



Market Report

From SDoH Data to Maternal Health Action

A Health Equity Maturity Path for Health Plans and Their Members



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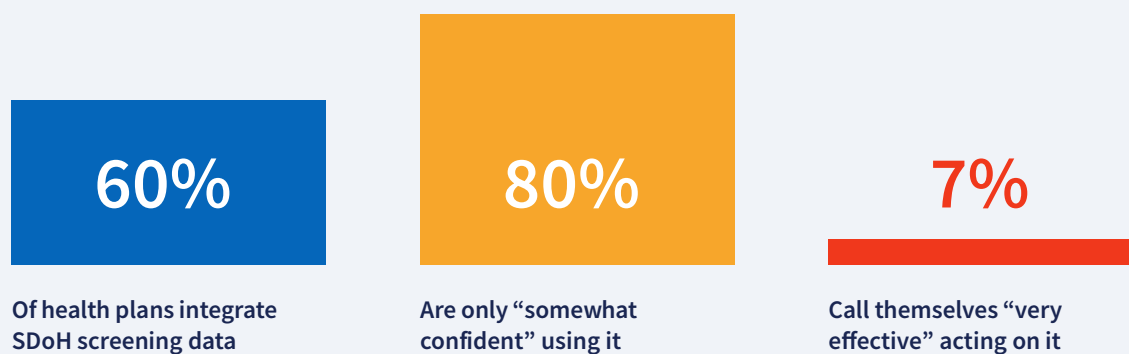
Executive Summary

Three Findings and Three Pivots: A Path to SDoH Operational Maturity

The first two reports in Sage Growth Partners' maternal health series revealed the [potential coverage cliff for mothers facing Medicaid redeterminations](#) and the [communication chasm between health plans and the new moms who are their members](#). The final report in our series reveals the fragile foundation that is the root cause of up to 80% of healthcare outcomes: the Social Drivers of Health (SDoH).

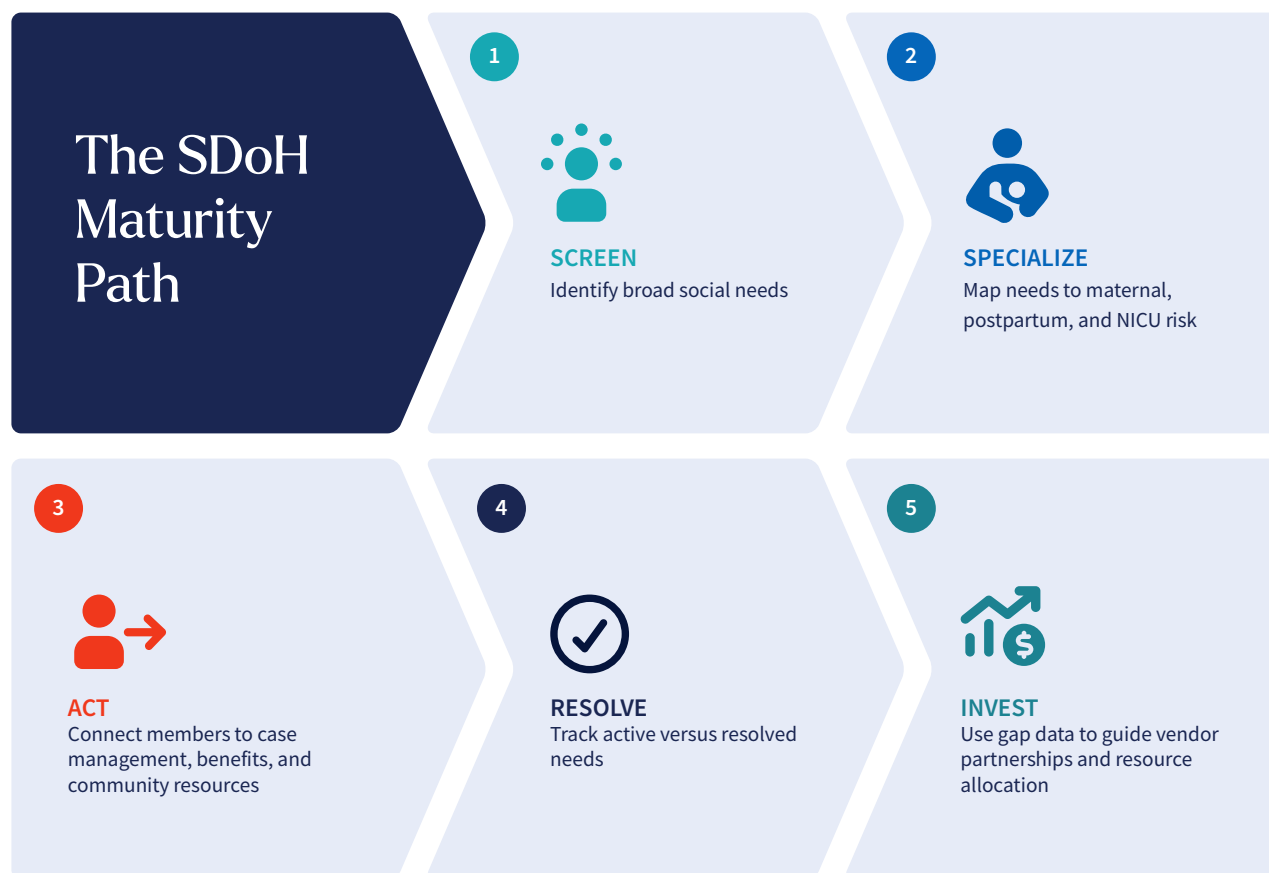
SDoH is no longer an emerging concept. Health plans know that transportation, housing, food insecurity, behavioral health, language, geography, and other health-related social needs shape maternal and infant outcomes. Yet when it comes to data, collection outpaces confidence. While 60% of health plans now integrate SDoH screening data into their programs, only 80% describe themselves as "somewhat confident" using it, and just 7% consider themselves "very effective" at turning that data into action.

The Gap: SDoH Data Collection Outpaces Confidence



These and other gaps mandate a shift from survey findings to operational pivots: activating non-clinical health data to guide case management, resource allocation, and investment. The solution? An SDoH Maturity Path that: begins with national alignment on non-clinical drivers; evolves to include more granular, population-specific factors; embeds resolution tracking of resource barriers; and allocates resources based on insight.

Health plans have the opportunity to embark on the five-step path to SDoH maturity by identifying needs among pregnant and postpartum women and mapping those to related risks, then connecting members to appropriate resources. From there, health plans can track what works and what doesn't, and leverage data about SDoH gaps in care to inform strategic decision-making.



Differing Terms, Common Challenge

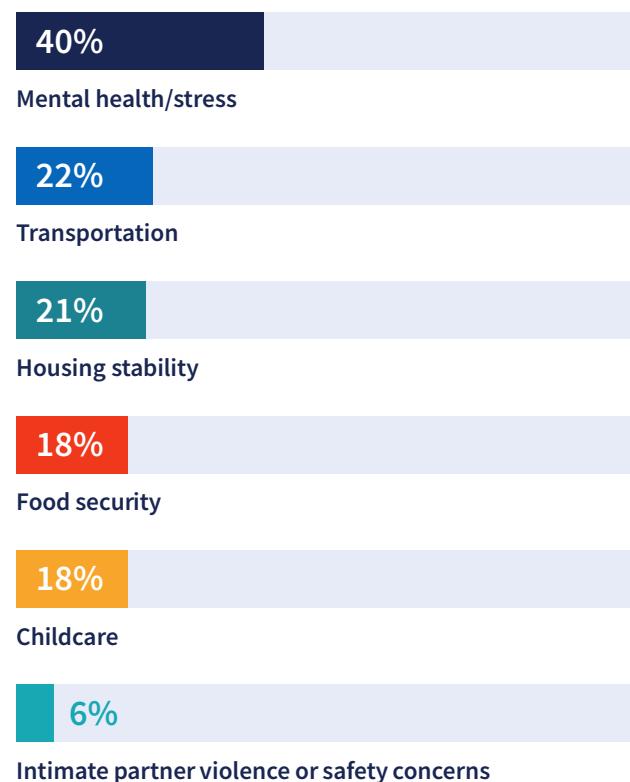
Depending on the market, line of business, or state environment, health plans may use different terms for the social drivers of health that impact health equity and contribute to healthcare disparities. These terms include health-related social needs, non-clinical drivers, social needs, and resource barriers, but the operational challenge is the same: connecting members to effective resources, measuring whether those needs are resolved, and connecting SDoH to other vital outcomes.

The Findings

What Mothers Say They Need

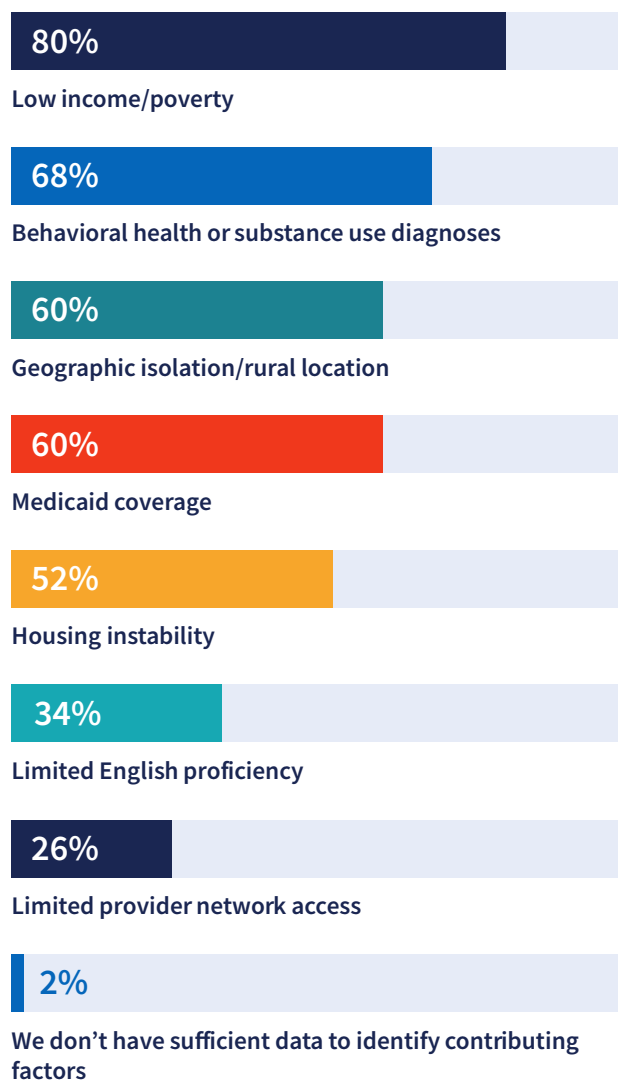
The women and caregivers we surveyed are clear on their challenges during and after pregnancy: 40% point to mental health and stress, more than 20% to transportation and housing stability, and 18% to food security.

Did you/the mother face challenges related to any of the following during pregnancy, postpartum or during a NICU stay?



For their part, health plan leaders named a combination of social, clinical, and coverage factors that contribute to outcome disparities for mothers and their babies.

Which social/structural factors contribute most to maternal/infant outcome disparities for your members?



The First Pivot

Map Broad Social Needs to Identified Risks

The first two steps of the SDoH Maturity Path include screening to identify broad social needs, then mapping those needs to maternal, postpartum, and NICU risks.



[The U.S. federal government's Healthy People 2030](#) (HP2030) offers a valuable national framework for understanding health equity and defines SDoH across five domains: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. In addition, HP2030 emphasizes creating environments that promote full health potential; identifies specific maternal-health targets that health plans already track today; and promotes the use of accurate, timely, and accessible data to drive targeted action.

National frameworks provide a foundation, not a finish line

Maternal and infant health programs also require a more specialized lens. A pregnant member's barriers often overlap in ways that are clinically urgent and operationally actionable: transportation affects prenatal access; digital access affects engagement; food insecurity affects pregnancy health; behavioral health and substance use needs affect both parent and infant outcomes; and cultural or language needs shape trust, navigation, and follow-through.

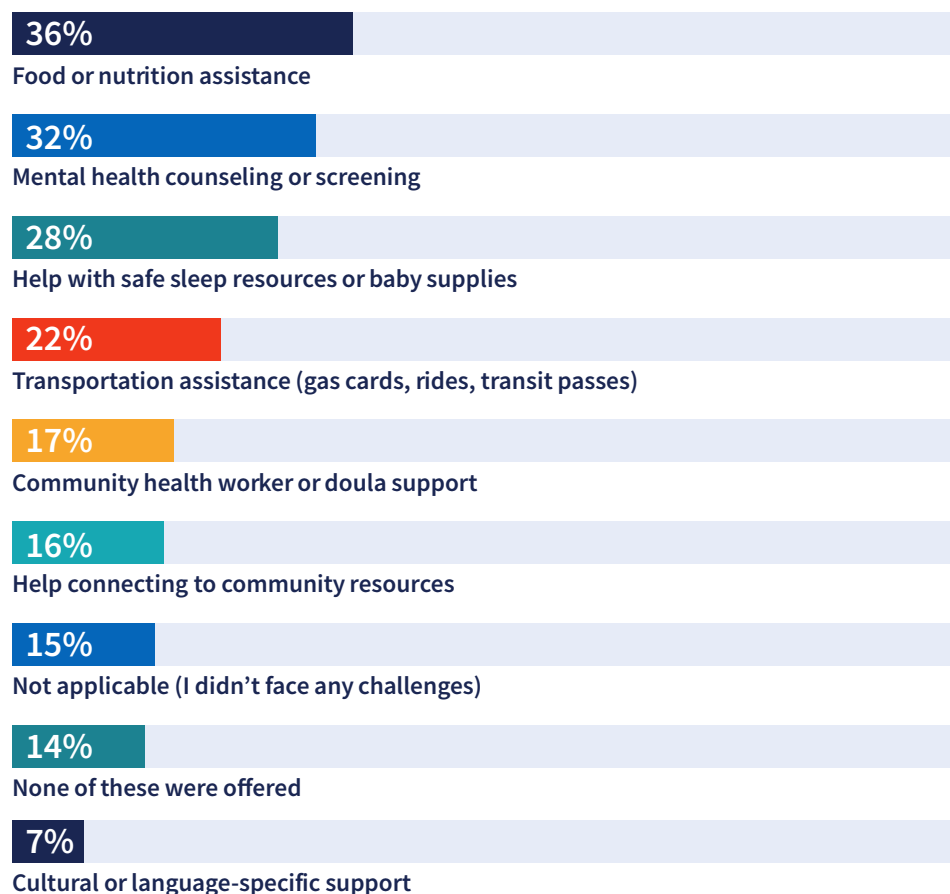
The best-positioned health plans will push HP2030's national framework further to include details that are most relevant to the served population while directing resources more precisely.

The Findings

What Mothers and Their Babies Actually Receive

Operational maturity in health plan equity strategy should include what members are asking for, whether non-clinical needs are being resolved, where resource gaps exist, and whether member-level detail is available. Health plans have been working hard to invest in benefits that could better support their pregnant members, but have not been as effective in promoting/connecting them to members to address gaps. Take mental health counseling/screening. Women named this their greatest challenge during pregnancy, postpartum, and NICU stays, but only 32% reported receiving this support.

What maternal support services did your health plan offer to you?



Closing these gaps — including the lack of community health worker/doula support and community resources — starts with a strategy that health plans already favor: targeted case management for high-risk groups.

The Second Pivot

Connect Mothers to Targeted Case Management with Follow-Through

Connecting members to case management, benefits, and community resources is the next step of the SDoH Maturity Path.



Targeted outreach strengthened by digital resources can bridge healthcare’s most critical gaps, and none are more critical than those experienced by mothers and newborns at risk. Health plans ranked targeted care management as their top intervention (80%) to reduce maternal health disparities, followed by transportation and food security support, funding community-based organizations, financial incentives for equity-focused outcomes, and bias/cultural competency training for providers.

Health plan interventions to reduce maternal health disparities



Case management is not a solely digital endeavor. The differentiator is a human-led, technology-enabled model that identifies risks early, keeps members engaged, connects families to the right clinical and community resources, and tracks whether social needs are actually resolved. The latter is a powerful pivot for health plan leaders to make.

Resolution tracking is vital

Health plans may know which social needs exist, but many still lack a reliable operating model for determining which needs are active, which are resolved, which community or vendor resources are working, and where additional investment is needed.

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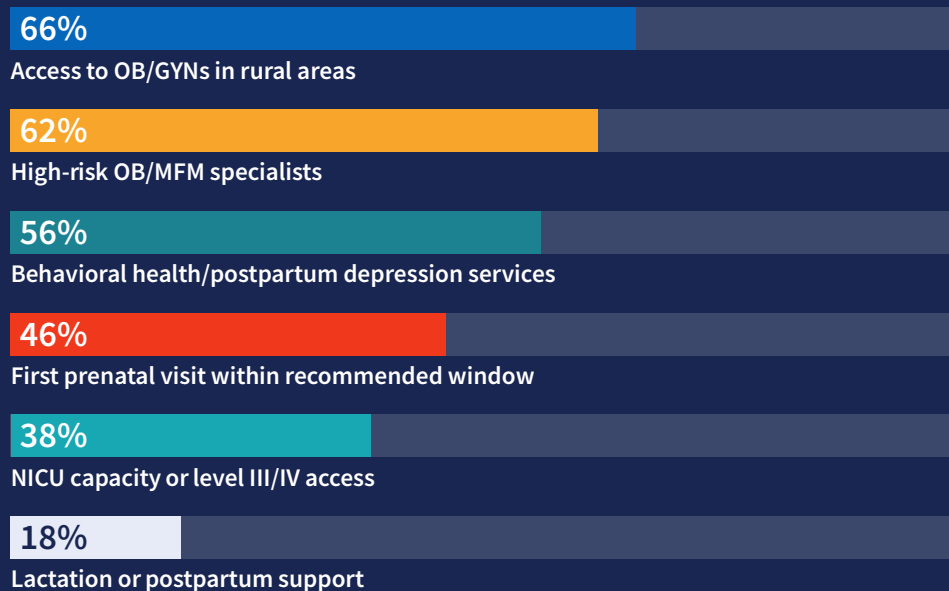
RESOLVE

Track active versus resolved needs

Resolution tracking is the true case management value story: supporting the cost and quality outcomes that health plans need and the continuity, coordination, and human connection that moms and their newborns deserve.

Further, striving for SDoH maturity is more critical than ever given the prevalence of significant gaps in access to care today, notably for women who live in rural areas, women who need specialists for high-risk pregnancies, and women who seek behavioral health and postpartum depression services.

Most significant access gaps today?



The Findings

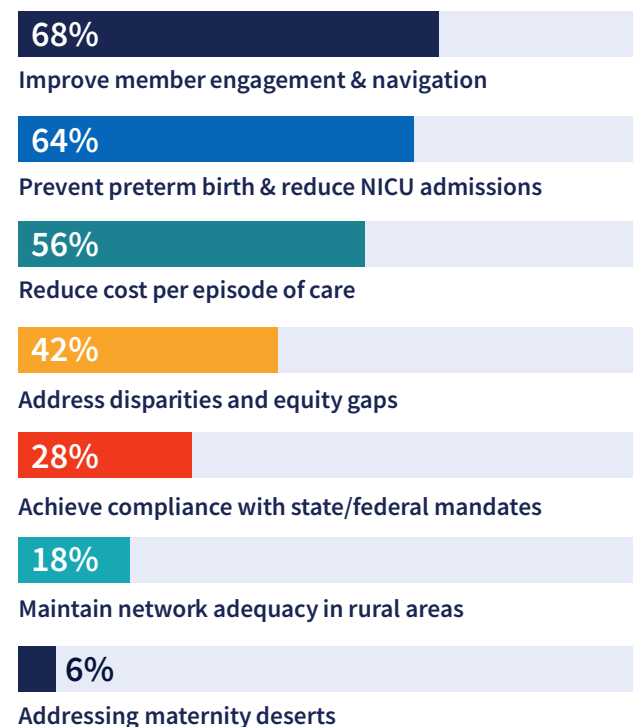
Health Equity Data Doesn't Equate to Health Equity Investment

While 42% of payers ranked addressing disparities and equity gaps as a *leading maternal/NICU strategy* over the next two years, only 12% of health plans ranked health equity with dedicated resources as a *top strategic priority overall*.

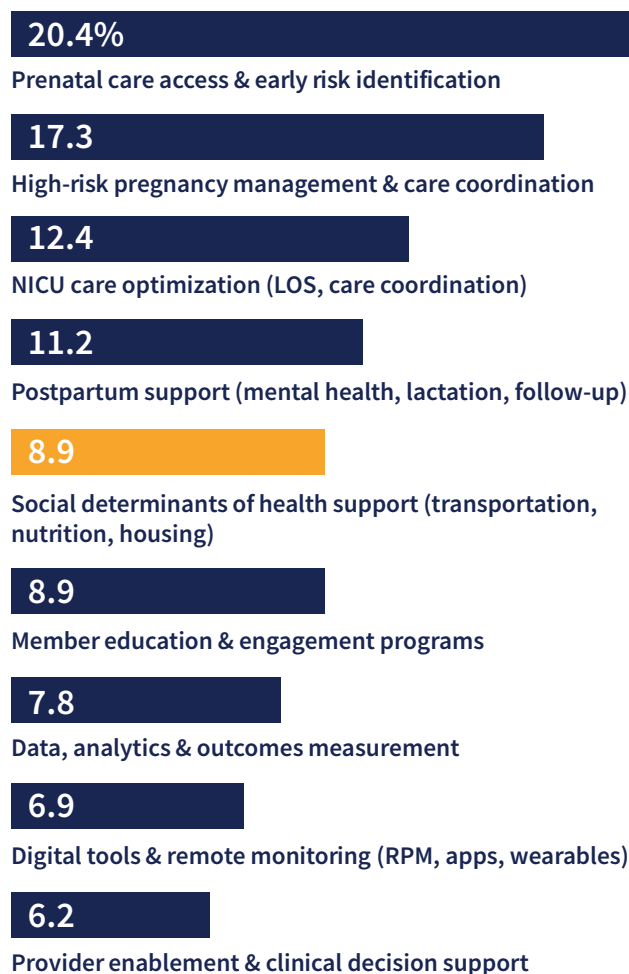
In addition, when health plan leaders were asked to allocate 100 points across nine maternal and NICU care priorities, SDoH received just 8.9 points. This is despite the fact that 54% of health plans believe that health equity is likely to worsen as Medicaid redeterminations continue (noted in our first report).

These are difficult realities for health plan leaders who told us for the second report that if money were no object they would invest now in comprehensive upstream maternal-NICU programs. Such programs would address non-clinical and SDoH barriers, but clearly are not among health plan priorities.

What are your top priorities for your plan's maternal/NICU strategy in the next 24 months?

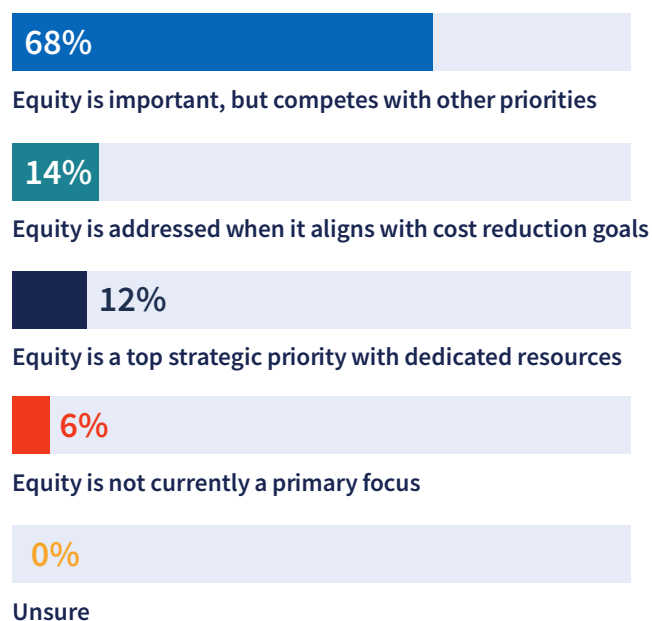


How would you allot 100 points across these maternal/NICU initiatives?

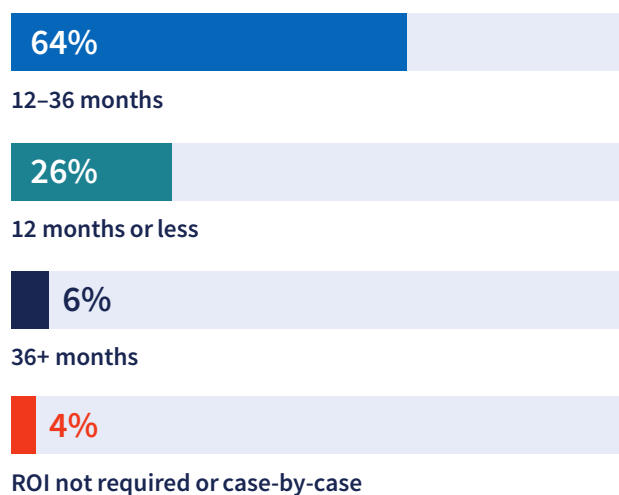


The working assumption is that improving healthcare disparities and addressing the non-clinical drivers of health takes longer to achieve, with harder-to-prove ROI. But the survey responses complicate that assumption. While 26% of health plans required ROI within 12 months, 64% were comfortable with a 12-to-36-month horizon. This reveals a larger, unresolved debate: Should health equity and the investment/ROI attached to it be treated as a separate goal or embedded with the cost and quality objectives with which they often compete?

Which statement best describes your organization's approach to equity in maternal/NICU programs?



When evaluating programs, what ROI time horizon do you require most often?



The Third Pivot

Fund Actions That Resolve Needs

This report has surfaced three paradoxes. Health plans collect SDoH data but don't act on it confidently or effectively. They often fund the consequences of these non-clinical drivers rather than addressing upstream root causes. And their ROI timelines could support initiatives that begin to address upstream SDoH challenges, yet equity investment still lags.

Every health plan we surveyed (100%) reported facing some degree of financial pressure in their maternal/NICU care programs. SDoH investment is often difficult to prioritize when framed as a separate initiative. Using gap data to guide vendor partnerships and resource allocation is the final step of the SDoH Maturity Path.

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INVEST

Use gap data to guide vendor partnerships and resource allocation

The most useful SDoH intelligence does more than identify barriers. It helps health plans see where existing resources are working, where members are still falling through gaps, and where new partnerships or benefit design changes may be needed. For example, if food insecurity needs resolve at higher rates when a meal-support partner is available, that finding should inform future contracting, benefit design, and resource planning. If transportation or childcare barriers remain unresolved, those gaps should be treated as program-design issues rather than isolated member challenges.

When SDoH intelligence is embedded with the maternal health journey, it can help plans focus resources where they are most likely to improve access, reduce avoidable escalation, support quality goals, and strengthen member experience.

What Health Plans Can Do Now

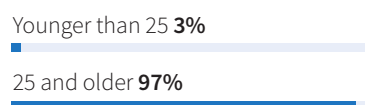
- 1. Move from broad SDoH screening to maternal-infant-specific risk intelligence.** Use Healthy People 2030 as a foundation, then add factors that matter for pregnancy, postpartum recovery, NICU transitions, behavioral health, digital access, and family stability.
- 2. Track resolution, not just identification.** Shift from simply recognizing a resource barrier to clearly identifying which needs are active, which have been resolved, and where gaps remain.
- 3. Use SDoH data to guide resource investment.** Allocate budget toward support and partnerships that close the most common or persistent gaps.
- 4. Embed equity into quality and cost strategies.** Treat health-related social needs as part of access, engagement, utilization management, HEDIS performance, member experience, and outcomes, not as a separate initiative.
- 5. Make the story usable for multiple audiences.** Translate the insights from non-clinical drivers of health into operational dashboards for care teams, investment decisions for executives, and value stories for states, employers, and other stakeholders.

Survey Methodology

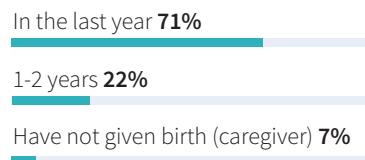
In Q1 2026, Sage Growth Partners independently surveyed consumers and payer leaders on the topic of Maternal and NICU care. Consumer respondents included 300 recently pregnant women as well as their caregivers. Health plan respondents included 50 leaders at the Director-level and above, including C-suite executives with a range of responsibilities related to Maternal and NICU care, including Care Management, Case Management, and Population Health & Quality. The health plan respondents were representative of the market. Approximately 75% of these organizations were either National or Regional plans with more than 250K covered lives and offering multiple lines of business.

Survey Demographics

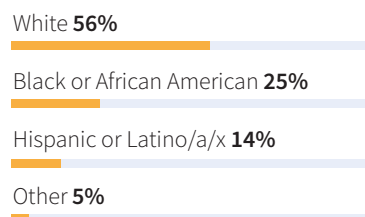
Consumer Age



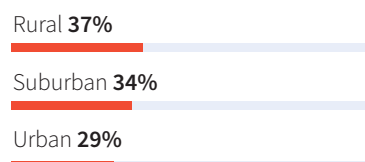
How Recently Given Birth



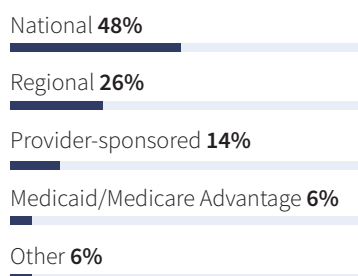
Race/Ethnicity



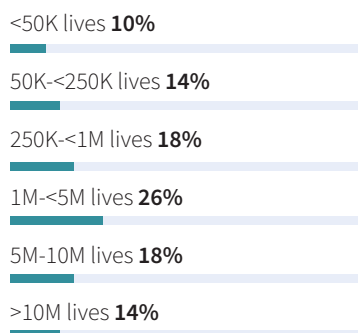
Place of Residence



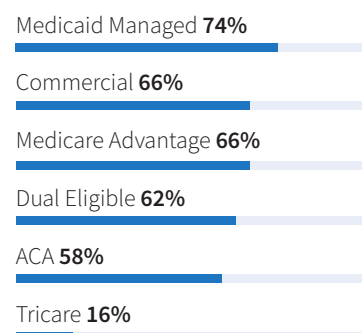
Type of Health Plan



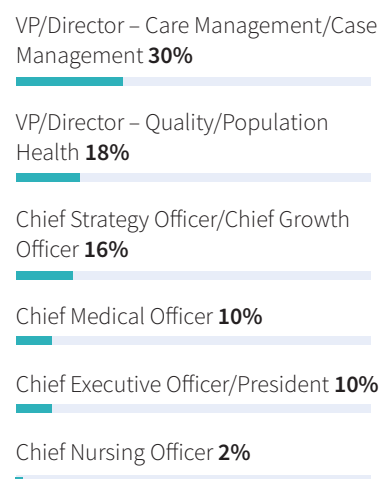
Total Lives Covered



Types of Plans Offered



Title





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