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Celebrating 60 Years of Medicaid: Driving Access and Innovation in Maternal Health

History

Medicaid Program and Maternal Health

When Medicaid was first enacted in 1965, pregnant women were not explicitly covered. Rather, Medicaid coverage was historically targeted to low-income families with dependent children, low-income older adults, and low-income individuals with disabilities. It was not until the Deficit Reduction Act of 1984 was introduced that lawmakers expanded Medicaid coverage to include pregnant women. The expansion aimed to provide Medicaid to women who were eligible for Aid to Families with Dependent Children (AFDC) (now referred to as TANF) in cases where a child is born to a single parent household, or to a family where one parent was unemployed.

Coverage slowly evolved through initiatives like the Omnibus Budget Reconciliation Act of 1989, which required states to provide Medicaid coverage for all pregnant women whose family income were at or below 133% FPL, and the Omnibus Reconciliation Act of 1990, which required states to provide continuous coverage for all pregnant women through the 60-day postpartum period.[i]

The American Rescue Plan Act (ARPA) of 2021 provided states with the option to extend postpartum coverage from 60 days to 12 months for a time-limited period of

five years. In doing so, states must provide pregnant and postpartum individuals with full Medicaid benefits. The Consolidated Appropriations Act of 2023 furthered this option, with 48 states implementing 12-month continuous coverage on a permanent basis[ii]. As of 2023, pregnant individuals and their children are a significant population covered by the Medicaid program, with 41% of births nationally and nearly half of births in rural areas being paid for by Medicaid.[iii]

Current State of Maternal Health Coverage

As Medicaid leaders continue to innovate around maternal healthcare coverage, states are implementing policies and programs to improve maternity care and outcomes and ensure access for those who depend on Medicaid.

The Transforming Maternal Health Model

In January 2025, the Center for Medicare & Medicaid Services (CMS) announced that 15 states were chosen to participate in their Transforming Maternal Health (TMaH) Model. The model envisions a multipronged, holistic approach to the prenatal, perinatal, and postpartum stages that reduces program expenditures while improving both access to care and outcomes for both mothers and their children. Participating states are encouraged to develop a value-based payment system and extend postpartum coverage to 12 months, if they have not done so already.

Through this decade-long initiative, states will be expected to leverage community-based providers and managed care organizations (MCOs) to implement customized evidence-based care delivery and to augment their data collection methods.[iv]

Advancing Maternal Health Through Culturally Competent Care

Increased investment and training around culturally competent maternal healthcare is needed. Studies show that women of color are at greater risk for maternal health complications and increased infant mortality, with black women being three to four times as likely of dying from a pregnancy related complication compared to white women.[v]

Culturally competent care is important as healthcare providers are able to understand and connect with an individual's background and culture and successfully create an inclusive environment where beneficiaries feel comfortable.

Doula care has become a key preventative culturally competent care intervention that states have used to address maternal mortality and morbidity. Doulas are tasked with providing comprehensive educational, physical, and emotional support throughout the pregnancy cycle.[vi] Expectant mothers who utilize doula services have seen increased rates of self-efficacy, increased breastfeeding rates, higher APGAR scores, and lower rates of birth complications and low birth weight (LBW) issues.[vii]

As of May 2025, 23 states' Medicaid programs are actively reimbursing doula services; 7 are currently in the process of implementing reimbursement processes, and 16 have proposed action.[viii]

Postpartum Initiatives

In 2016, CMS released a bulletin on payment methodologies states can use to improve access to long-acting reversible contraception (LARC).[ix] LARCs serve as an important tool to ensure proper birth spacing, or inter-pregnancy interval. LARCs like intrauterine devices (IUDs) have a far lower failure rate compared to other forms of

contraception.[x] As of November 2023, forty-five states across the US and DC have implemented reimbursement of LARC under the Medicaid program, with most states utilizing an unbundled method with separate payments for the device and insertion.[xi]

In a study analyzing Medicaid reimbursement of postpartum LARCs, researchers found that across 15 states, 86.83% of Medicaid recipients studied saw an increased use of immediate postpartum LARCs due to changes in payment methodology.[xii]

In addition to LARCs and doula care, states have also begun offering Medicaid enrollees educational services and product reimbursement, with Colorado, Connecticut, Illinois, Missouri, Nebraska, New Hampshire, New Mexico, and Tennessee recently adding breastfeeding and lactation support to their benefits.[xiii] For example, in January, Nebraska started its Prenatal Plus Program (PPP), which allows reimbursement of certain counseling services for at-risk mothers, such as nutritional, psychosocial, general patient education and health promotion, targeted case management, and breastfeeding support to reduce the incidence of adverse birth outcomes and improve a mother's quality of life.[xiv]

Appropriate access to diapers is another key issue related to postpartum care. In 2023, 66% of households earning ≤200% FPL reported experiencing diaper need.[xv] On average, diapers can cost families about $1,000 per year[xvi]. In August 2024, Tennessee launched its diaper benefit under its section 1115 waiver demonstration, under which TennCare and CoverKids will provide up to 100 diapers per month for enrolled children under the age of two.[xvii]

Future Directions and Outlook

Budget Reconciliation

On July 4, 2025, President Trump signed H.R.1, the "One Big Beautiful Bill Act" (OBBBA, or the Act), into law. The Act includes several provisions that could impact maternal health.

Non-Profit Health Clinics

The Act institutes a 1-year federal funding ban to community-based reproductive health non-profit clinics that have received $800K in FY2023, if they provide abortions in cases other than health, rape, or incest.[xviii] (*Note: as of July 29, 2025, implementation of this provision has been blocked by a federal judge.)*

Planned Parenthood is among the non-profit entities that risk closure. With over 600 clinics spanning across the US, Planned Parenthood serves over 2 million people a year.[xix] Currently, 64% of Planned Parenthood clinics are located in rural, medically underserved areas or areas experiencing shortages for healthcare professionals. In 2024 alone, the organization provided reproductive health services to more than 1 million people, including pregnancy tests, preventative care visits, prenatal care, and miscarriage services. Abortion services account for 4% of the services they provide.[xx]

Studies have shown that one in three women ages 18–64 has received some type of healthcare services at Planned Parenthood, 43% of whom are on Medicaid. Approximately 47% of Medicaid beneficiaries have received gynecological services and pregnancy tests from Planned Parenthood clinics at some point in their lives.[xxi]

Changes to Medicaid Eligibility

The Act also included a provision that changed the definition of "qualified alien" to include only lawful permanent residents (LPR), those residing in the US through Compacts of Free Association (CoFA), or eligible Cuban and Haitian immigrants.[xxii]

Coverage for refugees, asylum seekers, and humanitarian parolees will be no longer be considered qualified aliens beginning October 1, 2026.[xxiii] This narrowing of eligibility requirements has the potential to increase burden on emergency departments and lead to higher uncompensated care costs to states, as affected individuals will begin to seek care only when their conditions worsen, instead of utilizing cost-effective preventative care measures.[xxiv]

The Act also removes the ability for states to claim enhanced FMAP for emergency Medicaid for undocumented individuals who would otherwise be included in the state's Medicaid expansion.[xxv] As emergency Medicaid can be a key funding mechanism for labor and delivery for undocumented pregnant women, this change could restrain state financial resources when it comes to caring for this population.[xxvi]

While Medicaid coverage for maternal healthcare has grown significantly over Medicaid's sixty-year history, states and their federal partners can innovate and improve the scope and quality of care provided to this vulnerable population. Sellers Dorsey is committed to tracking developments in this space, sharing new insights and analysis, and assisting clients in navigating the evolving policy environment to provide the best care to pregnant women and mothers.

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[ii] Medicaid Postpartum Coverage Extension Tracker | KFF
[iii] *ibid*
[iv] Transforming Maternal Health (TMaH) Model | CMS
[v] Reducing Disparities in Severe Maternal Morbidity and Mortality - PMC
[vi] State Medicaid Approaches to Doula Service Benefits - NASHP
[vii] Impact of Doulas on Healthy Birth Outcomes - PMC ; 310155a8-fe98-406e-949b-aa6ad9f67fee
[viii] Doula Medicaid Reimbursement Rates by State – Center For Children and Families
[ix] DEPARTMENT OF HEALTH & HUMAN SERVICES
[x] Contraception and Birth Control Methods | Contraception | CDC
[xi] Medicaid Reimbursement for Postpartum LARC | ACOG
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[xiii] Medicaid Budget Survey 2024-2025 - Benefits | KFF
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