organizations predominantly manage the distribution of rewards and penalties and information collection on providers meeting these standards. However, based on progress on each metrics over a 2 year period, Texas' Health and Human Services department in conjunction with these MCOs should re-evaluate the financial incentives to maximize buy-in. If there are metrics under the penalties framework that continually fail to be met, the maximum penalty should be increased. On the purely financial reward maternal health metrics, the maximum reward can be increased or the incentive structure could be shifted to the reward/punishment system. These continual updates will ensure providers remain consistent in their adherence to these metrics. It will also ensure year-to-year improvement. Within this framework, however, providers should be able to provide reports on extenuating circumstances that resulted in failure to meet certain benchmarks for a given year. The goal is to not unnecessarily penalize and burden struggling systems, but to ensure a certain standard of care is met.

F. Cost Benefit Analysis

1. Cost: The cost is a complicated metric to ascertain currently as the Texas legislature would not be directly responsible for implementing these measures, and therefore, do not directly deal with the associated costs. While the options both incur costs to implement as the state would likely have to approve more discretionary funding to help finance these benefits,

[245] "Tailored Prenatal Care Delivery for Pregnant Individuals." Accessed April 9, 2026. https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2025/04/tailored-prenatal-care-delivery-for-pregnant-individuals.

since Texas Medicaid is managed by these MCOs, they incur the risks and additional costs associated with any healthcare interactions.[246]
Also, currently there are no explicit references to what the maximum reward for providers is for surpassing a benchmark outlined by the Pay for Quality Program in Texas. However, the Connecticut model determines bonuses retroactively based on the size of their state funding bonus pool and number of participants in the program. While the number is subject to change, providers stand to earn tens of thousands dollars annually, and the government would likely have to invest over a million dollars, if not a couple million.

2. Benefit: A major potentially financial benefit with enhanced prenatal and postpartum care is the decreased incidence of expensive complications during pregnancy or conditions after pregnancy. By managing conditions and stopping them from becoming more serious issues, Texas and hospitals save money by avoiding costs associated with treating more complicated conditions. Those who deliver via Cesarean section incur over $10,000 more in delivery costs. Neonatal intensive care unit (NICU) visits for specialized care or premature birth incur healthcare costs that are 5 times higher than those who do not utilize the NICU. Overall, it would save insurers and Texas state money in the long run to ensure quality preventative care to avoid more expensive treatment costs. Additionally, maternal health could vastly benefit from increasing prenatal and postpartum visits. As previously mentioned, these appointments are vital in shaping maternal health and avoiding the adverse health outcomes and severe maternal morbidity that we even see now.

Medicaid Coverage

Medicaid plays a critical role in ensuring access to healthcare for millions of Americans, but there are still significant gaps in awareness, provider participation, and sustainable funding. Many individuals who qualify for Medicaid coverage are either unaware of their eligibility or face barriers in navigating enrollment, while healthcare providers, particularly OBGYN specialists, often encounter reimbursement structures that can limit participation in the program. Addressing all of these barriers is necessary for strengthening the broader healthcare safety net and especially for improving material and reproductive health outcomes.

I. Introduction

A. Ensuring Eligible Individuals are Aware of and Enrolled in Medicaid

As of October 2025, 69,541,353 people were enrolled in Medicaid, highlighting the program's central role in providing health coverage across the United States. Despite this large enrollment, many eligible individuals remain unaware of their qualification status or face administrative and informational barriers that prevent them from

[246] "Texas Medicaid Provider Procedures Manual — April 2026." Accessed April 9, 2026. https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_12_Medicaid_Managed_Care%2F2_12_Medicaid_Managed_Care.htm%231842639&rhtocid=_23.

enrolling.[247] Therefore, one possible suggestion is to further integrate Medicaid eligibility screens in all community-based clinics, hospitals, family practices, OB/GYN practices, and labor and delivery units.[248] This would help identify uninsured but eligible individuals at the point where they are already seeking care, reaching them at their location which has been proven to be a more fruitful method in healthcare.[249] By making eligibility checks a routine part of patient intake or discharge processes, healthcare providers could connect patients to coverage in real time rather than relying on individuals to independently navigate enrollment systems. This approach would likely increase enrollment among eligible populations, reduce gaps in insurance coverage, and improve continuity of care, especially for pregnant patients and those requiring ongoing reproductive or preventive services. In turn, earlier enrollment can lead to better health outcomes, lower rates of uncompensated care for providers, and more consistent reimbursement through Medicaid, strengthening both patient access and healthcare system stability.[250]

B. Integration of AI tools in RCM, Reimbursement, and Financial-Related Processes

The rapid growth of artificial intelligence (AI) in healthcare administration has significantly transformed revenue cycle management (RCM), reimbursement optimization, and billing workflows. Across the United States, healthcare systems are increasingly adopting AI-driven tools to automate insurance eligibility verification, coding, claims submission, and denial management, improving efficiency and reducing administrative burden. Nearly half of U.S. hospitals now use AI within revenue cycle operations, and adoption of AI billing technologies continues to rise as organizations seek to minimize claim errors and accelerate reimbursements.[251] However, this technological progress remains uneven. Smaller practices, rural hospitals, and community clinics lag behind larger health systems due to financial constraints, limited IT infrastructure, and workforce capacity challenges, creating a growing digital divide in healthcare administration.[252] Expanding access to affordable AI-enabled RCM tools through grants, shared technology platforms, or Medicaid-supported innovation initiatives could help underserved providers improve reimbursement accuracy, stabilize revenue streams, and sustain access to care in medically underserved regions.

II. National Medicaid and Maternal Care

[247] Medicaid.gov. "November 2025 Medicaid & CHIP Enrollment Data Highlights | Medicaid," 2025. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/no vember-2025-medicaid-chip-enrollment-data-highlights.

[248] kffsamanthaa. "Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population | KFF." KFF, March 2, 2016.

[249] Hughes, Mark T. "Meeting Patients Where They Are." AMA Journal of Ethics 15, no. 4 (April 1, 2013): 293–98. https://doi.org/10.1001/virtualmentor.2013.15.4.ecas2-1304.

[250] Buchmueller, Thomas, Amelia Whitman, Christie Peters, and Nancy De Lew. "Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024." Nih.gov. Office of the Assistant Secretary for Planning and Evaluation (ASPE), June 7, 2024. https://www.ncbi.nlm.nih.gov/books/NBK611354/.

[251] American Hospital Association. "3 Ways AI Can Improve Revenue-Cycle Management | AHA." www.aha.org, May 14, 2024. https://www.aha.org/aha-center-health-innovation-market-scan/2024-06-04-3-ways-ai-can-improve-revenue-cycle-m anagement.

[252] Austin, Milledge. "Digital Divide Heightens Impact on Health Care in Rural Georgia and South, Reveals New Study Co-Authored by Augusta University Provost." Jagwire, June 13, 2023.

Babies born to Medicaid-insured mothers experience higher rates of preterm birth than those born to privately insured mothers, with preterm birth occurring in 11.7% of Medicaid-covered births compared with 9.6% of privately insured births.[253] This difference highlights that Medicaid disproportionately serves higher-risk pregnancies. At the same time, gaps in coverage remain common. In many states, particularly those that have not expanded Medicaid, about 20–25% of women with recent births experience a period of uninsurance in the year before, during, or after pregnancy. These disruptions are largely driven by eligibility rules that limit pregnancy-related Medicaid coverage to pregnancy and only 60 days postpartum.[254]

III. Medicaid in Texas

Nearly half of all births in Texas, about 45.8%, are covered by Medicaid, making it the primary payer for maternity care in the state. Texas also faces significant maternal and infant health challenges. The state's preterm birth rate is 11.1%, representing 43,344 preterm births in 2024, and it receives a "D" grade on the March of Dimes maternal and infant health report card. Texas reports a maternal mortality rate of 29.3 deaths per 100,000 births and an infant mortality rate of 5.8 deaths per 1,000 live births, with babies born to black mothers experiencing an infant mortality rate 1.7 times higher than the state average.[255,256] Access to prenatal care also remains limited: about 22.8% of women in Texas receive inadequate prenatal care, and the state ranks 48th out of 52 jurisdictions on measures of adequate prenatal care.[257] Consistent with these gaps, one in three mothers in Texas is not seen by a physician during the first trimester, indicating significant access and coverage challenges despite the high share of births financed by Medicaid.[258]

IV. Uninsured but Eligible

Several policy factors help explain why many women in Texas remain "uninsured but eligible" under a broader Medicaid framework. Texas has implemented a 12-month Medicaid postpartum coverage extension but has not adopted full Medicaid expansion for low-income adults under the Affordable Care Act, leaving many women who would qualify under expansion ineligible for coverage outside of pregnancy.[259] According to March of Dimes policy tracking, Texas has implemented only two of six key maternal and infant health policy initiatives: the postpartum Medicaid extension and a maternal mortality review committee. The state has not

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[253] March, "Texas Receives D Grade in March of Dimes 2025 Report Card on Maternal and Infant Health," Prnewswire.com (Cision PR Newswire, November 17, 2025), https://www.prnewswire.com/news-releases/texas-receives-d-grade-in-march-of-dimes-2025-report-card-on-maternal-and-infant-health-302616201.html.

[254] Elizabeth Boggs et al., "Medicaid Expansion and Rural–Urban Disparities in Postpartum Medicaid Coverage," Public Health Reports®, February 3, 2026, https://doi.org/10.1177/00333549251403896.

[255] March, "Texas Receives D Grade in March of Dimes 2025 Report Card on Maternal and Infant Health," Prnewswire.com (Cision PR Newswire, November 17, 2025), https://www.prnewswire.com/news-releases/texas-receives-d-grade-in-march-of-dimes-2025-report-card-on-maternal-and-infant-health-302616201.html.

[256] "2022 March of Dimes Report Card for Texas," March of Dimes | PeriStats, n.d., https://www.marchofdimes.org/peristats/reports/texas/report-card.

[257] "US Preterm Birth Rates Highest in Texas Cities, Highlighting Maternal Health Crisis Nationwide," Clinical Advisor, December 3, 2025, https://www.clinicaladvisor.com/news/us-preterm-birth-rates-highest-texas-cities-maternal-health-crisis/.

[258] "Early Prenatal Care: Texas, 2021-2024 Average," March of Dimes | PeriStats, 2021, https://www.marchofdimes.org/peristats/data?reg=99&top=5&stop=21&lev=1&slev=4&obj=10&sreg=48.

[259] Amber Kite, "Texas Earns 'D' on March of Dimes Report as Infant Mortality Worsens," FOX 26 Houston, November 19, 2025, https://www.fox26houston.com/news/texas-earns-d-march-dimes-report-infant-mortality-worsens.

adopted Medicaid expansion, paid family leave, or Medicaid reimbursement for doulas.[260] As a result, many low-income women qualify for Medicaid during pregnancy, retain coverage through the postpartum extension, and then lose eligibility afterward, cycling back into uninsurance even though their incomes would likely qualify them under a Medicaid expansion framework.

V. Graphical Summary of Medicaid Coverage of Maternal Healthcare

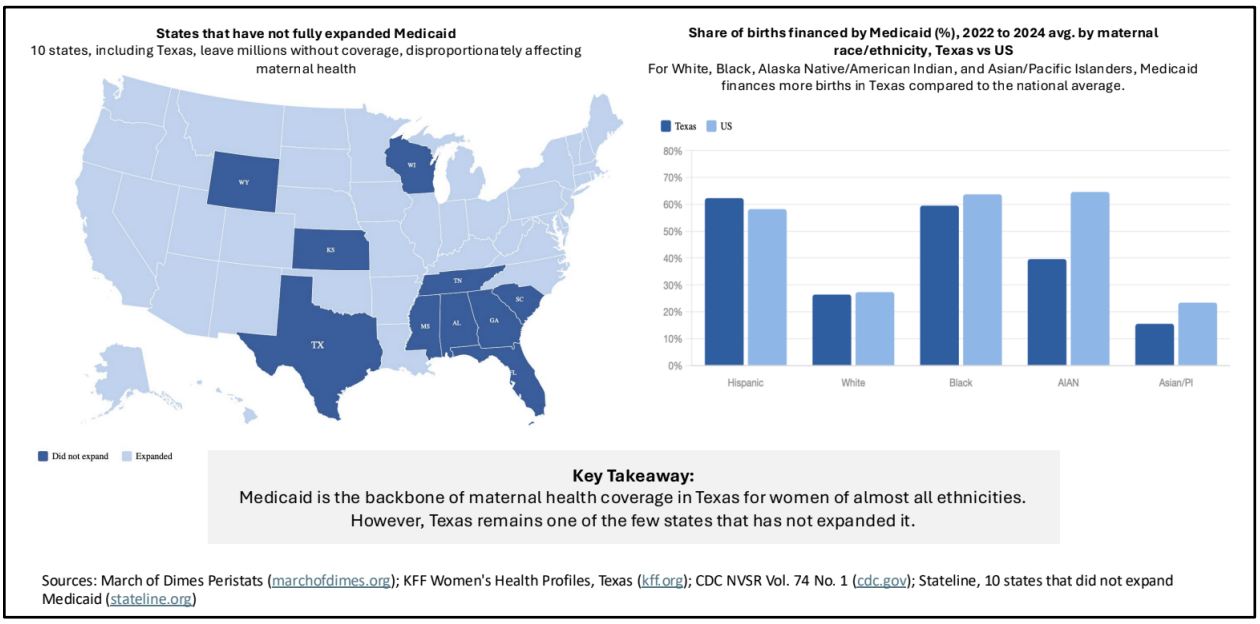


Figure 18: The Impacts of Limited Medicaid Expansion on Maternal Health Coverage

Policy Interventions for Medicaid Coverage of Maternal Healthcare

I. Automatic Medicaid Enrollment at Point of Care

The problem of accessing Medicaid related is translating eligibility into enrollment. Even though many individuals are enrolled in Medicaid, a significant number of eligible individuals do not get covered because of various reasons including complexity of the process and the time needed[261]. Such individuals may include pregnant women who do not always have contact with the health care system and therefore do not enroll in the system because they simply do not have time.

A possible solution to this issue is for the state to implement legislation mandating automatic eligibility testing and presumptive enrollment for Medicaid benefits in all healthcare facilities participating in the Medicaid program. Such legislation will ensure that hospitals, OB/GYN facilities, community health centers, and labor delivery rooms incorporate automatic eligibility, thereby ensuring that beneficiaries identified as presumptively eligible are immediately covered for 60-90 days by Medicaid benefits until completion of full enrollment.

In this proposed solution, presumptive eligibility rights would be extended not only to hospitals but also to outpatient facilities like OB/GYN clinics and other family practice clinics. Beneficiaries determined to be presumptively eligible would thus have their healthcare needs

[260] March of Dimes | PeriStats. "2025 March of Dimes Report Card for Texas," 2025. https://www.marchofdimes.org/peristats/reports/texas/report-card.
[261] Medicaid.gov, "Medicaid & CHIP Enrollment Data Highlights," 2025.

attended to immediately with Medicaid benefits for 60-90 days while the process of full enrollment proceeds.

The law will require states to allocate funding for the development of interoperable digital infrastructure which will enable providers to confirm the eligibility of their patients in real-time. Federal matching dollars can also be sought to fund electronic eligibility programs and personnel and training needs in addition to the other expenses, with opportunities for federal matching funds under existing Medicaid administrative provisions.[262] The implementation of such a law means that enrollment will be integrated into the delivery of healthcare, effectively solving the problem of the need for patients to individually engage with complicated systems.[263]

Overall, the impact of the proposed law will be considerable. To begin with, the number of eligible people without insurance coverage will be lowered, especially pregnant and postpartum women. Next, the continuity of care will be enhanced due to reduced coverage gaps prenatally and postpartum. Moreover, the burden on the shoulders of healthcare providers will be lessened because they will receive reimbursement for the services provided from the federal Medicaid program. Finally, improved access to care may lead to better results.

A. Case Study: Tennessee's TennCare

For states that have automatic enrollment for Medicaid, pregnant women have the ability to care for themselves and their pregnancy much more substantially. Consider Tennessee, which has implemented TennCare, a Presumptive Eligibility for Pregnant Women (PE-PW) program. Under this program, expectant mothers who would likely qualify for the Medicaid health insurance program are allowed to get prenatal health care services on a provisional basis without completing the whole application procedure first.[264] This program covers both prenatal care, such as physician visits for prenatal care, emergency room prenatal visits, prescription drugs related to pregnancy, and prenatal laboratory care, as well as non-prenatal related care, including dental care.[265] Coverage under this program spans from the day a pregnant woman is found eligible for PE-PW services until at least one year postpartum. A study performed on the effects of presumptive eligibility on the receipt of prenatal care and the occurrence of low-birthweight births and neonatal, perinatal, and infant mortality found that women who took advantage of presumptive eligibility were 30% more likely to obtain prenatal care in the first trimester, 300% more likely to fill a prescription for prenatal vitamins in the first trimester and 16% more likely to have begun prenatal care before the third trimester.[266]

II. Medicaid Reimbursement Reform AI-Supported Administrative Infrastructure

While explaining enrollment addresses demand-side barriers, access to care also depends on the availability of providers willing to accept Medicaid. Currently, low reimbursement rates and high administrative burdens discourage provider participation, particularly among OB/GYN

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[262] Centers for Medicare & Medicaid Services (CMS), "Federal Financial Participation for Medicaid Administrative Activities."

[263] Hughes, Mark T. "Meeting Patients Where They Are." AMA Journal of Ethics 15, no. 4 (2013): 293–98.

[264] "TennCare Presumptive Prenatal Medicaid Program | Shelby County Health Dept., TN." Www.shelbytnhealth.com, www.shelbytnhealth.com/266/TennCare-Presumptive-Prenatal-Medicaid-P.

[265] Providing Eligibility Assistance to Pregnant Women and Newborns Eligibility Assistance for Pregnant Women and Newborns: A Step-By-Step Guide for Hospitals and Birthing Centers.

[266] Piper, J M, et al. "Presumptive Eligibility for Pregnant Medicaid Enrollees: Its Effects on Prenatal Care and Perinatal Outcome." American Journal of Public Health, vol. 84, no. 10, Oct. 1994, pp. 1626–1630, https://doi.org/10.2105/ajph.84.10.1626. Accessed 28 May 2022.

specialists and in rural or underserved areas. This is especially concerning in states like Texas, where Medicaid finances nearly half of all births but access to prenatal care remains inadequate, with approximately 22.8% of women receiving insufficient prenatal care.[267]

In order to solve these problems, a two-policy method for policy reform should be developed and implemented, which would involve (1) Medicaid payment reform for maternity services and OB/GYN and (2) investments in AI-based revenue cycle management systems.

The first measure in the solution should be a reform of the payment policy of Medicaid that will provide for the introduction of minimum rates of payments for maternity services equal to those of Medicare. For instance, a legislative act should stipulate that providers receive 100% of Medicaid rates for OB/GYN or some percentage increase for prenatal, delivery, and post-delivery period or additional fees in case of high-risk pregnancy and/or meeting quality criteria such as early beginning of prenatal visits. The second solution should imply the development of a grant program of the state for financing the introduction of AI technologies for management within revenue cycles of Medicaid providers. It is worth noting that almost 50% of American hospitals already use these technologies, but there is an uneven implementation across different healthcare facilities.[268]

To address this disparity, the state could develop a shared RCM platform accessible to smaller providers, reducing the need for individual investment in costly systems. Grants and technical assistance programs would prioritize safety-net providers, rural hospitals, and independent OB/GYN practices. By improving the accuracy and efficiency of billing processes, these tools can reduce claim denials, accelerate reimbursements, and stabilize provider revenue streams.

The overall impact of higher reimbursement payments and more efficient administration would be the growth in physician participation within Medicaid, especially in rural regions. Increased reimbursements would ensure that it is economically beneficial for doctors to join the program, whereas lower administrative costs would ensure that it is administratively possible for doctors to do so.

III. Summary of Policy Recommendations for Maternal Medicaid Coverage in Texas

[267] March of Dimes, "2024 Maternal and Infant Health Report Card: Texas."

[268] Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Improving Access to Affordable and Equitable Health Coverage," 2024.

Problem	Policy Solution	Key Mechanism	Expected Impact
Eligible pregnant women don't get enrolled due to complex, time-consuming processes.	Automatic Medicaid enrollment at point of care.	Presumptive eligibility for up to 90 days at hospitals, OB/GYN clinics, and community health centers.	Fewer uninsured pregnant women, continuous prenatal & postpartum care, and reduced coverage gaps.
Providers avoid Medicaid due to low reimbursement rates and high administrative burden.	Medicaid reimbursement reform using AI-supported administrative infrastructure.	Match Medicare rates for maternity services and provide state grants for integration of AI-based revenue cycle management (RCM).	More OB/GYN participation (especially in rural areas), faster reimbursements, and stable provider revenue.

Key Takeaway:
Together, the policies of automatic Medicaid enrollment and point of care and AI-integrated Medicaid reimbursement reform address both demand-side and supply-side barriers.

Sources: Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid's Role in Financing Maternity Care," 2023, Centers for Disease Control and Prevention (CDC), "Maternal Mortality Rates in the United States," 2024, March of Dimes, "2024 Maternal and Infant Health Report Card: Texas"

Figure 18: Policy Interventions for Improving Medicaid in Texas

III. Expanding Access to Evidence-Based Group Prenatal Care Through Texas Medicaid's Existing CenteringPregnancy Benefit

Given that a substantial proportion of pregnancy-related deaths are linked to chronic medical conditions, policies and programs that aim to address prenatal health conditions provide the unique opportunity to reduce adverse maternal health outcomes through adequate care during gestation.

A. Background Research: Preconception and Prenatal Care

A substantial proportion of pregnancy-related deaths in the United States are linked to chronic medical conditions that are present before pregnancy (preconception) and inadequately managed during the pregnancy period (prenatal). Nationally, approximately 60-70% of pregnancy-related deaths are considered preventable, with missed opportunities in preconception and early prenatal care as significant contributing factors.[269]

Although these chronic conditions often originate in the preconception period, many opportunities to identify risk factors, improve disease management, and educate patients happen during prenatal care. Thus, strengthening access to comprehensive prenatal care is an essential pathway for reducing preventable maternal mortality.

B. Background: Centering Pregnancy - Maryland and South Carolina

Maryland provides an example of how states can expand beyond reimbursement alone and promote implementation of the CenteringPregnancy group prenatal care model. As of January 1, 2023, code 99078 pays an additional $50 per participant per visit for up to ten group prenatal care visits, acting as a financial incentive for providers.[270]

[269] Centers for Disease Control and Prevention, "Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees," CDC, 2022.
[270] Maryland Department of Health, *CenteringPregnancy Policy and Billing Guidance* (Baltimore: MDH, 2023).

Maryland's guidance also clarifies the scope of these group sessions, covering both medical and non-medical aspects of pregnancy, including nutrition, stress management, labor and birth, breastfeeding, and infant care. This holistic, education-intensive program meets the need where ordinary, short visits fail to meet the needs of mothers.[271] In January 2024, the Maryland Department of Health also announced a $278,500 grant to expand CenteringPregnancy sites through June 2026, suggesting value in the investment into additional areas of need.[272] While data is not available for pre- and post-CenteringPregnancy outcomes in Maryland, South Carolina—another state to invest in CenteringPregnancy—found clear success.[273] CenteringPregnancy participation was associated with a 36% reduction in premature birth risk, lower prevalence of low-birthweight and NICU use, and an estimated $2.3 million return after a $1.7 million state investment.[274] This data supports the effectiveness of evidence based prenatal education and indicates the potential to provide meaningful Medicaid savings if this model in Texas is further optimized in its implementation.

C. Recommendation for Texas: Implementation Strategy

Texas Medicaid already reimburses group clinical visits for pregnancy using procedure code 99078 with modifier TH, allowing providers to bill for group prenatal care services in addition to standard individual prenatal evaluation and management visits. Therefore, the primary gap is not coverage of the group prenatal care model but a lack of statewide implementation strategy that pushes more providers, organizations, and clinics to actually use the benefits at scale. Texas should leverage this existing billing pathway by targeting implementation efforts toward counties with poor prenatal care access, low rates of first-trimester care, and elevated burdens of chronic disease. Specifically, the Texas Legislature should direct the Health and Human Services Commission (HHSC) to expand uptake of Texas Medicaid's existing group prenatal care benefit by creating a strategy for implementing evidence-based group prenatal care for regions with high risk patients. High risk patients include those which have comorbidities associated with adverse maternal health outcomes including hypertension or diabetes. Potential implementation strategies include:

1. Using start-up funds or other grant sources for training, staffing, and scheduling support for providers in high-need counties.
2. Requiring Medicaid-managed care groups, or groups where patients receive care with Medicaid funding support to identify pregnancy members who would benefit from group care (i.e., at-risk populations) and refer them early. Texas might consider developing a risk guide standardized across hospital systems and clinics, incorporating both risk and disparities. For example, using geographic data in addition to information about diagnoses or comorbidities in risk assessment.

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[271] Ibid.

[272] *Maryland Department of Health Announces Nearly $278,500 in Grants to Expand CenteringPregnancy Sites*. Maryland Department of Health, 23 Jan. 2024, health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-announces-nearly-$278,500-in-grants-to-expand-CenteringPregnancy-sites.aspx.

[273] Maryland Department of Health, "Maryland Department of Health Announces Nearly $278,500 in Grants to Expand CenteringPregnancy Sites," January 2024.

[274] Melissa B. Gareau et al., "Group preconception Care Results in Medicaid Savings with Better Outcomes: A Propensity Score Analysis of CenteringPregnancy Participation in South Carolina," *Maternal and Child Health Journal* 20, no. 7 (2016): 1384–93.

IV. Use HB 1575's screening and case-management structure to require a standardized early-pregnancy education and navigation route for Medicaid beneficiaries.

A. Recommendation:

Texas should require the Texas Health and Human Services Commission and Medicaid-managed organizations to implement a standardized education and care navigation protocol for the first prenatal encounter or initial case management contact.[275] This builds on the existing legislative and administrative elements, as HB 1575 directs HHSC to implement standardized screening for nonmedical health-related needs among pregnant women and expands access to case management services.[276] Nevertheless, Texas policy does not currently require a uniform education and referral pathway for early pregnancy encounters. Implementation of Medicaid provider manual mandates is inconsistent across providers, which can contribute to variation in patients' receiving necessary information and access to support services. [277]

B. Case Study: Maryland's EMPOWER Moms

Maryland's EMPOWER Moms initiative is a replicable model for integrating education into maternal health. As part of Maryland's Maternal Health Innovation Program, EMPOWER provides structured training and educational materials focused on warning signs and patient self-advocacy.[278] The program has multiple training sessions, multilingual educational materials, and patient-facing resources, which equip both providers and patients with the background and skills to recognize and respond to complications.[279]

C. Applicability to Texas: Standardizing Education and Care Navigation

Texas can adapt Maryland's EMPOWER model by requiring that all Medicaid-covered pregnancy visits include:

- A standardized maternal warning signs and self-advocacy education module
- Screening-based referrals to case management, doulas, or community health workers embedded in the written policy.
- Integration of education delivery between clinical visits and case management encounters.

Thus, implementation would leverage existing Medicaid funding streams and provider types, minimizing administrative burden and improving continuity of care.

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[275] Texas Legislature, *House Bill 1575*, 88th Leg., R.S. (2023).

[276] Centers for Medicare & Medicaid Services (CMS), "Texas State Plan Amendment (SPA) 24-0006," approved November 2024.

[277] Texas Medicaid & Healthcare Partnership (TMHP), *Provider Procedures Manual*.

[278] Maryland Maternal Health Innovation Program (MDMOM), "EMPOWER Moms Initiative Overview," University of Maryland School of Medicine.

[279] Ibid.